

Spring 2018

אמהות ותינוקות: The Adaptation of a Prenatal Postpartum Depression Intervention for Orthodox Jewish Women

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Recommended Citation

Klein, Samantha L., "אמהות ותינוקות: The Adaptation of a Prenatal Postpartum Depression Intervention for Orthodox Jewish Women" (2018). *Senior Projects Spring 2018*. 270.
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אמהות ותינוקות:

The Adaptation of a Prenatal Postpartum Depression Intervention for Orthodox Jewish Women

Senior Project submitted to
The Division of Science, Mathematics, and Computing
of Bard College

By
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Annandale-on-Hudson, New York

May 2018

Acknowledgements

First, thank you to my primary advisor, Professor Sarah Dunphy-Lelii for helping me turn an interest into a feasible future endeavor. Thank you for answering any (and all) questions (no matter how outrageous or panicked). Most importantly, thank you for always pushing me to do my best work; I am a better student and scientific consumer because of it.

Thank you to Professor Deirdre d'Albertis for acting as a second advisor, and helping me incorporate gender & sexuality studies into my project-- I could not have gotten through these four years without your academic guidance! Thank you to Professor Stuart Levine for sitting on my boards and providing helpful feedback. Thank you to the entire psychology department for consistently positive classroom and lab experiences.

Thank you to Miroslav Skular for your endless patience helping me learn to code in R statistics. Thank you to Marika Krupitsky for being able to share a space with me during the final weeks of senior project, and reading over any emails I sent while I was applying to graduate school when you 'had a sec'. Thank you to Dr. Dunphy-Lelii's other senior project advisees, and my psychology cohort: I'm so happy to have had you guys on this journey. Thank you to my friends, who have made my time at Bard everything I could have dreamed of— and more. Lastly (but definitely not least), this college experience has been sponsored by my wonderful parents— words cannot describe how thankful to you I am.

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Abstract

Postpartum depression affects 10-15% of the Western population, and even larger numbers in specific cultural groups. Certain factors of Orthodox Jewish culture place Orthodox Jewish women at risk for developing perinatal depression. There are two main schools of psychotherapeutic treatment for perinatal depression: interpersonal therapy, and cognitive-behavioral therapy (CBT). This study proposal is concerned with the adaptation of the Mothers and Babies Course (MBC), a cognitive-behavioral therapy, for an Orthodox Jewish population. 705 participants will be stratified randomly placed in either the MBC, an Interpersonal Therapy intervention, or on a waitlist. I predict that the MBC will not only be an effective form of perinatal depression intervention, but it will also be more effective than Interpersonal Therapy because of the nature of Orthodox Jewish culture. I predict that mothers in the MBC intervention will have a higher number post-treatment of securely attached infants than those in the other two groups. I will also be using the data collected to determine the distribution of attachment styles among the Orthodox Jewish population.

Keywords: Postpartum depression, cognitive-behavioral therapy, interpersonal therapy, Orthodox Jewish

Postpartum depression is located in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) under Major Depressive Disorder (American Psychiatric Association, 2013). It is a separate diagnosis from “baby” blues or “perinatal bereavement” (Zauderer, 2012). While many women (40-85% in Western countries) experience baby blues, postpartum depression (PPD) is seen in 10-15% of women, and is characterized by symptoms similar to Major Depressive Disorder (MDD) (Rai et al., 2015). Baby blues will often last approximately 10 days following birth and symptoms peak between 3-5 days postpartum, whereas persisting baby blues may be an indicator of postpartum depression (Rai et al., 2015). The difference between PPD and MDD is that negative thoughts and feelings are often about the newborn, and the onset of PPD occurs in the perinatal period. These thoughts and feelings can occur during pregnancy or in the year that follows birth.

Symptoms of postpartum depression can include mood swings, rumination (especially in relationship to the infant), and delusional thoughts (particularly relating to harming the infant or putting the infant in danger) (Rai et al., 2015). Symptoms of major depressive disorder that are also found in postpartum depression include depressed mood, insomnia/hypersomnia, lack of pleasure in usual activities, fatigue, lack of concentration, and recurring thoughts of death or suicide (American Psychiatric Association, 2013). These symptoms are specific to a perinatal onset when in reference to postpartum depression.

Despite the apparent need for treatments, research is only beginning to cover culturally appropriate treatments (Muñoz et al., 2007; Le et al, 2011, Tandon et al., 2014). Unlike disorders such as schizophrenia, depression (and postpartum depression) involve an individual within their environment. While both depression and schizophrenia may be expressed through a combination

of genetics and environment, the development of depression can be triggered by harmful thoughts stemming from specific cultural elements. The reason it is necessary to treat depression in a cultural context is because the nature of depression is inherently cultural. Depression needs to be assessed and treated in the context with which it develops— which is why it is vital that treatment for depression incorporates the cultural context.

Attachment & Postpartum Depression

Attachment style was originally defined by Bowlby (1958) as the relationship between an infant and caregiver, and later defined by Hazan & Shaver (1987) as the relationship between an adult and their romantic partner. Attachment is measured by the set of mother-child responses that define the feeling of security in their relationship (Bowlby, 1958; Ainsworth & Bell, 1970). Attachment has evolutionary beginnings; by feeling secure in an environment, young primates are able to comfortably explore, while receiving protection from threats (Bowlby, 1958). Through creating the safe bond that inspires infants and toddlers to explore, an attachment style can continue to define the relationships a person will have for their life— regardless of whether it is secure or insecure. Ainsworth and Bell (1970) later created the Strange Situation Task in order to measure the attachment. Secure attachment in this task can be defined as the child exploring while the caregiver is present, visibly upset when the caregiver departs, and then excited or happy to see the caregiver upon the ‘reunion’ task phase. Insecure attachment (anxious-ambivalent, avoidant, or disorganized) is defined by an inconsistency in the child’s behavior (e.g., lack of emotion when the caregiver departs, continued visible agitation when caregiver returns, comforting via stranger) (Ainsworth & Bell, 1970). Each inconsistency reflects a different type of insecure attachment. Infant attachment style can be an indicator of child

well-being— securely attached infants tended to be more socially developed than insecurely attached infants, and they tended to seek out their caregivers more than insecurely attached infants (Egeland & Farber, 1984). Attachment style has been shown to follow a person into adulthood, and define their relationships as an adult (Hazan & Shaver, 1987; Mickelson et al., 1997).

Hazan and Shaver (1987) found the distribution of attachment styles in an adult, Western population to be just over half secure (56%), 25% avoidant, and 19% anxious-ambivalent. This study defined adult attachment as similar to infant attachment styles; which researchers reported as 62% secure, 23% avoidant, and 15% anxious-ambivalent (Campos et al., 1983 as cited by Hazan & Shaver, 1987). This distribution of attachment styles is important to consider when examining specific populations: while this may be the distribution of Western attachment styles, it is possible variation exists among specific communities due to cultural factors, which will be discussed later in this section. Mickelson and colleagues (1997) find similar results with 59% of the population reporting secure attachment, 25% reporting avoidant, and 11% reporting anxious-ambivalent. Approximately 4-5% of the population was categorized as disorganized or fearfully attached (Mickelson et al., 1997). The inclusion of a fourth category in the research done by Mickelson and colleagues (1997) introduces the idea of an attachment style that does not necessarily have to conform with either of the two insecure attachment styles. Disorganized/fearful can represent a combination of multiple attachment styles, or the response of fear to a parental cue.

In a study by Schmitt and colleagues (2004), researchers examined attachment styles across 17,804 participants in 62 cultures to determine whether culture played a role in attachment

style. Researchers found that some cultures had higher frequencies of avoidant (dismissing) attachment than secure attachment; these cultures included Bolivia, Belgium, Ethiopia, and Malaysia (Schmitt et al., 2004). Less individualistic cultures also had higher rates of anxious-ambivalent (preoccupied) attachment; these cultures were Malaysia and Japan (Schmitt et al., 2004). Fearful attachment was also more frequent than secure attachment in Ethiopia, Belgium, and Indonesia (Schmitt et al., 2004). These results provide evidence that while secure attachment is largely the most predominant attachment style, that is not the truth for all cultures.

Different cultures report different attachment style distributions, which is also the case for different psychopathologies. Psychopathology and insecure attachment have been linked through depression and obsessive-compulsive disorder (Myhr et al., 2004). Researchers found that participants with obsessive-compulsive disorder and participants with clinical depression had higher rates of insecure attachment than those in a non-psychopathological sample (Myhr et al., 2004). This link between psychopathology and insecure attachment also contributes to the idea that depression and insecure attachment are linked.

Specifically insecure attachment and maternal postpartum depression have been linked in a number of ways throughout the literature in terms of negative infant and child outcomes. Children of mothers with perinatal depression had higher rates of insecure attachment than children of healthy mothers at 20, 36, and 48 months postpartum. Attachment style, in this instance, was a mediator of postpartum depression and a child's negative representation of the self and mother (Toth, Cicchetti, Rogosch, & Sturge-Apple, 2009). Having negative self and parental representations can create challenges in organizational development, which can subsequently may have negative effects on infant social and emotional development. In order to

remedy this issue, it is necessary for mothers to be securely attached to their offspring. As a way to increase the likelihood of more securely attached infants, it is necessary to prevent the development of postpartum depression.

In a study focusing on perinatal depression in a Latina community, researchers found that maternal depression during pregnancy was highly correlated with postpartum attachment from mother to infant (Perry et al., 2011). Specifically, depressive symptoms during the latter portion of pregnancy was correlated to maternal attachment to the infant (Perry et al., 2011). Not only does maternal insecure attachment to the infant have negative consequences for the infant, but it also has negative consequences for the mother. This relationship between depressive symptoms and provides the basis for an intervention need— not only for postpartum depression, but for attachment to the infant as well. I will discuss relevant interventions and treatments in a later section of this introduction.

Postpartum depression is also linked to experience during the entire perinatal period and mother's attachment style, previous literature suggests. Ikeda and colleagues (2014) found that the prevalence of postpartum depression was significantly correlated to pregnancy experience, symptoms of depression during pregnancy, and attachment style of the mother. Women who had a negative pregnancy experience (e.g the pregnancy 'hassles' them more than 'uplifts' them) and symptoms of depression while pregnant were significantly more likely to develop postpartum depression (Ikeda et al., 2014). Women who had insecure attachment styles were also more likely to develop postpartum depression (Ikeda et al., 2014). There was a much higher rate of avoidant attachment style, previously thought to be "low-risk", which did correlate to the development of postpartum depression. Researchers pose that this may have been a cultural

phenomenon (the research only included Japanese women with high-risk pregnancies), or the results of higher levels of education and awareness of postpartum depression. While this study was only utilizing a specific population, it provides evidence that positive or negative pregnancy experience, previous depressive symptoms, and attachment style all may influence whether or not a woman develops postpartum depression.

In another specific cultural sample, women from Turkey had higher scores on the Edinburgh Postnatal Depression Scale also had higher insecure attachment scores on an adult attachment questionnaire (Sabuncuoglu & Berkem, 2006). This sample is also non-Western, and demonstrates the connection between postpartum depression and insecure attachment in the mother. Researchers mention that although Turkey has adopted Western thought, local culture continues to be pervasive in some areas (Sabuncuoglu & Berkem, 2006). This study was also particularly interesting because Turkey is a predominantly Muslim nation; another monotheistic religion, besides Christianity or Judaism. As previously mentioned, there can be cultural differences in attachment style and postpartum depression.

Orthodox Judaism, Culture, and Postpartum Depression

Judaism is a religion and a culture, which is broken down into four sects: Reconstructive, Reform, Conservative, and Orthodox. Orthodox Jews encompass 11% of the Jewish population (Zauderer, 2012). Within the Orthodox Jewish community, there are three different sects of Orthodox Judaism: modern-Orthodox, ultra-Orthodox, and Hasidic. The difference of which is not only quantitative, but qualitative as well. All accept the Torah, adhere to strict Jewish laws, and incorporate religion throughout their everyday life. Modern-Orthodox Jews adhere to the Torah in the most liberal sense of the three, while Hasidic Jews adhere to it in the most

conservative (Ringel & Bina, 2007). While both ultra-Orthodox and Hasidic Jews are highly observant and rely on the rabbi as a confidant, the ultra-Orthodox are much more exposed within secular society (Ringel & Bina, 2007). Hasidic Jews reject popular culture, and remove themselves from secular society as much as possible. Orthodox Jews tend to form close communities for a multitude of reasons; as a whole this group is less intertwined with the world surrounding their communities, even if they fall into one of the two sects that is tolerant of secular society. Ultra-Orthodox and Hasidic Judaism involves limited contact with the media, technology, and the public; whereas in modern-Orthodox Judaism, religion is incorporated into choices made in the secular sphere.

Within Orthodox Judaism, there is a distinction between Orthodox Jews who were born into the community, and Orthodox Jews who are entering the community after being raised in less religious households (“returnees”) (Ringel & Bina, 2007; Pirutinsky, 2009). This distinction can play a role in attachment security. According to Pirutinsky (2009), Orthodox Jews who were not born into the community reported greater maternal and paternal attachment insecurity than those who were born into the community. There are at least two possible explanations for this; it is unknown whether ‘returnee’ individuals were insecurely attached and therefore more comfortable leaving their previously formed bonds to convert, or whether more individuals with insecure attachment were seeking new attachments and decided to convert to attempt to forge those. In addition, one of the other concerning aspects of being a ‘returnee’ is the notion that because an individual was not necessarily raised on the strict gender-role values of the Orthodox community, they may have a difficult time adapting (Pirutinsky, 2009).

The role of women in Orthodox Judaism is one of house and home care. Women are predominantly prescribed the role of wife and mother (Zauderer, 2012), and occasionally financial provider in cases where the husband dedicates his time to studying Torah (Ringel & Bina, 2007). The strict gender roles of Orthodox Judaism are seen as a positive, and women are predominantly happy to fulfill God's wish of reproducing (Zauderer, 2012). They are also primarily content to support their husbands in cases where husbands choose to study Torah full time, because that is what God has commanded (Zauderer, 2012). The idea is that the role of women will play a counterpart to the role of men within the religion. Gender roles are extremely strict in this society, and contact between males and females are highly prohibited— so much so that boys and girls attend separate schools (Ringel & Bina, 2007). Modesty laws dictate what women can and cannot wear; *tzniut* dictates that women must cover their knees and elbows, and cover their hair with a wig at all times. Many women shave their head for this purpose. Husbands are also forbidden to view their wives naked body (Semenic et al., 2004). The use of these strict rules and roles is seen as contributing to the functioning of society and fulfilling God's commandments. However, all Jewish laws may be suspended if a life is in danger (Semenic et al., 2004); this rule can be broken during the perinatal period if a woman or fetal life is in danger.

A study by Semenik and colleagues (2004) found that birth in an Orthodox Jewish population was often described as a 'bittersweet paradox'. New mothers, ranging from modern-Orthodox to Hasidic Orthodox, found that giving birth truly connected them with God. One new mother commented that God put women on earth to have babies, and she felt closer to Him during the birth process (Semenic et al., 2004). This emphasis on birth and the connection to God, while helpful for some women, might make women who are experiencing perinatal

depression symptoms feel as though they are not performing their duties as a woman. The integration of religion into an intervention may help women throughout the process connect something familiar (spirituality) with something unfamiliar (birth and motherhood).

The culture of Orthodox Judaism is to fulfill the wish of God, by ‘being fruitful and multiplying’ (Genesis 1:28). Many Orthodox and ultra-Orthodox Jewish families are large, and older siblings (particularly girls) may share the responsibility of caring for younger siblings. In a study by Pirutinsky and colleagues (2015), researchers examined whether the number of children per family had an impact on depression, anxiety and overall family functioning. In four studies, researchers examine different cohorts of Orthodox Jews (Canadian, American, Israeli, and International) to determine whether there is a correlation between number of children and negative psychosocial consequences. In an Orthodox Jewish population, the number of children in families did not have an impact on the level of depression, anxiety, functioning, communication, satisfaction, or even stress. Despite a large number of children being a stressor in many cultures, in Orthodox Judaism it appears to be a protective factor; potentially due to the culture of large families (Pirutinsky et al., 2015). There were limits to this study; by having all patients recruited from mental health centers, it might be indicative of a more severe sample. The reason having a large family may serve as a protective factor in the development of postpartum depression is because it is considered God’s wish for humans to reproduce.

It is considered a minimum obligation for Jews to have one daughter and one son (Semenic et al., 2004)— to complete the *mitzvah*, or commandment, to “Be fruitful and multiply” (Genesis 1:28). The more offspring a family has, the more of a *mitzvah* they are performing (Berkowitz, 2008). Having many children is a clear positive attribute of Orthodox

Jewish culture, and struggling with fertility may pose as a significant hardship to women in this community. Many Orthodox Jewish women have the ultimate goal of becoming a mother and raising children— according to God, it is the most important *mitzvah* a woman can do (Berkowitz, 2008). The pressure to fulfill this *mitzvah* may be disconcerting to some women who do not connect as thoroughly to motherhood.

In another study by Danker and colleagues (2000), religiosity was found to be a protective factor against the development of postpartum depression. Researchers sampled secular, traditional, religious, and Orthodox Jewish women in Israel, and found that greater religiosity was associated with lower rates of postpartum depression (Danker et al., 2000). Orthodox, religious, and traditional Jewish women were at intermediate risk for developing postpartum depression while secular Jewish women were at the highest risk (Danker et al., 2000). Researchers pose that this is due to the culturally protective factors of new mothers in religious communities— in more religious communities, new mothers might have an easier time accepting the role transition into being a mother because they were raised with the idea of motherhood in their future. However, there may be a cultural aversion to reporting postpartum depression symptoms due to a cultural disapproval of help-seeking. In addition Orthodox Judaism in Israel may have cultural differences to Orthodox Judaism in America.

Despite the culturally protective factors of Orthodox Judaism against the development of postpartum depression, the need for an intervention is still present. In a study examining the prevalence of seeking treatment for postpartum depression in a sample of Israeli women, approximately 44% of the women who screened positive for postpartum depression self-identified as Orthodox (Bina, 2014). This study also found that those who sought

professional help for postpartum depression had higher confidence in the ability of mental health professionals as well as recognition that they needed to obtain help (Bina, 2014). Since the culture of Orthodox Judaism disapproves of help-seeking outside of the community, religious women may have less confidence in mental health professionals and may be less likely to seek help if needed. In this study, the majority of participants were Orthodox Jewish, which may have been an indicator of the high percentage of Orthodox Jewish women who received a diagnosis or simply the majority of women surveyed identified as Orthodox Jewish (Bina, 2014). Since women who sought professional help for postpartum depression had higher confidence in mental health professionals, this could reflect cultural bias. The Orthodox Jewish community has been known to underutilize mental health resources (Zauderer, 2012), which may indicate that if experiencing perinatal depression, these women may choose to suffer in silence. Since the expectation is to be happy within a prescribed role, Orthodox Jewish people may not seek treatment because of the fear of disappointing their family and not living up to the wishes of God (Zauderer, 2012).

Specifically in an Orthodox Jewish population, postpartum depression symptoms can look similarly to postpartum depression symptoms within a general population— mostly feeling a disconnect with the world around them (Zauderer, 2012). In a study examining postpartum depression qualitatively in an Orthodox Jewish population, half of the participants reported appetite-related issues or sleep-related troubles, and a few reported suicidal thoughts or visions (Zauderer, 2012). Suicidal thoughts specifically might contribute to lack of mental health professional-seeking behavior because of the stigma against suicide within the Orthodox Jewish community.

Glasser and colleagues (2016) found that women aged 18-24 in the ultra-Orthodox community had the highest prevalence of postpartum depression scores of ≥ 10 on the Edinburgh Postnatal Depression Scale (indicative of clinical postpartum depression). This age group of women might be at higher risk due to a first pregnancy and young age. In addition, researchers found that the number of children a woman had was also related to the EPDS; women who had their first pregnancy were more likely to have postpartum depression symptoms as opposed to women who already had children (Glasser et al., 2016). These two factors, age and previous number of children, may potentially implicate this specific group of women to be more at risk of developing postpartum depression.

Another risk factor for postpartum depression is in birthing experience. Segal-Engelchin and colleagues (2009) found that a negative or traumatic birthing experience was correlated to postpartum depression in a study of women in Israel. Cesarean-section and vacuum extraction births were both considered negative or traumatic birthing experiences (Segal-Engelchin et al., 2009). Also included in negative birthing experiences were childhood sexual abuse and/or recently experienced domestic violence (Segal-Engelchin et al., 2009). There is no ritual, aside from a baby naming, for Jewish baby girls (whereas males are circumcised). Instead, it may be that there is a cultural belief that since women can give birth to sons, they are included in the covenant through their ability to give birth. God's covenant with Abraham includes Sarah by means of her allowing to conceive and subsequently give birth to Isaac (Genesis 17:16). Having a C-section delivery may disrupt this covenant because the delivery of the baby will not pass through the vaginal canal. It also may be that a vacuum extraction delivery can disrupt this covenant because during a vacuum extraction, a second device must be utilized to help deliver

the baby. When a second device is used, a mother may believe as though she is unable to do her job as a woman— depriving her of her femininity.

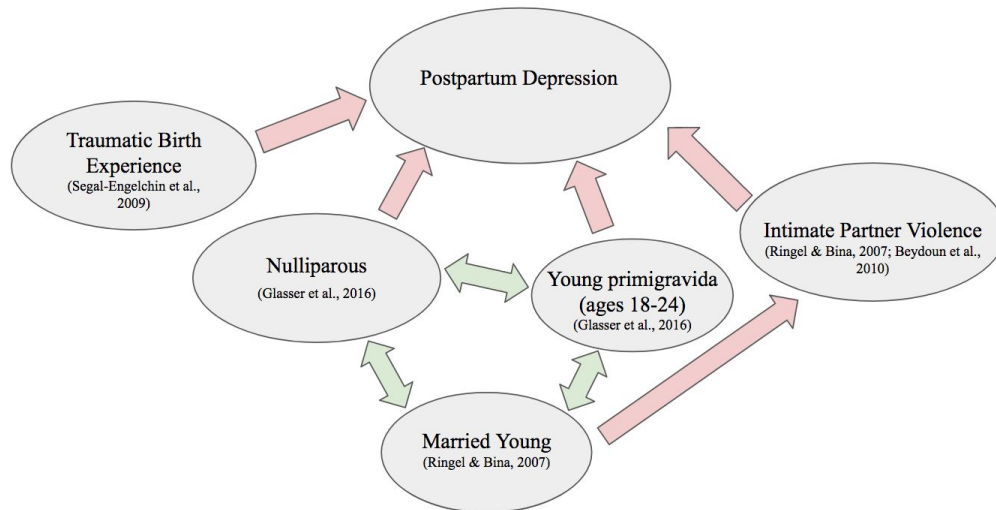


Figure 1. Risk factors and relationships between risk factors for postpartum depression. Green double-headed arrows indicate a relationship between individuals (cohort) with factor labels, pink arrows indicate ‘risk factors for...’ in the direction they are pointing (e.g nulliparous is a risk factor for postpartum depression).

Intimate Partner Violence Within the Orthodox Jewish Community

Intimate partner violence has occasionally been addressed in the media in reference to the Orthodox Jewish community, such as within the documentary ‘One of Us’. However, there is minimal information available because of how private the nature of Orthodox Jewish culture is. Previous research has indicated that people living in highly religious communities in a monotheistic religion (such as Christianity) are less likely to acknowledge domestic violence, which may account for low intimate partner violence rates (Ringel & Bina, 2007). Women in these communities are also less likely to vocalize their struggles, or report domestic violence due to the stigma or feelings of guilt and responsibility for keeping their family together. By being socialized into the role of homemaker, women may feel less like they have the ability to speak up

about domestic violence (Ringel & Bina, 2007). Specifically within the Orthodox Jewish community, there is an emphasis on family harmony (Ringel & Bina, 2007).

In a study specifically concerned with rabbis in different sects of Judaism, researchers found that Orthodox rabbis were more likely to believe that there was less abuse within their congregations as opposed to Conservative or Reform rabbis (Ringel & Bina, 2007). There was also work done on the Jewish community at large, finding that it was a significant issue throughout all sects of Judaism (Ephross, 1996 as cited by Ringel & Bina, 2007).

In their study concerning women survivors of intimate partner violence, Ringel & Bina (2007) investigate qualitative factors within the Orthodox Jewish community. Researchers found that there were three main aspects of the survivor responses: 1. The causes of intimate partner violence included early marriage, lack of premarital education surrounding communication skills, and personality characteristics, 2. Religious beliefs and social values were barriers to seeking treatment, and 3. The role of the rabbi was viewed differently by different respondents—out of the 8 survivors, only one reported that her rabbi was helpful (Ringel & Bina, 2007). The overall information collected from the survivors indicated that barriers to seeking help for intimate partner violence included the more conservative social outlook towards men and women, and the stigma against receiving mental health help. Researchers also noted a majority of participants were ‘returnees’ (Ringel & Bina, 2007). However, this study was not large enough scale to generalize to the whole Orthodox Jewish community.

Healthcare Among the Orthodox Jewish Population

Due to the strict nature of *Halachic* law, there are many rules Orthodox Jews (women in particular) must follow throughout pregnancy and childbirth. There is often a disconnect between

healthcare professionals and their Orthodox Jewish patients because of this strict law observance— in turn, this can produce an added strain on the mother-to-be. The rules of strict Judaism are often difficult for people of secular society to grapple with. *Yichud*, the rules of privacy, dictate that a woman should opt to choose a female physician, however she can choose a male physician if he is in good moral standing and the more capable choice (Feldman, 1992). In addition, a woman should ensure that whenever she is alone with a male physician, there are people in the surrounding areas and other medical personnel should be able to enter the room (Feldman, 1992).

Family purity (*Tahirat Hamishpacha*) is another important aspect of Orthodox Jewish sexuality. While sexuality is highly encouraged (“be fruitful and multiply”) among married individuals, there are many rules surrounding when a man and woman can engage in sexual activity. From the first day of a woman’s menstrual period, until 7 days after it stops, women and men are barred from touching each other or sleeping in the same bed. It is only after the woman emerges from the *mikveh*, a ritual bath, that she is allowed contact with her spouse again (Feldman, 1992). Some couples view this sexual separation and rekindling like a “wedding night” every month (Berkowitz, 2008). However, this can become quite a disruption in family planning or a couple’s sexual life due to the necessary abstinence period after any bleeding, including irregular spotting. This sexual unavailability (*niddah*), has some exceptions: Feldman (1992) reports that when the cause of the bleeding is cervical rather than uterine, there is no need for a 7 day abstinence period post-bleed. For example, when an Orthodox Jewish woman receives a gynecological examine and there is post-exam bleeding, this bleeding can be attributed to the cervix rather than the uterus.

There are cases of difficulty conceiving due to a short menstrual cycle, in which a woman experiences a fertile window while she is still *niddah*. This poses problems for many couples, however there is an acceptable solution. In cases like this, women can and do receive hormone therapy in order to conceive (Berkowitz, 2008). The need to fulfill God's command outweighs the need for medical intervention— it is acceptable to receive medical help if it will help perform the *mitzvah* of life.

During birth, any form of blood from the uterus makes a woman *niddah*. Some rabbis even deem that a woman is in *niddah* the minute her contractions begin (Noble et al., 2009; Berkowitz, 2008). This can be particularly difficult for a woman, because her husband is unable to physically touch her (and provide physical comfort), starting at the moment her contractions begin. He is not even allowed to touch objects and then give them to her. Due to this lack of physical contact or comfort, women may feel more isolated during the birthing process. Husbands are available for emotional and spiritual support, and some women choose to bring female friends, sisters, or mother into the delivery room for the physical comfort aspect of birth (Berkowitz, 2008). After giving birth, a woman is *niddah* for 7 days after the birth of a baby boy, or 14 days after the birth of a girl. The reason for this sex difference is because when a woman gives birth to a boy, she is only *niddah* for herself. When she gives birth to a baby girl, she is *niddah* for herself and for the future menstrual blood of the baby girl. During delivery, husbands are permitted to stand in the room at a point where they are not able to observe the actual birth of the child (Noble et al., 2009). In one study, only 37% of Orthodox Jewish husbands were present for the physical birth of their infant (Callister et al., 1999).

These factors of Orthodox Jewish healthcare are important to recognize for the treatment and prevention of postpartum depression. Orthodox Jewish women may have some concerns surrounding birth, and may be less likely to share these concerns due to the stigma of mental health issues in the community. If left unaddressed, these issues could provoke the development of postpartum depression. In the current study proposal, I would like to tackle some of these issues in adapting an intervention for the prevention of postpartum depression in Orthodox Jewish women.

Previous Treatments of Postpartum Depression

Treatment of depression can either fall into biomedical or psychotherapeutic. Biomedical treatment can include selective-serotonin reuptake inhibitors (SSRIs), and are the most common form of depression treatment in pregnant and non-pregnant women (Ko et al., 2012). While there are some negative aspects of medication— such as the 4 weeks SSRIs need to begin to physically feel the effect, or the potential for fetal defect in some SSRIs— the lack of time commitment and ease at which a person can take them can be seen as highly positive. In an Orthodox Jewish population, women perceived anti-anxiety and anti-depression medications as the most helpful in treating postpartum depression (Zauderer, 2012), however some women may be reluctant to begin medication due to stigma and fear from the community. One woman reported that she thought people would think she was crazy if she told them she was on medication (Zauderer, 2012). The reluctance to use medication may serve as an appealing factor to receive psychotherapeutic treatment.

There appear to be two different schools of thought when it comes to psychotherapeutic approaches of treating postpartum depression: interpersonal therapy (IPT) and

cognitive-behavioral therapy (CBT). Interpersonal therapy is a short-term, time-limited psychotherapy intervention that takes a biopsychosocial perspective by addressing interpersonal connection and depression (Forman et al., 2007). In treatment, patients select one of the four following areas: role transition, role dispute, grief/loss, or interpersonal deficits. Because interpersonal therapy focuses on depression of the self in relationship to others, these four areas involve the externalization of each role change in order to help new mothers adjust (e.g. how can you involve the people in your life?). Each of the four areas previously mentioned are categorized as a 'role change'. Focusing on role transitions helps patients to transition into being a mother. Focusing on role dispute serves as a platform to discuss potential role disagreements with a partner. Focusing on grief or loss encompasses feelings that may accompany having a child (e.g. the loss of being an autonomous individual). Or, focusing the potential shortcomings of a relationship (other than mother/child) are considered the main problem areas. A common thread through all the categories of 'role change' is that external individuals (a partner, the infant, other individuals within a new mothers' life) are used to put the role change into perspective. In treatment, patients choose one of these areas to focus on. However, the individuality of IPT can adjust for individual needs in a combination of these areas.

Over the course of the 12-20 week treatment, the psychologist and patient work together to create better problem-solving skills for relationship building (Fittleson et al., 2011). One of the benefits to choosing interpersonal therapy over cognitive-behavioral therapy is the short-term, time-limited therapy sessions— which may fit better into a busy mother's schedule (Fittleson et al., 2011). Interpersonal therapy is usually used postnatally— after the development of postpartum depression. However, recently an intervention framed in the context of interpersonal

therapy was developed for women on public assistance by Zlotnick and colleagues (2006). In IPT treatment, the focus is externally on an individual's issues with others. As I will discuss in the next paragraph, interpersonal therapy was successful in treating postpartum depression symptoms, but was not enough to mend the mother/child relationship (Forman et al., 2007). IPT may not be as successful as cognitive-behavioral therapy because it forces the participant to externalize the problems; focusing on issues with others instead of self-regulation. In the current study proposal, an interpersonal therapy intervention will be proposed as a comparison group.

Forman and colleagues (2007) found that interpersonal therapy was successful in treating postpartum depression symptoms, however treatment did not significantly alter the amount to which the mothers attended to their children. This study focused on three groups: depressed mothers who received interpersonal therapy treatment, depressed mothers who were placed on a waitlist condition, and non-depressed mothers. While depressed mothers who received treatment experienced lower parenting stress, they still reported significantly more negative child affect ('affect' as characterized by attachment insecurity, temperament issues, and behavioral problems) than those in healthy control groups. This can be indicative of a lack of focus on the mother-child relationship during treatment. Depressed mothers who were placed on a waitlist also showed significantly more negative child affect, and did not differ from depressed mothers who received treatment (Forman et al., 2007).

While these results could be due to reporting bias of a depressed mother, if treatment were successful, then the depression should not be a potential bias in reporting negative child affect. These results were also compared to observational data of the infant and mother, where there was no significant negative affect reported by observers (Forman et al., 2007). Results

indicate that while interpersonal therapy was effective for treating postpartum depressive symptoms, it did not have a significant impact on the mother-child relationship as assessed by negative child affect (Forman et al., 2007). Depressed mothers who received treatment still rated their children higher in attachment insecurity, negative temperament, and behavioral problems than non-depressed mothers. Researchers stipulate that treatment surrounding postpartum depression should target the mother-infant relationship (perhaps with an attachment intervention) instead of solely focusing on the depressive symptoms of the mother (Forman et al., 2007). The reasoning behind why depression treatment is not affecting the mother-child relationship could potentially stem from the nature of interpersonal therapy— the externalization of issues, while helping the mother to cope, does not necessarily provide any information about how to connect with your child. Attachment therapy is missing in interpersonal therapy, which may be part of the reason it fails in forging secure attachments.

Cognitive-behavioral therapy, on the other hand, helps depressed patients by teaching them to modify abnormal patterns of behavior or negative thinking in order to implement behavioral changes. Instead of teaching patients to externalize their problems and involve others in their treatment, cognitive-behavioral therapy helps patients modify their own patterns of thinking to help them self-regulate. Where interpersonal therapy focuses on an individual's relationship with others, CBT focuses on what the individual can do to change their own mindset (Fittleson et al., 2011). CBT has been shown effective as therapy for depression, as well as successfully decreasing rates of relapse even after treatment is completed (Fittleson et al., 2011). Cognitive behavioral therapy is also a short-term intervention; operating under the assumption that once a person undergoes the therapy, they will have the tools to continue practicing even in a

non-therapeutic environment. Previous studies have used CBT in combination with selective serotonin reuptake inhibitors in order to treat postpartum depression, however there seem to be no significant differences in the groups treated with CBT + medication versus the groups treated with only CBT (Fittleson et al., 2011). The only significant difference between groups had to do with the duration of treatment (in weeks)— indicating that the effect of CBT might have to do with the amount of time a patient undergoes treatment.

The Mothers and Babies Course

The Mothers and Babies Course is a cognitive-behavioral intervention that identifies groups of women who are at “high-risk” for developing postpartum depression. The goal of the course is to teach mood-management, maternal self-efficacy, and focus on changing a person’s personal reality through 12-, 8-, or 6-weeks of therapy (Le et al., 2011; Tandon et al., 2014). The external reality refers to the physical world, while the internal reality refers to a person’s response; a “personal” reality is the combination of the two, and this concept of personal reality makes the therapy cognitive-behavioral. Personal reality is not necessarily in real existence, but more of a thought process about reality. Helping to change a “personal” reality can help a new mother feel more confident and secure in this role. For example, a woman recently finds out she is pregnant, and although she is currently single and facing money issues, she does want a baby at this time in her life. Her external reality is the world around her, particularly the fact that she is pregnant, single, and facing money issues. Her internal reality is the way she perceives her external reality; how she feels about the pregnancy, what plans she is beginning to make to prepare for the baby. Her personal reality is a combination of the two— essentially how she internalizes the world around her, and chooses to act.

The Mothers and Babies course was designed as a prevention program, which makes it extremely applicable to the current study proposal. In the 6-week intervention, there are 6 sessions during pregnancy and 3 “booster” sessions after the infant is born. A 6-week version of the intervention was examined in a high-risk population of African American women in Baltimore (Tandon et al., 2014). This specific treatment combines cognitive-behavioral with attachment and developmental perspectives in order to foster the mother-child relationship (Muñoz et al., 2007; Le et al., 2011). By also incorporating attachment therapy into treatment, mothers can learn to bond with their children and create a secure attachment style. Because, as previously mentioned, effective treatment for postpartum depression can be ineffective at creating a secure attachment between mothers and infants; the use of an attachment aspect in therapy would help foster a stronger relationship between mother and infant (or fetus during prenatal intervention). This important aspect of the Mothers and Babies cognitive-behavioral therapy is absent in interpersonal therapy and may be part of the reason interpersonal therapy fails at fostering a healthy mother-child relationship, despite properly treating postpartum depression. Perinatal depression and attachment are still linked in this way, however even though the two are related, treating one does not necessarily guarantee treatment of the other.

The Mothers and Babies course has been previously implemented around the country, and shown effective with different cultural groups of women— especially in high-risk, low-income communities (Muñoz et al., 2007; Tandon et al., 2014). In a previously studied Latina population, the Mothers and Babies course has been extremely effective in the prevention of depression (Muñoz et al., 2007). In this study, both the mood management intervention comparison group and the Mothers and Babies course were both effective in terms of treating

postpartum depression— however neither was more effective than the other. Researchers speculate that with a larger effect size, or a population that has comorbid risk factors for postpartum depression, there will be a significant effect of treatment group (Muñoz et al., 2007). While interpersonal therapy has been shown effective for minority groups and low-income women (Grote et al., 2004), the lack of mother/child relationship improvement and specific targeting of cultural components of depression make the Mothers and Babies course the best option for treatment of specific ethnic or cultural minorities. By incorporating specific cultural components into postpartum depression prevention, women may be able to better identify with program and have an easier time integrating strategies into their lives. Symptoms of depression include depressed mood and lack of pleasure in most or all daily/usual activities (American Psychiatric Association, 2013); by making treatment culturally appropriate, women may have an easier time implementing the cognitive-behavioral strategies into their daily life. In addition, interpersonal therapy focuses on the mother in relationship to others— where low-income or cultural minority women may not have the same relationships or resources and may benefit more from learning about self-regulatory strategies.

Using the Mothers and Babies 6-week course, I will be focusing on the prevention of postpartum depression in an Orthodox Jewish community. Due to the cognitive-behavioral and attachment therapy aspects of the Mothers and Babies intervention, I hypothesize that the Mothers and Babies course adaptation will be a successful intervention for Orthodox Jewish women not only in terms of depression intervention efficacy, but also in creating successful mother/infant bonds. In this study proposal, there will be five hypotheses: First, I predict that the Mothers and Babies Course will be an effective form of postpartum depression treatment.

Second, I predict that the Mothers and Babies Course will be more effective than Interpersonal Therapy intervention comparison and the waitlist control condition. Third, I predict that the mothers in the Mothers and Babies Course will produce the highest frequency of securely attached infants; as compared to the Interpersonal Therapy and control conditions. Fourth, I predict that mothers in the Mothers and Babies Course condition will have the highest frequency of securely attached mothers at the post-intervention attachment assessment compared to the Interpersonal Therapy and control conditions. Fifth, I predict that the attachment distribution of mothers at the pre-intervention attachment assessment will resemble the attachment distribution of the general population.

Methods

Participants

Participants will be women of Orthodox Jewish identification, who are expecting their first child (nulliparous). The goal is to presumably obtain younger women who have not yet had a child; this may help create a safe environment and cohort. As previously stated, risk factors for postpartum depression include young primigravida (18-24) and married young, which are associated with being nulliparous (Fig. 1) (Glasser et al., 2016; Ringel & Bina, 2007; Beydoun et al., 2010). At least 235 participants will be assigned to each group, as per Muñoz and colleagues (2007) in their clinical trials of the MBC in a Latina population. Even though Tandon and colleagues (2014) examined the 6-week MBC intervention in a low-income, African American population, I will be following the original study Muñoz and colleagues (2007) experimental design plan. Participants will be divided based on attachment style (secure, anxious-ambivalent,

avoidant, disorganized) and then will be placed in stratified random assignment and sorted into conditions so to evenly distribute the different attachment styles.

Recruitment. Participants will be recruited from obstetrician offices in known areas with large Orthodox Jew populations in the lower New York area. These areas include Westchester County, NY, Monsey, NY (Rockland County), and Brooklyn, NY (Williamsburg).

Pre-Intervention Assessments

Before intervention implementation, participants will receive the Beck Depression Inventory-II (BDI-II) (Beck et al., 1996) and the Adult Attachment Interview (AAI) (George et al., 1996).

Beck Depression Inventory-II. The Beck Depression Inventory-II is a 21-item questionnaire that is used to measure the existence and severity of depression (Appendix A) (Beck et al., 1996). The scale is measured from 0-63, and will be used to gauge the level of depression before the treatment begins to evaluate a baseline level among this population (Beck et al., 1996). The cutoff score for determining whether a patient has clinically significant depression will be set at ≥ 20 , to encompass moderate and severe clinical depression scores. The BDI-II can be used to show an initial level of depression, and then subsequently used in the post-intervention assessment.

Adult Attachment Interview. The Adult Attachment Interview is approximately a 60 minute long interview (ranging from 45 minutes to 90 minutes) that examines the relationship between an individual, their parents, and their current/future offspring (Appendix B) (George et al., 1996). The AAI will also be used to gauge the division of attachment styles among this specific population, as well as allow researchers to determine if mother attachment style will be related to infant attachment style post-intervention (George et al., 1996). The AAI will be scored

in terms of secure attachment, anxious-ambivalent, avoidant, and disorganized attachment; the goal is to examine whether or not mothers are secure or insecurely attached, as well as the distribution of attachments within the four general categories. While on the AAI, the categories are labeled “Secure/Autonomous”, “Preoccupied”, “Dismissing”, and “Unresolved/Disorganized” respective to the previously mentioned four categorizations, I will be referring to the categories as stated in the former description.

Post-Intervention Assessments

After the intervention, I will re-use the BDI-II and the AAI for post-treatment assessments. I will also be using the Edinburgh Postnatal Depression Scale (EPDS), and the Strange Situation Task.

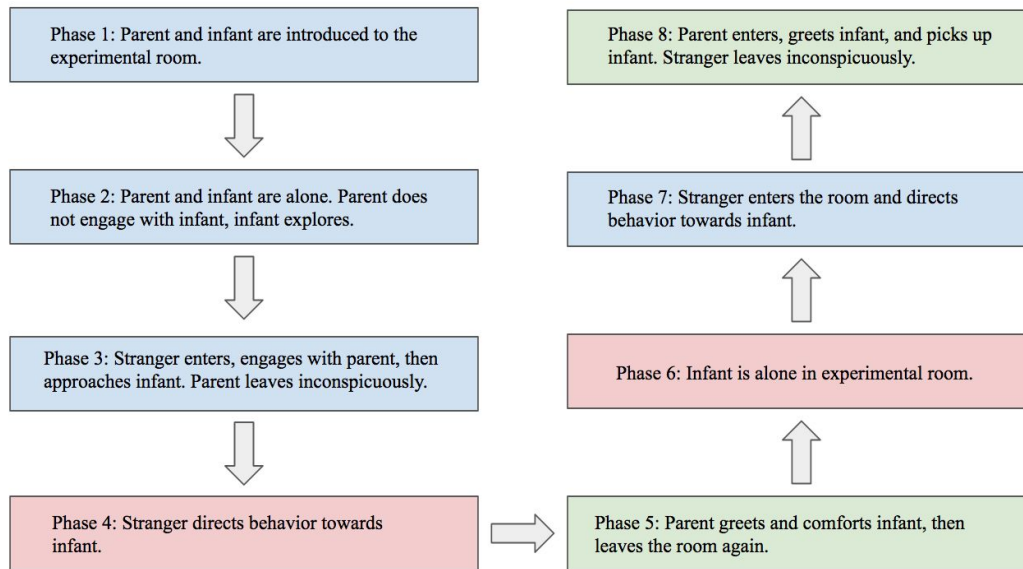
Beck Depression Inventory-II. The BDI-II will be used again to collect postpartum data on participants. This will be given at the same time as the EPDS, and will be at 6 weeks postpartum. Though it is unlikely that the mother will be pregnant at the time of receiving this assessment, the BDI-II will be given regardless of pregnancy status. The reason it is important whether to know if the mother is pregnant at the time of post-treatment assessment is because her score may be impacted by pregnancy. Because the EPDS can be used postnatally, the BDI-II will serve as a difference in depression indicator— accounting for the difference between depression in early pregnancy and depression postnatally. Scores on the pre-treatment BDI-II will be created by using a random number generator and percentages of scores based on a national sample (American Psychiatric Association, 2013). Scores on the post-test BDI-II will be adapted using a national sample and educated predictions based on previous research American Psychiatric Association, 2013; Muñoz et al., 2007).

Adult Attachment Interview. The AAI will be used again in order to determine whether the treatment had an effect on the attachment style of the mother. The original Mothers and Babies Course includes elements of attachment therapy (Muñoz et al., 2007), while Interpersonal Therapy has been shown to not mend the mother-infant relationship (Forman et al., 2007). It is important to gauge whether the adapted Mothers and Babies Course will have an effect on the attachment style of mothers as well. This post-intervention measure will be given at 6-weeks postpartum.

Edinburgh Postnatal Depression Scale. The EPDS is a 10 question scale with a maximum score of 30 (Appendix C) (Cox et al., 1987) This depression inventory is advantageous because it does not include the physical symptoms of depression which may simultaneously be symptoms of the postpartum recovery period (Muñoz et al., 2007). Mothers who score ≥ 13 on the EPDS are likely to be suffering from clinical postpartum depression (Cox et al., 1987). However, the nature of this scale is ‘postnatal’ so it will only be used as a post-intervention measure. This measure will be given at 6 weeks postpartum to ensure the participant has postpartum depression and not “baby blues”, and will be given at the same time as the post-intervention BDI-II. The scores for this measure will be generated using a random number generator, using national samples of perinatal depression and educated predictions using previous research (Muñoz et al., 2007; Rai et al., 2015)

Strange Situation Task. The Strange Situation Task is a 21 minute long observational examination that is used to measure infant attachment style. I will also be using the Strange Situation Task (Ainsworth & Bell, 1970) to evaluate the attachment style of the children at 12 months (Ainsworth & Bell, 1970). This task involves eight episodic interactions between the

mother, child, and a stranger (Fig. 2). The Strange Situation Task will be evaluated in terms of secure or insecure attachment, and additionally the breakdown of insecure attachment (anxious-ambivalent, avoidant, and disorganized/fearful).



Ainsworth & Bell, 1970

Figure 2. Phases of the Strange Situation Task. Pink boxes indicate a ‘separation episode’, green boxes indicate a ‘reunion episode’.

Control

There will be a control group who receives no treatment, however will be offered ‘booster’ treatment or will be offered prevention therapy for their next child if results are significant. They may also be eligible to participate in future studies where variables will include having previous children.

Interpersonal Therapy

An interpersonal-therapy oriented intervention similar to that in Zlotnick and colleagues (2006) will be administered. This regimen will be 6-weeks of interpersonal therapy and will be used as a comparison group. The original intervention was created, as previously mentioned for

women living on public assistance, and is only a 4-week/90-minute session program (Zlotnick et al., 2006). In order to truly compare these two groups, this intervention will be made 6 weeks long and will be revised to be 60 minutes per session. While necessary cultural adaptations may be made in the language in order to make this intervention comprehensible for this community, there will be not be an adaptation above and beyond that. The main focus of this project is to examine the adapted Mothers and Babies course in comparison to a normative interpersonal therapy intervention. Due to socially protective mechanisms already in place within the Orthodox Jewish culture (Danker et al., 2000), it is hypothesized that this therapy will not be as effective in preventing postpartum depression.

Mothers and Babies Course

As previously mentioned, the Mothers and Babies Course was designed as an attachment-based cognitive behavioral therapy to prevent perinatal depression in minority and high-risk populations. The 6-week version of the Mothers and Babies Course was found to be successful in a high-risk population of African American women in Baltimore (Tandon et al., 2014). I will adapt the 6-week version of the Mothers and Babies Course (Appendix E, Appendix F) for the Orthodox Jewish population by focusing on aspects of Orthodox Jewish culture that may pose a risk for the development of perinatal depression. Although this course was designed as either an open or closed group, this version of the course will be offered in a closed group setting due to the cultural nature of Orthodox Jewish communities as being very private. The nature of the original MBC was a group intervention, and some Orthodox Jewish women reported feeling comfort in sharing their experiences (Zauderer, 2012) so the adapted intervention will still remain in group format. People flowing in and out of the class, however,

may pose as harmful because women may feel less like sharing personal information with a ‘stranger’.

Experimental Timeline

Mothers will complete the pre-treatment assessments (the Beck Depression Inventory-II and the Adult Attachment Interview) prior to being enrolled in each group. This can occur any time in the first trimester of pregnancy. After scores are completed, participants will be placed in stratified random assignment into three groups— control, interpersonal therapy, and the Mothers and Babies Course. These courses will begin in the second trimester of pregnancy (between weeks 22-27) and may continue into the third (between weeks 28-31). Participants will be asked to notify experimenters of the birth and will be contacted 6 weeks after birth to complete the post-assessment BDI-II, EPDS, and AAI. At one year postpartum, the Strange Situation Task will be administered to infants.

Mothers and Babies Course - My Contribution

Course 1: Introduction

The first part of Course 1, is to establish a rapport with the participants and create a safe environment. This is where I would introduce myself, explain my interest in working with mothers/infants, and do group introductions. Depending upon the size of the group, the group introductions can be done in partners or as a whole group. For the purpose of this course, it would be best to do introductions as a whole group in order to establish a feeling of community. This will be a closed group due to the private nature of the Orthodox Jewish community— there will be no participants allowed into the group after the first session. Then, I will describe the purpose of the course and thank participants for taking the time to be here.

After establishing rapport with participants and making group introductions, I will go over the topic of each individual class session. This first class session is called the introduction, followed by ‘Thoughts and My Mood’, ‘Fighting Harmful Thoughts and Increasing Helpful Thoughts that Affect My Baby and Myself’, ‘Activities and My Mood: Pleasant Activities Help Make a Healthy Reality for Myself and My Baby’, ‘The Miracle of Life: Birthing Strategies for Myself and My Baby’, and “Interpersonal Relationships and My Mood”.

Next, I will discuss the class guidelines; emphasizing safety and confidentiality. I will emphasize that the only topics that would not be confidential are: elderly abuse, child abuse, if someone is going to hurt themselves/another person. I will discuss the importance of attending class and coming on time, saying that together we can problem solve tardiness. The foundation of the class is through listening, being respectful, and sharing your own experiences. Then I will discuss the importance of keeping up with the personal project.

I will next cover the first topic: stressors in the mother/baby relationship. These stressors can include money problems, too much work, household chores, problems with your partner (domestic abuse: verbal, physical, sexual), problems breastfeeding, health problems, and birthing complications. Throughout the course, we will explore how each of these stressors can put strain on the mother/baby relationship.

We will talk about common mood problems after birth, establishing the difference between postpartum depression, “baby blues”, and depression. Each of these terms will be accompanied by the proper definition. Participants will then have to distinguish each of these terms from each other to ensure all participants understand the difference. Next, we will go over how this course can benefit the mother/baby relationship. Emphasis will be placed on

stress-management, helpful/harmful thoughts, mood, and the relationship with God. Lastly, we will define personal reality and go over the personal project (which can be found in Appendix F).

Course 2: “Thoughts and My Mood”

First, we will go over announcements and the class agenda— reviewing general points from the previous class. Next, we will go over the personal project. Questions will be posed such as: How did you feel about it? What did you learn from tracking your mood? When was your mood at the highest? When was your mood lowest? Did you discuss what you learned with a family member or friend?

Next, we will learn a relaxation exercise. This exercise is centered around a deep breathing technique, however we can incorporate aspects of religion here as well. For example, if a woman has a favorite Torah portion or quote that she would like to reflect on, we as a class can find a few and spend time discussing which quotes we would like to focus on. Alternatively, participants could use this time to strengthen their connection with God through prayer.

After relaxation, we will discuss the “Sarah and Rebecca” cartoons (Appendix D1). The discussion will revolve around the character’s activities and mood changes. Both Sarah and Rebecca begin their day at the same mood— but how do they each end it? What does Sarah do differently than Rebecca? How does this affect her mood? This discussion should always be continued throughout the remainder of class, and should be weaved into the new material.

Next, we will begin discussing new material. We will discuss: The Path that Leads to a Healthy Mood, What are thoughts? How do different thoughts lead to different moods?, Helpful Thoughts vs. Harmful Thoughts, and Types of Harmful Thought Patterns/Talking Back. One addition that is not currently in the Mothers and Babies Instructor manual is the inclusion of

“God’s plan”. We will discuss each woman’s connection with God and how a person can still fulfill God’s plan despite these individualities.

As part of the solutions section, we will go over how to give yourself good advice. This includes talking back to harmful thoughts and giving advice to ourselves from the point of view of another. We will also talk about using scripture as an example of where to take advice, and how scripture can be helpful/harmful.

Lastly, we will go over the take-home message: thoughts are part of your personal reality and can determine whether you have high mood or low mood. Using positive thoughts can help improve your mood, and giving yourself advice or looking to God can also help rid yourself of harmful thoughts. We will go over the personal project, and wrap up class.

Course 3: “Fighting Harmful Thoughts/Increasing Helpful Thoughts That Affect Me and My Baby”

As usual, we will start class with announcements and agenda, personal project review, a relaxation exercise, and Sarah and Rebecca (Appendix D2) before getting into new material. When we begin new material, I will go over all the topics before we cover them. The topics are as follows: thoughts about becoming a mother, harmful and helpful thoughts about pregnancy/birth/parenting, helpful thoughts, ways to change harmful thoughts that affect me and my baby, thoughts I want to learn to teach my baby, my future, and my baby’s future. All of these sections will include information in the Instructor manual.

In the “harmful and helpful thoughts about pregnancy/birth/parenting” section, I will add information about identifying helpful/harmful thoughts surrounding birth and the covenant with God. We will briefly discuss epidurals, C-sections, and potential harmful thoughts surrounding

birth. This will be discussed briefly because there will be an entire class dedicated to birthing strategies. I will also begin to mention ways to cope with the pain of labor, and incorporate the meditation/prayer exercise into this aspect of the course. In “helpful thoughts” section, I will add information about how delivering the baby safely is the most important way to fulfill God’s wish of bringing life into this world.

The rest of the class will progress as per the instructor manual— and will end with a take-home message.

Course 4: “Pleasant Activities Can Make a Healthy Reality For My Baby and Myself”

This course will begin as usual; with announcements/agenda, personal project review, a relaxation exercise, and a discussion of Sarah and Rebecca (Appendix D3). Then, we will discuss new material (as per the instructor’s manual): how does what we do affect how we feel?, identifying a minimum of three activities you would like to do with your baby, how do babies learn? What do babies like to do?, Birth → age 1: things babies like to do, pleasant activities and my baby, and overcoming obstacles.

In the “identifying a minimum of three activities you would like to do with your baby” section, I will add information about incorporating God or prayer into these activities. For example, making bonding time with your child also a time to connect with God. Sharing this aspect of life with the child may help strengthen the relationship. In addition, participants will also have to identify three helpful thoughts they can take into birth in order to alleviate stress about the situation.

We will also discuss the post-birth *niddah* period here. Together, we will brainstorm how the *niddah* period can be a time of peace and bonding between you and your child, instead of

feeling isolating. While a woman at this point might be accustomed to a long *niddah* period, during the postpartum period it may feel particularly isolating instead of a familial closeness with herself and her partner.

The session will end as per the instructor's manual, with a take-home message and personal project assignment.

Course 5: “The Miracle of Life: Birthing Strategies for Myself and My Baby”

First, we will begin with the announcements and agenda for the day. Reviewing the agenda can not only serve as a guideline, but also as a warning about any potentially difficult subjects. Next, participants will review their personal projects, and we will discuss improvements and setbacks on their weekly mood chart. Addressing improvements and setbacks in class can give participants a realistic idea of mood changes, not only in themselves but in others who lead similar lives. Next, participants will take part in the relaxation exercise. This exercise can not only be used to help with deep breathing, but participants can also mentally recite specific Torah portions or verses that help remind them of their connection to God.

The second part of class includes the “Sarah and Rebecca” cartoon strip. Sarah and Rebecca are both placed in the same situation— they are told they will need to have a C-Section delivery (Appendix D4). However, both women handle the situation differently within their thought process, which then translates to their mood. During the discussion, questions will be posed such as: What mood do Sarah and Rebecca begin with? How do their thoughts affect their mood? How does this change throughout the birth process? By examining these questions specifically, participants can begin to understand their own attributions and thoughts surrounding birth.

The third part of class is new material. During this section we will first address ‘Communication Styles, Mood, and Birth’. Identifying each participant’s individual communication style and then discussing strategies as a group can help each woman to identify what they need to work on when communicating with important figures. Questions will be posed such as; How will your communication style influence how you communicate with your partner? Doctor/midwife? What can you do to make sure your express yourself properly and thoroughly?

Next, we will discuss the importance of getting your needs met during and after birth. We will talk about what a doctor or midwife can say or do to help participants feel more secure and safe in the birthing environment. Questions will be posed such as: What are some securities you will need from your doctor or midwife to make you feel better about the delivery? What can your partner, or friends, do? What are some strategies you can take with you into birth? During this section, we will also discuss how partners, family, and friends can act as a support system. We will talk about how husbands can provide spiritual support without physical support, and how other women can provide physical support. For example, mothers are often sought out as physical support systems during this time (Callister et al., 1999). Each participant will be asked to select two or three female family members or friends that they would prefer to bring into the delivery room with them to provide physical comfort. They will each discuss why they would like to bring these women into the delivery room, and what they would prefer these women know before accompanying them.

This can create a good segway into the next section, addressing harmful thoughts during birth. As previously mentioned, C-Sections are considered ‘traumatic birthing experiences’ and are associated with perinatal depression. This section is important because it address what some

of the harmful thoughts that could occur are, and then points out solutions. In this section, it is important to discuss why these thoughts are harmful— however, it is important to consider this from a religious vantage point. Questions posed will include: What are some harmful thoughts that could occur during birth? Why is this a harmful thought? What are some ways to remedy those thoughts? We will also talk about communication with your partner and physician/doula during this time. In terms of physician/doula communication, it is important to talk about how you are feeling about the birth. Together we will brainstorm ways to let your physician/doula know if you are uncomfortable and how to ask for what you need from them (communication-wise; for example, if you need certain assurance or if you need scripture in the delivery room).

Next, we will go through different birthing scenarios: C-section, breech, vacuum extraction, forceps, premature, and epidural. During each of these scenarios, we will role play what happens if a doctor or midwife says one of these interventions is necessary and discuss the harmful/helpful thoughts that accompany them. The most important aspect of this section is to remind participants that they are fulfilling their covenant with God having children, regardless of how the babies are born. We will discuss worst-case scenarios, and repeat that the most important part of this whole process is fulfilling God's wish to bring life into the world. During this section we will brainstorm helpful thoughts and Psalms that may be helpful during delivery. What can help you feel more connected with God, if you are in one of these situations?

Lastly, we will discuss the *niddah* period after birth. This is a time of solitude for women after they have any vaginal bleeding, however for mothers going through postpartum depression, this can be extremely difficult. In order to ease the transition into this period, it is important to

discuss some of the apprehension and concerns new mothers might have. Some important questions we will cover: How can you make your time bonding with your child as positive as possible? What are some thoughts you can bring to this situation? What are the negatives of alone time with your baby? What are the positives?

To sum up class, we will go over the take-home message: You are fulfilling your covenant with God because you are reproducing, regardless of how the baby is born, and it is important to bring helpful thoughts into birth with you. Going over birthing and communication strategies are important because they help to change harmful thoughts into helpful thoughts. It is also important to discuss what happens if a C-section or other type of delivery is needed, not only because of the harmful thoughts that may accompany them, but also because these types of delivery cannot always be planned ahead. If something needs to happen spontaneously, it is better to have already gone through the scenario internally. To wrap-up class we will discuss the personal project for next week, as well as having feedback from participants about class.

Course 6: “Interpersonal Relationships and My Mood/Graduation”

We will begin with announcements and agenda, personal project review, a relaxation exercise, and the Sarah and Rebecca cartoons (Appendix D5). Then, we will transition into new material, consisting of: breaking the vicious cycle, interpersonal relationships and depression, role disagreements/disputes, safety in relationships, attachment between the parents and baby, and role models/God.

In the “safety in relationships” portion, sexual and domestic violence will be emphasized because of the nature of the Orthodox Jewish community. One of the goals for this section is to make clear that options are always available for people seeking to escape unhealthy

relationships. At this point in the class, information will be distributed about seeking help if yourself of someone you know is currently in a dangerous domestic situation. We will role-play what should happen if you or someone you know is in a domestic violence situation. We will discuss the role of the rabbi and how the rabbi can help during this time. In the “role models/God” portion of class, we will identify role models that participants would like their babies to have, and also discuss how your relationship with God can be helpful in your relationship with your baby.

Lastly, we will have a course review emphasizing the main points of the course, our last personal project review, and a final activity. In this activity, mothers will go around the group and tell each person what makes them a good mother. Finally, we will have a graduation ceremony and a celebration.

Results

During first clinical trials, the Mothers and Babies course originally produced a small effect size ($h = .28$). This effect size requires 235 participants in each group (Muñoz et al., 2007), however researchers pose this number could be decreased if the population used had a higher risk for postpartum depression. The Orthodox Jewish community has different risk factors for postpartum depression, traumatic birthing experience and other cultural factors (Segal-Engelchin et al., 2009). However, they are protected through religiosity and social support (Danker et al., 2000). Despite these differences, I propose that the effect size should remain the same using the sample size in the original Mothers and Babies course literature (Muñoz et al., 2007). I propose that a small effect will be produced as well using the same number of participants, considering these factors.

The participants will be placed in stratified random assignment in order to ensure that each group will have an appropriate distribution of secure/insecurely attached mothers and an appropriate distribution of pre-intervention BDI-II scores above and below 20. The women who are placed in each group will be quasi-randomly placed, based on their pre-treatment BDI-II score and attachment style. The predicted results were analyzed using SPSS and R in a variety of statistical methods.

Hypothesis 1

I hypothesize that the adapted Mothers and Babies Course will be an effective intervention for postpartum depression. Mothers who are assigned to the MBC condition will have lower EPDS scores as opposed to mothers who are assigned to the Interpersonal Therapy condition and the Waitlist condition. The scores of mothers in the MBC condition are predicted to have more scores <13, whereas mothers in the IPT or waitlist conditions will have a higher frequency of scores ≥ 13 . The predicted results were analyzed using a chi-squared ($\chi^2 = 8.86, p = .01$) (Fig. 3a & 3b). The distribution of scores was created based on information about postpartum depression within a general population (Rai et al., 2015).

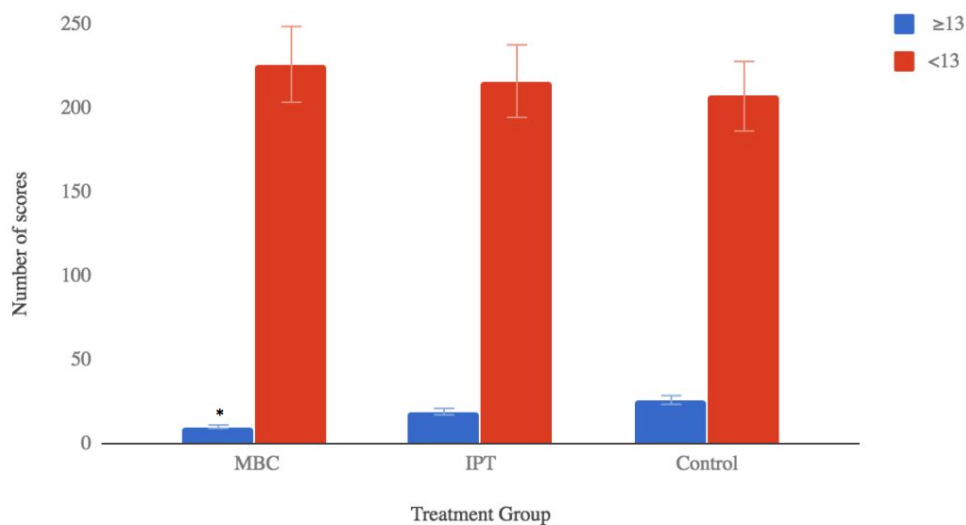


Figure 3a. Composition of total predicted scores on the Edinburgh Postnatal Depression Scale. * indicates $p = .01$.

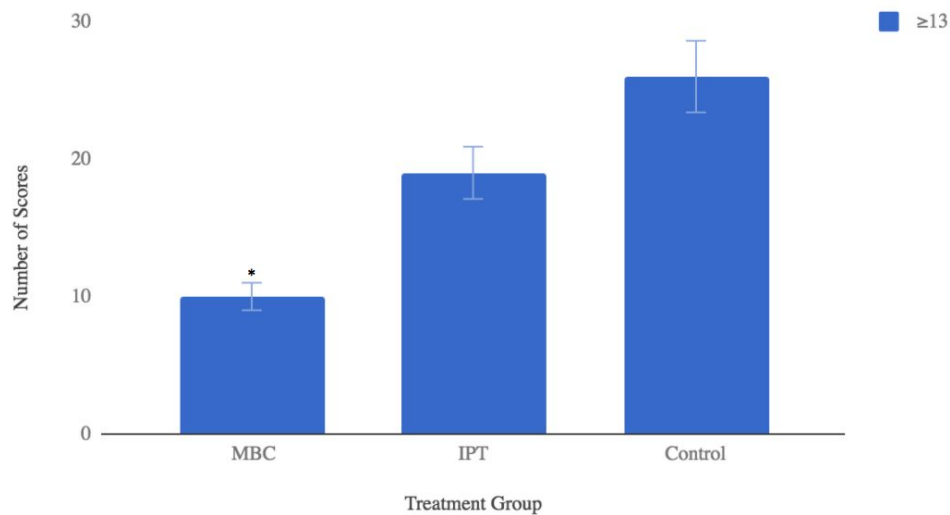


Figure 3b. Composition of predicted scores ≥ 13 on the Edinburgh Postnatal Depression Scale. * indicates $p = .01$.

Hypothesis 2

I predict that not only will the MBC be efficacious prevention of postpartum depression, it will also be more effective at preventing postpartum depression in this specific population of women than Interpersonal Therapy or the control. Using a t-test, I predict that the mothers in the MBC course condition will have overall significant decreases in their pre-/post-BDI-II scores ($t = 12.73, p = .000$), whereas mothers in the Interpersonal Therapy ($t = 1.13, p = .261$) and control groups are proposed to have no significant differences or a significantly increased BDI-II score ($t = -1, p = .318$) (Fig. 4). By comparing the difference between the pre-/post-BDI-II test differences, I will be able to effectively compare the amount of change within each group to the amount of difference between the groups.

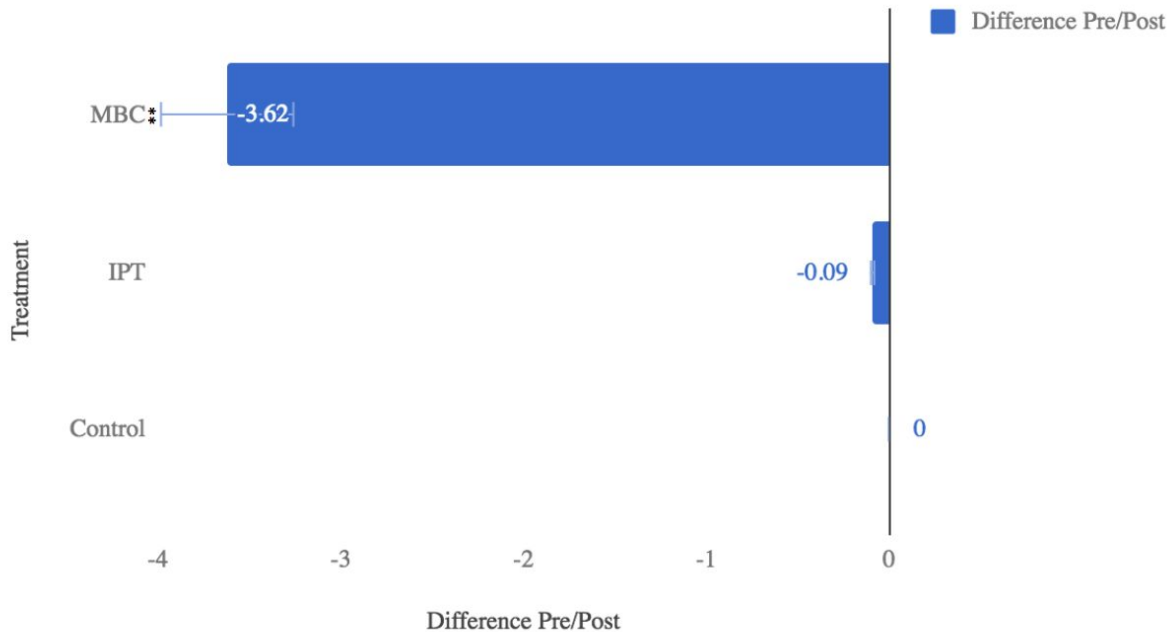


Figure 4. Mean difference in the pre- and post-treatment score on the Beck Depression Inventory-II. ** indicates $p < .001$.

Hypothesis 3

I predict that the MBC will be most effective at forging secure attachments between mothers and infants. The mothers in the MBC group are expected to produce a higher frequency of securely attached infants than mothers in the Interpersonal Therapy group, and the control condition. As previously mentioned, infants at 12 months will take part in the Strange Situation task with their mothers. The predicted results were analyzed using a chi-squared ($\chi^2 = 13.84$, $p = .031$) (Fig. 5). The predicted results were approximated based on Campos and colleagues (1983) as cited by Hazan & Shaver (1987), with predictions about dismissing/fearful attachment derived from an adult general population sample (Mickelson et al., 1997) and the predicted attachment therapy result of mothers receiving the MBC intervention.

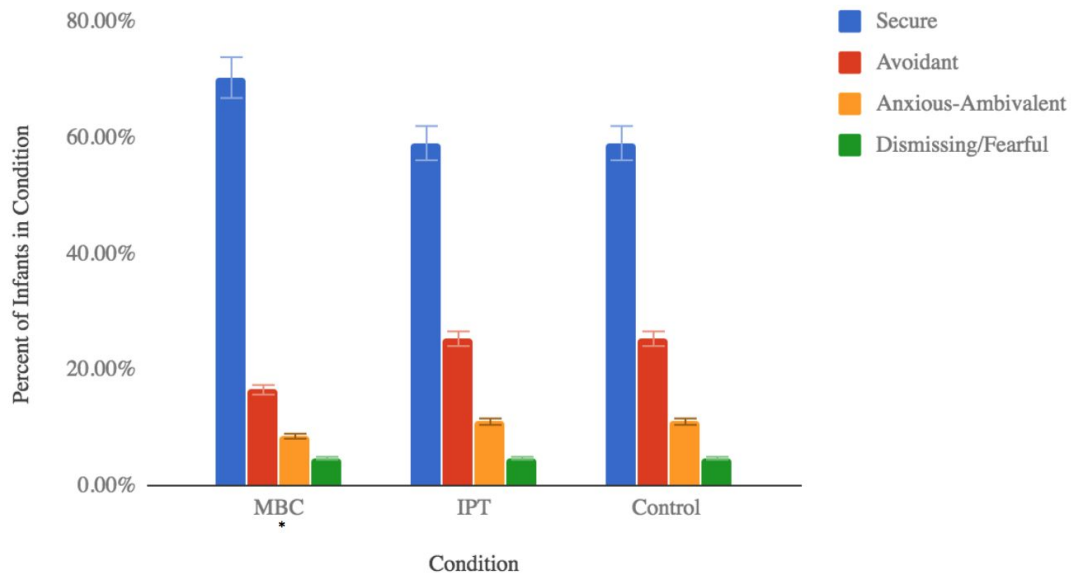


Figure 5. Predicted Attachment Styles of Infants. Attachment styles of infants in the three different intervention conditions. * indicates $p < .05$ for MBC condition.

Hypothesis 4

I expect that there will be a relationship between the attachment style of the mother at the pre-intervention evaluation to the post-intervention attachment style; specifically for mothers in the Mothers and Babies Course condition. Due to the attachment portion of the MBC intervention, I predict that mothers in this condition who have an insecure attachment style will have a secure attachment post-intervention result. I also predict that there will be no effect of an intervention for mothers in the interpersonal therapy or control group (Fig. 6). The expected results were analyzed qualitatively because the use of a chi-square, the statistical method for analyzing most categorical variables, would appear not significant. This would be indistinguishable from a correct not significant result, which poses an issue. I will address this

conflict later in the discussion. Qualitative analysis in this instance focuses on the percent change to securely attached pre-intervention to post-intervention.

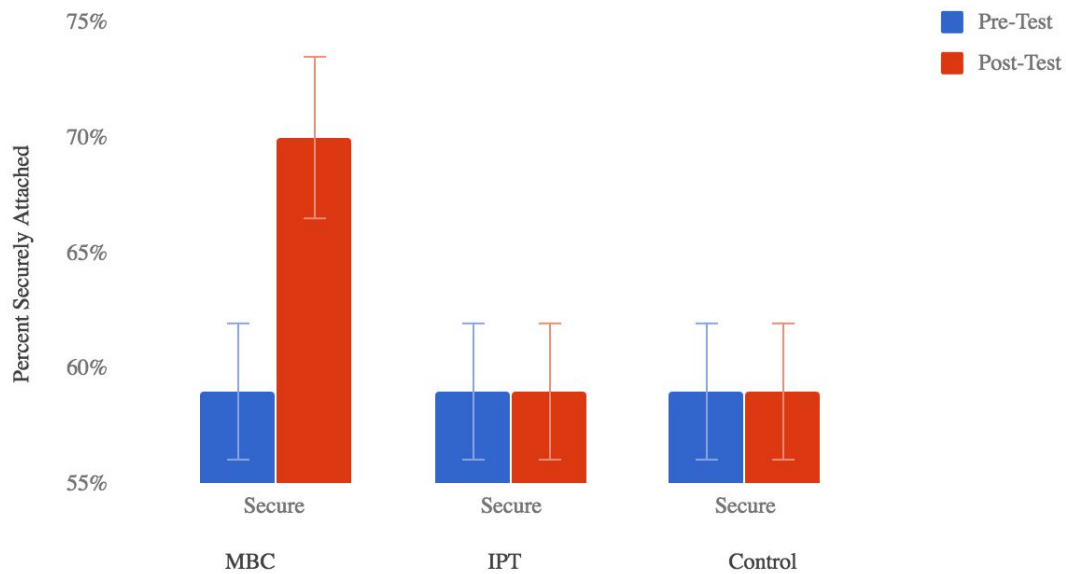


Figure 6. Predicted Pre- & Post-Test % of Securely Attached Mothers. Pre- and post-intervention attachment scores of mothers in each condition.

Hypothesis 5

I expect that the distribution of attachment styles across this population of women will resemble the distribution of attachment styles among the general population, however this may not be the case. The attachment styles of sexual abuse survivors are more disorganized/fearful than the general population (Alexander, 1993). There have been reported rates of sexual abuse in Orthodox Jewish community (Yehuda et al., 2007), as well as intimate partner violence (Ringel & Bina, 2007). Despite this, there is not enough quantitative research on abuse and intimate partner violence to deviate from the general population. According to Ainsworth & Bell (1970), the attachment distribution should be mostly securely attached, with some anxious-ambivalent

and avoidant, and even fewer fearful. While this aspect of the project is not necessarily related to the Mothers and Babies Course, there is a lack of literature on the attachment style patterns of this population. By using data collected in the future implementation of this study, researchers will be able to determine the pattern of attachment styles in this specific culture of women. Based on the previous research, it is predicted that women in the Orthodox Jewish community will have a similar attachment distribution to the general population (Fig. 7).

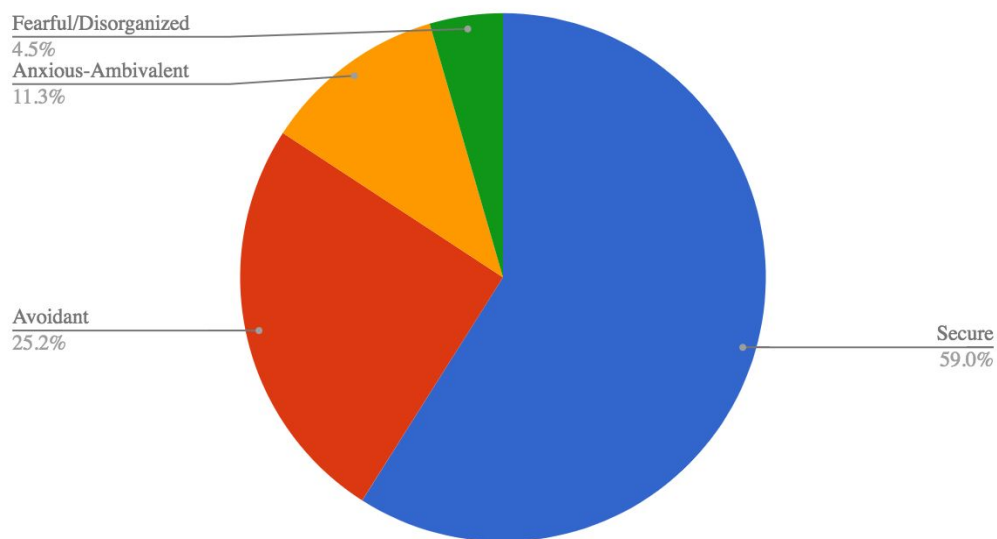


Figure 7. Predicted attachment style distribution among Orthodox Jewish women.

Discussion

The content in this section will be based on the *expected* results, as this is a project proposal. The reason this senior project was proposed rather than empirically collected was for a multitude of reasons. First, I did not have access to a large population of Orthodox Jewish women, specifically within the ultra-Orthodox and Hasidic communities. Second, the time to collect the data would have taken longer than the time allotted for a senior project. Lastly, the implementation of such a proposal requires clinical psychology training that I do not have. The

expected results are proposed to show that the Mothers and Babies course is not only an effective form of treatment, but that it is more efficacious than interpersonal therapy and a control condition for this population of women. The language used in the following section of this senior project will be based on data generated from a random number generator and informed by previous research (Muñoz et al., 2007; Mickelson et al., 1997; Rai et al., 2015; American Psychiatric Association, 2013).

Predicted Efficacy of the Program

Hypothesis 1. If this data were supported, the Mothers and Babies Course adaptation would be an effective form of prevention for postpartum depression. Using the EPDS score as an indicator, it is proposed that participants in the Mothers and Babies Course condition will have lower scores than mothers in the control or interpersonal therapy conditions. This hypothesis is necessary to examine the efficacy of the MBC as an intervention within the Orthodox Jewish population. The expected results are predicted to show that the treatment will be effective for perinatal depression within this population, based on the adaptations. If this data were not supported, then it would be necessary to reevaluate power, sample size, or culturally adapted aspects of the program because this hypothesis will determine if the adapted prevention plan is an effective intervention for this population.

This hypothesis is unique from the second hypothesis in this study proposal because this hypothesis examines whether or not the Mothers and Babies Course can effectively decrease the frequency of postpartum depression within this population. While hypothesis 2 focuses on the comparison between the three groups, the goal of hypothesis 1 is to determine if the intervention

is effective. If the predicted data are supported, the adapted Mothers and Babies Course will be an effective intervention for Orthodox Jewish women.

The nature of Orthodox Jewish culture is such that it is important to be connected with God during birth (Callister et al., 1999). The need for spiritual support is clearly apparent, and evident through the fact that wives take comfort in the spiritual support provided by their husbands (as the only form of support they can receive from him during this time) (Callister et al., 1999; Berkowitz, 2008). Knowing that they are performing a *mitzvah* to fulfill their covenant with God can help them connect with the birthing process. Since an important aspect of birth for a woman is her covenant with God, which is attained through giving birth (specifically giving birth to boys through the vaginal canal), it was important to incorporate that into the therapeutic intervention. In order to reduce rates of postpartum depression, it is necessary to reinforce the idea that women are still performing a *mitzvah* (and therefore fulfilling their covenant with God), even if a C-section or vacuum extraction delivery is needed. The main goal of the study was to examine whether the Mothers and Babies Course, after being adapted to include cultural aspects and risk factors of perinatal depression for this population, would be an efficacious form of therapy.

Hypothesis 2. If the data were supported, the MBC will be more effective at preventing postpartum depression in this population than IPT or the control waitlist group. It is expected that the mothers in the Mothers and Babies course will have overall significantly lowered BDI-II pre/post scores, in comparison to the IPT and control groups— which was the case in the predicted results. The significantly lower BDI-II score is an indication that the MBC treatment was predicted to be more effective at preventing perinatal depression than interpersonal therapy

or the control group. If this hypothesis were to be false, the use of the Mothers and Babies course within this population may not be necessary and more individualized. If there were no difference between interpersonal therapy and the Mothers and Babies course, it would warrant an evaluation of the factors that may make an individual more likely to be helped by one prevention plan versus another.

These proposed results are based on the lack of need for cultural support that interpersonal therapy offers. The nature of the Orthodox Jewish community is inherently culturally supportive. Part of what differentiates becoming a mother in secular society versus becoming a mother in Orthodox Jewish culture may be the focus of the event. In secular society, the focus is predominantly on the baby— baby showers, buying things for the baby, etc. In Orthodox Jewish culture, because of strict gender roles and the expectation to bear children, mothers are fulfilling their duty to reproduce (Berkowitz, 2008). This ‘duty’ to bear children may be seen similarly to being successful in a career in a secular context; therefore, the focus is not only about new life, but also the mother bearing it. An interpersonal therapy intervention will not be as effective for Orthodox Jewish women in the prevention of perinatal depression because there are already cultural mechanisms in place which serve as protective factors for role transitions (Danker et al., 2000). Mothers will reach a ceiling effect of treatment; because of these cultural mechanisms, it is proposed that interpersonal therapy will not provide these mothers with the tools that they need to combat perinatal depression. Whereas, the mothers receiving the MBC intervention will be given helpful strategies based on their apparent needs (culturally).

This interpersonal therapy intervention, while shown to be effective at preventing perinatal depression (Zlotnick et al., 2006), has not been effective in repairing the mother-infant relationship (Forman et al., 2007). The goal of postpartum depression prevention should be two-fold; benefitting both mothers and infants. Mothers can benefit from the Mothers and Babies Course intervention because it will help prevent perinatal depression through teaching helpful thought strategies, and they will learn to bond with their infant. In addition, because there are elements of attachment therapy, mothers will learn to create secure attachments with their infants and potentially become securely attached themselves (if not previously). Since mothers are benefitting, infants will also receive positive impacts; such as secure attachment and healthy cognitive, social, and emotional development (Toth et al., 2009).

Hypothesis 3. I expect that mothers who were placed in the MBC will produce a higher frequency of securely attached infants. The frequency of securely attached infants in the interpersonal therapy and control groups were created to reflect the attachment styles of the general population, because there is a gap in the literature surrounding the attachment styles of the Orthodox Jewish population. The frequency of securely attached infants within the Mothers and Babies Course condition was generated to reflect the number of securely attached mothers in the post-treatment attachment evaluation (the number of mothers who had an attachment style shift to securely attached in combination with the number of mothers who were securely attached at the pre-treatment evaluation and remained securely attached within the MBC condition). There are elements of attachment therapy within the Mothers and Babies Course (Muñoz et al., 2007), so the expectation is that there will be a greater percentage of securely attached infants whose mothers were in the MBC treatment group. I also expect the distribution of attachment

styles among infants to reflect the attachment styles across general population in the control and interpersonal therapy groups, for reasons later described.

If this data were not supported, and there were no differences between the conditions in terms of infant attachment style, the attachment therapy piece of the Mothers and Babies Course would need to be reevaluated. Future research would need to examine what helps foster secure attachment within this population, and how it can be incorporated into the Mothers and Babies Course.

Hypothesis 4. If the data were supported, the attachment styles of the mothers in the Mothers and Babies condition pre- and post-intervention, are predicted to have a higher frequency of securely attached mothers at the post-intervention. In comparison, the attachment styles of the mothers in the other two conditions are expected to remain the same. There are elements of attachment therapy in the MBC treatment that are not present within interpersonal therapy or the control group. This is proposed to be reflected in the attachment style distribution, post-treatment, of the mothers who received the MBC intervention. Part of the Mothers and Babies Course involves attachment therapy (Muñoz et al., 2007). This differs from the interpersonal therapy, because while interpersonal therapy may be effective in treating postpartum depression for the general population, it may not be efficacious in helping secure the mother/infant bond (Forman et al., 2007). In this population, as previously mentioned, interpersonal therapy is expected to not be as effective for postpartum depression because of the cultural strategies already in place. It is expected that a greater number of mothers in the MBC condition will report secure attachment in their post-intervention attachment style distributions because of the elements of attachment therapy within the MBC treatment. Since interpersonal

therapy does not target attachment, there should be no change in that treatment or the control group.

One of the challenges with designing hypothesis 4 was data analysis. An ANOVA could not be performed on the data because attachment style is measured as a categorical variable; there are no continuous variables within this hypothesis. A chi-square could not be performed on the data because the measured variable would be attachment style 'changed' or 'did not change'. The difference between expected and observed would appear as a not significant result, even if more mothers attachment style changed from insecure to secure. This not significant result would be indistinguishable from a correct not significant result, which poses a challenge. Because of this, a qualitative analysis will be performed on the data. In future implementation of this study, a further examination into the measurement and statistical method will be used. For example, if attachment was measured using a continuous (as opposed to categorical) variable, an ANOVA could be used to analyze results.

Hypothesis 5. The purpose of hypothesis 5 is to fill a gap in the literature surrounding attachment styles within the Orthodox Jewish population. Despite the potential increased risk factors, it is proposed that the attachment distribution of Orthodox Jewish women will be close to the general population. Due to potential risk factors such as intimate partner violence (Ringel & Bina, 2007) and sexual abuse (Alexander, 1993), it may not be correct to assume similar attachments to the general population. For these reasons, assumptions about typical attachment style distributions in this population may not be accurate. However, with such little previous research on attachment styles in an Orthodox Jewish sample, I predict that mother's attachment styles pre-intervention will be similar to the general population because of other protective

factors within the community. While religiosity itself is not a protective factor, there are characteristics of the Jewish religion that may serve as protective factors. For example, because God's wish is 'to be fruitful and multiply' (Genesis 1:28), caregivers may be more attached to their children because the command is received from God. In addition, previous studies show that increased number of children serves as a mental health protective factor within the Orthodox Jewish community (Pirutinsky et al., 2015). For future research, it would be interesting to examine what factors in the Orthodox Jewish community make it more or less akin to the general attachment style distribution.

Limitations and Future Directions

While I designed this study proposal to the best of my ability, there are still aspects that may be further developed or explored in future implementations. The expected results are semi-randomly generated data based on the scores and population percentages from the general population because of the lack of data in current research on an Orthodox Jewish population. The Orthodox Jewish community in general is extremely private. This poses a challenge when attempting to design a study with cultural specificity.

One aspect of this study proposal that may be altered in future studies was the recruitment of only women who are expecting their first child. Nulliparous women were the focus for a few reasons; to try to eliminate confounds with having previous children and to create a relative cohort of younger women due to risk factors. Early marriages was seen to be a risk factor for intimate partner violence, and both were shown to be risk factors for postpartum depression (Ringel & Bina, 2007; Beydoun et al., 2010; Glasser et al., 2016). In combination (young primigravida, early marriage, intimate partner violence, and expecting a first child), these

factors target a group of individuals that could be considered high risk (Fig. 1). By excluding mothers who have already had children, there will hopefully be a group of predominantly young women. While this could potentially with a cohort effect, these women might be able to better relate to each other. This reasoning lead me to exclude women who were primi- or multiparous from the study. However, in doing so, this may have excluded a population of women who might benefit from the Mothers and Babies intervention. There is still much research that needs to be done on this population in terms of data collection about risk factors within this community, in addition to perinatal depression research. Future research can include age and number of children as factors in efficacy of the Mothers and Babies Course.

In this proposal, infant attachment style was not used to generally measure the attachment distribution in the population for a number of reasons. The reason infant attachment style was not used to indicate frequencies of attachment in the population is because it would be too far removed from the main goals of the study proposal. The attachment styles of mothers were gauged pre-treatment and hypothesized to be similar to the distribution of general population attachment styles (Mickelson et al., 1997). The main focus of the study proposal was to determine the efficacy of the adapted Mothers and Babies Course for this specific population of women. The reason attachment styles of women were examined specifically here is because this proposed study focuses on the ‘mothers’ aspect of the Mothers and Babies Course. While the outcomes of infant attachment style are important, they are not the focus of this study proposal. Examining the attachment styles of infants was used as an outcome variable of whether the Mothers and Babies Course intervention was successful. Because of this, the use of infant attachment styles to determine the attachment styles within this population would have been too

far on the periphery of the goals of this study. The attachment styles of mothers were taken to fill a gap in the literature with such a large population of samples collected. Collecting 705 participant pre-intervention samples may be enough to generalize throughout this population. Future studies should be dedicated to examining infant attachment within this population, perhaps with data collected from the control group of this study (if executed in the future).

In terms of future directions, gender differences may exist in attachment styles within the Orthodox Jewish population. Specifically because males are heavily valued in this culture, a mother might be more attentive to her male children than her female children. The male covenant with God is through a *brit milah* (Berkowitz, 2008), or a circumcision; giving birth to a male child may be more exciting or fulfilling because he carries the covenant with God, whereas a female does not. Because gender roles are also heavily valued in this culture, it may also be the case that female children need to be more independent so to learn from their mothers— and may therefore be given less attention than their male siblings. In a culture where reproduction is also valued very heavily, older female children may be expected to watch over younger children as practice for motherhood. In modern reform Judaism, Jewish mothers are often said to coddle their male children and are frequently described as “overbearing”. For future research directions, it would be interesting to examine the attachment distribution of infants considering gender as a variable. If this is the case, a section on the “gender reveal” of the baby might be necessary in the intervention— in order to prevent mothers from feeling differently towards a baby girl versus a baby boy.

The attachment styles of the mother were measured pre- and post-treatment to explore how the intervention may have affected mothers in different conditions. The tool chosen to

measure attachment style in this proposal was the Adult Attachment Interview (George et al., 1996), which has benefits and drawbacks. One of the benefits to using the AAI is that it gives an extremely detailed image of the relationship between an individual, their parents, and their current/future offspring due to the elaboration of the interview (George et al., 1996). This can give researchers a clear depiction of an individual's attachment style. In addition, this measure asks questions about an individual's relationships with both their parents and children; this is especially useful to this study proposal because can be clearly shown how each intervention may have an effect on the mother's relationship with their infant (in the future at pre-intervention, and in the present at post-intervention). It is a reliable measure for gauging attachment overall (Ravitz et al., 2010) and will give a general picture of attachment style for hypothesis 5.

However, there are drawbacks the AAI. It is a structured interview that is concerned with both parental and offspring relationships— and using it in a longitudinal study (such as this proposal) where the focus is solely on mothers and infants— may not be the most effective tool at measuring attachment. While after the Mothers and Babies Course, participants may have a different outlook on the questions relating to their offspring, they may not have different answers surrounding their parents and childhood— which may impact their scores. The reason the AAI was chosen is because it can give a valid and reliable depiction of an overall attachment style— which is necessary for the population distribution, as well as determining a pre-intervention attachment style basis. In future studies, a different attachment measurement tool may be used to solely focus on the mother's relationship with their infant. The Prenatal Attachment Inventory (at pre-intervention) and the Maternal Attachment Inventory (at post-intervention) have high

reliability and validity ratings, and are specifically concerned with the mother-infant relationship (Albuquerque Perrelli et al., 2014).

In this project proposal, the interpersonal therapy intervention was not as clearly described as the Mothers and Babies Course. The focus of this intervention was not interpersonal therapy, but whether the Mothers and Babies Course was an effective course of treatment (and whether or not it was more effective than interpersonal therapy— because there is very little research comparing the two treatments, if any). This gap in the literature was the reason I decided to propose to use an interpersonal therapy group as a comparison group. In previous readings, the two main schools of psychotherapeutic treatment for postpartum depression include cognitive-behavioral therapy and interpersonal therapy (Fittleson et al., 2011). Using an interpersonal therapy group as the comparison allows the two standards of treatment to be compared for this specific population. The interpersonal therapy intervention was slightly adapted from the ROSE program (Zlotnick et al., 2006). This intervention is typically conducted in small groups for 90 minutes over the course of 4 weeks. Instead, the program will be adapted to have 60 minute sessions over the course of 6 weeks in order to run during the same time period as the Mothers and Babies Course.

The lack of spiritual adaptation was also a significant choice in using interpersonal therapy. The choice in not including a cultural aspect to the IPT program (besides simply using language familiar to this population) was to differentiate the two treatments. The focus of this study proposal was the Mothers and Babies Course; and therefore concerned with creating an adaptation of the Mothers and Babies Course that adheres to culturally appropriate norms and risk factors. The target of an interpersonal therapy intervention is to connect an individual with

the people around them; to essentially form a support system. The goal of this proposal is to evaluate how this interpersonal therapy intervention compares to a culturally appropriate cognitive-behavioral therapy; because of the way interpersonal therapy is performed, it would be difficult to adapt it culturally. Cognitive-behavioral therapy is mostly concerned with the personal reality that is derived from a person's experiences (Muñoz et al., 2007) and subsequently, their culture. Interpersonal therapy is mostly concerned with the externalization of issues (involving people in the individual's life) and transitioning into the role of motherhood (Forman et al., 2007). Part of the reason the Mothers and Babies Course is predicted to be more effective at preventing postpartum depression than the interpersonal therapy is because there are already mechanisms within Orthodox Jewish culture that attend to transitioning into the role of motherhood. Future research should examine the comparison of a completely culturally adapted interpersonal therapy intervention (if possible) to this CBT, however I would predict that the results of a future study would continue to be similar to the predicted results of this study proposal.

When imagining future implementation, this project proposal would need to begin on a smaller scale. In an ecologically valid setting, multiple experiments may be conducted to obtain the necessary information in order to fully administer this proposal. For example, first a pilot study would need to be done in order to gauge whether or not the Mothers and Babies Course intervention was efficacious for this population. Essentially, the pilot would examine hypothesis 1 without an interpersonal therapy comparison group. Then, after establishing efficacy, the intervention could be compared and contrasted against other perinatal depression interventions such as interpersonal therapy. The first implementation of this study should be solely focused on

two groups of women (a Mothers and Babies condition and a control condition) in order to determine if treatment is effective for only specific groups within the community (e.g young mothers versus older mothers, nulliparous versus primi- or multiparous). For future research, it might be useful to use age and number of children as factors in the development of postpartum depression and examining the efficacy of the Mothers and Babies Course.

In addition to reevaluating the steps of the Mothers and Babies Course, it may also be necessary to reevaluate the necessary sample size and power. The sample size and power reported in this project proposal were also based on previous literature pertaining to another population of individuals. They were based on the original literature of the *Mamas y Bebes*: The Mothers and Babies Course, which included risk factors and analysis for a Latina population (Muñoz et al., 2007). This, however, poses a challenge because with a three-condition study, needing to acquire 235 participants in each group (705 participants total) may not be the most feasible option. The choice to not reevaluate the power analysis comes from a lack in research on the Orthodox Jewish population and the conclusion that, while there are different risk and protective factors for each community, the overall risk/protection may be similar. In a future pilot study, the power and sample size will be reevaluated to determine a more accurate number of participants per condition.

The body of literature on the Orthodox Jewish community is minimal at best, and needs exploration. While Orthodox Jewish communities can be found within secular society, the ultra-Orthodox and Hasidic Orthodox primarily stay within the borders of their own community. This rejection of secularism may indicate different frequencies of attachment, perinatal depression, and intimate partner violence. Strict gender roles are highly promoted within this

culture, and as gender roles become less defined within secular society, it is particularly interesting to observe within a community removed. The community itself is extremely private by nature and therefore difficult to obtain information from. Future research should examine this community in a culturally appropriate manner, while also obtaining important data such as attachment style distribution, intimate partner violence levels, and perinatal depression levels.

Conclusion

Perinatal depression is a debilitating disorder that can have a negative impact on the mother and infant, both physically and psychologically. While there are different options for treatment, medication can be accompanied by stigma in certain populations which may lead to patients choosing psychotherapy. Finding an effective prevention of perinatal depression will be an important contribution to the field of maternal mental health. Through the cognitive-behavioral therapy based intervention called the Mothers and Babies Course, this project is proposing a version of the methods specifically adapted for an Orthodox Jewish population. Orthodox Jewish women are at risk of developing perinatal depression through “traumatic” birthing experiences, young marriages/motherhood, being nulliparous, and being a victim of domestic or sexual violence. This adapted intervention specifically targets these areas in order to decrease the frequency of women who will develop perinatal depression. Orthodox Jewish culture heavily values reproduction, and having perinatal depression may be accompanied by stigma, and therefore women will not be able to seek help.

The current research on the Orthodox Jewish community is extremely sparse. Understanding this population may provide more insight into how better to conduct the proposed project. Future research should include the attachment styles of infants within an Orthodox

Jewish population, rates of intimate partner violence among an Orthodox Jewish population, and general rates of perinatal depression within the community. Much of the research available currently involves qualitative analysis of these topics, if any. Quantitative information will be able to help gauge the necessity and methods of delivering an intervention. As for the current study proposal, information was based on the general population and the original Mothers and Babies Course study (Muñoz et al., 2007) because there was a lack of information regarding Orthodox Jewish women. Future studies in the area of perinatal depression prevention should focus on the implementation of a cognitive-behavioral therapy with elements of attachment therapy within this population.

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Appendix A

Beck Depression Inventory-II

<Roch Beck Depression Inventory Baseline

V 0477 CRTN: _____ CRF number: _____ Page 14 patient inits: _____



Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle *the* number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

<p>1. Sadness</p> <p>0 I do not feel sad.</p> <p>1 I feel sad much of the time.</p> <p>2 I am sad all the time.</p> <p>3 I am so sad or unhappy that I can't stand it.</p> <p>2. Pessimism</p> <p>0 I am not discouraged about my future.</p> <p>1 I feel more discouraged about my future than I used to be.</p> <p>2 I do not expect things to work out for me.</p> <p>3 I feel my future is hopeless and will only get worse.</p> <p>3. Past Failure</p> <p>0 I do not feel like a failure.</p> <p>1 I have failed more than I should have.</p> <p>2 As I look back, I see a lot of failures.</p> <p>3 I feel I am a total failure as a person.</p> <p>4. Loss of Pleasure</p> <p>0 I get as much pleasure as I ever did from the things I enjoy.</p> <p>1 I don't enjoy things as much as I used to.</p> <p>2 I get very little pleasure from the things I used to enjoy.</p> <p>3 I can't get any pleasure from the things I used to enjoy.</p> <p>5. Guilty Feelings</p> <p>0 I don't feel particularly guilty.</p> <p>1 I feel guilty over many things I have done or should have done.</p> <p>2 I feel quite guilty most of the time.</p> <p>3 I feel guilty all of the time.</p>	<p>6. Punishment Feelings</p> <p>0 I don't feel I am being punished.</p> <p>1 I feel I may be punished.</p> <p>2 I expect to be punished.</p> <p>3 I feel I am being punished.</p> <p>7. Self-Dislike</p> <p>0 I feel the same about myself as ever.</p> <p>1 I have lost confidence in myself.</p> <p>2 I am disappointed in myself.</p> <p>3 I dislike myself.</p> <p>8. Self-Criticalness</p> <p>0 I don't criticize or blame myself more than usual.</p> <p>1 I am more critical of myself than I used to be.</p> <p>2 I criticize myself for all of my faults.</p> <p>3 I blame myself for everything bad that happens.</p> <p>9. Suicidal Thoughts or Wishes</p> <p>0 I don't have any thoughts of killing myself.</p> <p>1 I have thoughts of killing myself, but I would not carry them out.</p> <p>2 I would like to kill myself.</p> <p>3 I would kill myself if I had the chance.</p> <p>10. Crying</p> <p>0 I don't cry anymore than I used to.</p> <p>1 I cry more than I used to.</p> <p>2 I cry over every little thing.</p> <p>3 I feel like crying, but I can't.</p>
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Beck Depression Inventory

Baseline

V 0477

CRTN: _____ CRF number: _____ **1 Page 15** patient inits: _____

<p>11. Agitation</p> <p>0 I am no more restless or wound up than usual.</p> <p>1 I feel more restless or wound up than usual.</p> <p>2 I am so restless or agitated that it's hard to stay still.</p> <p>3 I am so restless or agitated that I have to keep moving or doing something.</p> <p>12. Loss of Interest</p> <p>0 I have not lost interest in other people or activities.</p> <p>1 I am less interested in other people or things than before.</p> <p>2 I have lost most of my interest in other people or things.</p> <p>3 It's hard to get interested in anything.</p> <p>13. Indecisiveness</p> <p>0 I make decisions about as well as ever.</p> <p>1 I find it more difficult to make decisions than usual.</p> <p>2 I have much greater difficulty in making decisions than I used to.</p> <p>3 I have trouble making any decisions.</p> <p>14. Worthlessness</p> <p>0 I do not feel I am worthless.</p> <p>1 I don't consider myself as worthwhile and useful as I used to.</p> <p>2 I feel more worthless as compared to other people.</p> <p>3 I feel utterly worthless.</p> <p>15. Loss of Energy</p> <p>0 I have as much energy as ever.</p> <p>1 I have less energy than I used to have.</p> <p>2 I don't have enough energy to do very much.</p> <p>3 I don't have enough energy to do anything.</p> <p>15. Changes in Sleeping Pattern</p> <p>0 I have not experienced any change in my sleeping pattern.</p> <p>1a I sleep somewhat more than usual.</p> <p>1b I sleep somewhat less than usual.</p> <p>2a I sleep a lot more than usual.</p> <p>2b I sleep a lot less than usual.</p> <p>3a I sleep most of the day.</p> <p>3b I wake up 1-2 hours early and can't get back to sleep.</p>	<p>17. Irritability</p> <p>0 I am no more irritable than usual.</p> <p>1 I am more irritable than usual.</p> <p>2 I am much more irritable than usual.</p> <p>3 I am irritable all the time.</p> <p>18. Changes in Appetite</p> <p>0 I have not experienced any change in my appetite.</p> <p>1a My appetite is somewhat less than usual.</p> <p>1b My appetite is somewhat greater than usual.</p> <p>2a My appetite is much less than before.</p> <p>2b My appetite is much greater than usual.</p> <p>3a I have no appetite at all.</p> <p>3b I crave food all the time.</p> <p>19. Concentration Difficulty</p> <p>0 I can concentrate as well as ever.</p> <p>1 I can't concentrate as well as usual.</p> <p>2 It's hard to keep my mind on anything for very long.</p> <p>3 I find I can't concentrate on anything.</p> <p>20. Tiredness or Fatigue</p> <p>0 I am no more tired or fatigued than usual.</p> <p>1 I get more tired or fatigued more easily than usual.</p> <p>2 I am too tired or fatigued to do a lot of the things I used to do.</p> <p>3 I am too tired or fatigued to do most of the things I used to do.</p> <p>21. Loss of Interest in Sex</p> <p>0 I have not noticed any recent change in my interest in sex.</p> <p>1 I am less interested in sex than I used to be.</p> <p>2 I am much less interested in sex now.</p> <p>3 I have lost interest in sex completely.</p>
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_____ Subtotal Page 2
 _____ Subtotal Page 1
 _____ Total Score

NR15645

Appendix B

Adult Attachment Interview

This material is not a substitute for training in AAI administration procedure. It is provided because it is important for consumers of AAI research to have easy access to the interview questions. Without them, it is difficult to evaluate published research. Seeing the full interview protocol can also help consumers of AAI based research appreciate the level of interview information and detail underlying AAI scores. It can also help them make important decisions about the adequacy of procedures in various reports they may encounter.

The authors of the AAI make the scoring manual available only in conjunction with their training courses. Researchers interested in understanding more about the logic of scoring the AAI can however see the scoring manual for Crowell & Owens' Current Relationship Interview (CRI) which is available in full on this site. The logic and procedures for scoring the CRI closely parallel those for the AAI. The primary difference is that the AAI focuses on relationships to parents and the CRI on relationships to adult attachment figures. At present this is the only detailed source of insights into the criteria for scoring the AAI available to those who do not take the training course.

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ADULT ATTACHMENT INTERVIEW PROTOCOL

George, C., Kaplan, N., & Main, M. (1985). *The Adult Attachment Interview*. Unpublished manuscript, University of California at Berkeley.

(Note: This document is for illustration only. Contact the authors for information about training and the most current version of the interview protocol.)

Introduction

I'm going to be interviewing you about your childhood experiences, and how those experiences may have affected your adult personality. So, I'd like to ask you about your early relationship with your family, and what you think about the way it might have affected you. We'll focus mainly on your childhood, but later we'll get on to your adolescence and then to what's going on right now. This interview often takes about an hour, but it could be anywhere between 45 minutes and an hour and a half.

1. Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?

This question is used for orientation to the family constellation, and for warm-up purposes. The research participant must not be allowed to begin discussing the quality of relationships here, so the "atmosphere" set by the interviewer is that a brief list of "who, when" is being sought, and *no more than two or three minutes* at most should be used for this question. The atmosphere is one of briefly collecting demographics.

In the case of participants raised by several persons, and not necessarily raised by the biological or adoptive parents (frequent in high-risk samples), the opening question above may be *"Who would you say raised you?":* The interviewer will use this to help determine who should be considered the primary attachment figure (s) on whom the interview will focus.

Did you see much of your grandparents when you were little? If participant indicates that grandparents died during his or her own lifetime, ask the participant's age at the time of each loss. If there were grandparents whom she or he never met, ask whether this (these) grandparents had died before she was born. If yes, continue as follows: Your mother's father died before you were born? How old was she at the time, do you know? In a casual and spontaneous way, inviting only a very brief reply, the interviewer then asks, Did she tell you much about this grandfather?

Did you have brothers and sisters living in the house, or anybody besides your parents? Are they liv-

*ing nearby now or do they live
elsewhere?*

2. *I'd like you to try to describe your relationship with your parents as a young child if you could start from as far back as you can remember?*

Encourage participants to try to begin by remembering very early. Many say they cannot remember early childhood, but you should shape the questions such that they focus at first around age five or earlier, and gently remind the research participant from time to time that if possible, you would like her to think back to this age period.

Admittedly, this is leaping right into it, and the participant may stumble. If necessary, indicate in some way that experiencing some difficulty in initially attempting to respond to this question is natural, but indicate by some silence that you would nonetheless like the participant to attempt a general description.

3. *Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting from as far back as you can remember in early childhood--as early as you can go, but say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me.*

Not all participants will be able to think of five adjectives right away. Be sure to make the word *relationship* clear enough to be heard in this sentence. Some participants do use "relationship" adjectives to describe the parent, but some just describe the parent herself --e.g., "pretty"... "efficient manager"--as though they had only been asked to "pick adjectives to describe your mother". These individual differences are of interest only if the participant has heard the phrase, "that reflect your childhood *relationship*" with your mother. The word should be spoken clearly, but with only slight stress or emphasis.

Some participants will not know what you mean by the term *adjectives*, which is why we phrase the question as "adjectives or words". If the participant has further questions, you can explain, "just words or phrases that would describe or tell me about your relationship with your (mother) during childhood".

The probes provided below are intended to follow the entire set of adjectives, and *the interviewer must not begin to probe until the full set of adjectives has been given*. Be patient in waiting for the participant to arrive at five adjectives, and be encouraging. This task has proven very helpful both in starting an interview, and in later interview analysis. It helps some participants to continue to focus upon the relationship when otherwise they would not be able to come up with spontaneous comments.

If for some reason a subject does not understand what a memory is, you might suggest they think of it like an image they have in their mind similar to a videotape of something which happened when they were young. Make certain that the subject really does not understand the question first, however. The great majority who may seem not to understand it are simply unable to provide a memory or incident.

The participant's ability (or inability) to provide both an overview of the relationship and specific memories supporting that overview forms one of the most critical bases of interview analysis. For this reason it is important for the interviewer to press enough in the effort to obtain the five "overview" adjectives that if a full set is not provided, she or he is reasonably certain that they truly cannot be given.

The interviewer's manner should indicate that waiting as long as a minute is not unusual, and that trying to come up with these words can be difficult. Often, participants indicate by their non-verbal behavior that they are actively thinking through or refining their choices. In this case an interested silence is warranted. Don't, however, repeatedly leave the participant in embarrassing silences for very long periods. Some research participants may tell you that this is a hard job, and you can readily acknowledge this. If the participant has extreme difficulty coming up with more than one or two words or adjectives, after a period of two to three minutes of supported attempts ("Mm... I know it can be hard ...this is a pretty tough question... Just take a little more time"),

then say something like "Well, that's fine. Thank you, we'll just go with the ones you've already given me." The interviewer's tone here should make it clear that the participant's response is perfectly acceptable and not uncommon.

Okay, now let me go through some more questions about your description of your childhood relationship with your mother. You say your relationships with her was (you used the phrase) Are there any memories or incidents that come to mind with respect to (word)

The same questions will be asked *separately* for *each* adjective in series. Having gone through the probes which follow upon this question (below), the interviewer moves on to seek illustration for each of the succeeding adjectives in turn:

You described your childhood relationship with your mother as (or, 'your second adjective was', or 'the second word you used was'). Can you think of a memory or an incident that would illustrate why you chose to describe the relationship?

The interviewer continues, as naturally as possible, through each phrase or adjective chosen by the participant, until all five adjectives or phrases are covered. A specific supportive memory or expansion and illustration is requested for each of the adjectives, separately. In terms of time to answer, this is usually the longest question. Obviously, some adjectives chosen may be almost identical, e.g., "loving ... caring". Nonetheless, if they have been given to you as separate descriptors, you must treat each separately, and ask for memories for each.

While participants sometimes readily provide a well-elaborated incident for a particular word they have chosen, at other times they may fall silent; or "illustrate" one adjective with another ("loving ...um, because she was generous"); or describe what usually happened--i.e., offer a "scripted" memory--rather than describing specific incidents. There are a set series of responses available for these contingencies, and it is vital to memorize them.

If the participant is silent, the interviewer waits an appropriate length of time. If the participant indicates non-verbally that she or he is actively thinking, remembering or simply attempting to come up with a particularly telling illustration, the interviewer maintains an interested silence. If the silence continues and seems to indicate that the participant is feeling stumped, the interviewer says something like, "well, just take another minute and see if anything comes to mind". If following another waiting period the participant still cannot respond to the question, treat this in a casual, matter of fact manner and say "well, that's fine, let's take the next one, then". Most participants do come up with a response eventually, however, and the nature of the response then determines which of the follow-up probes are utilized.

If the participant re-defines an adjective with a second adjective as, "Loving ---she was generous", the interviewer probes by repeating the original adjective (loving) rather than permitting the participant to lead them to use the second one (generous). In other words, the interviewer in this case will say, "Well, can you think of a specific memory that would illustrate how your relationship was loving?" The interviewer should be careful, however, not to be too explicit in their intention to lead the participant back to their original word usage. If the speaker continues to discuss "generous" after having been probed about loving once more, this violation of the discourse task is meaningful and must be allowed. As above, the nature of the participant's response determines which follow-up probes are utilized.

If a specific and well-elaborated incident is given, the participant has responded satisfactorily to the task, and the interviewer should indicate that she or he understands that. However, the interviewer should briefly show continuing interest by asking whether the participant can think of a second incident.

- If one specific but poorly elaborated incident is given, the interviewer probes for a second. Again, the interviewer does this in a manner emphasizing his or her own interest.
- If as a first response the participant gives a "scripted" or "general" memory, as "Loving. She always took us to the park and on picnics. She was really good on holidays" or "Loving. He taught me to ride

a bike"--the interviewer says, "Well, that's a good general description, but I'm wondering if there was a particular time that happened, that made you think about it as loving?"

- If the participant does now offer a specific memory, briefly seek a second memory, as above. If another scripted memory is offered instead, or if the participant responds "I just think that was a loving thing to do", the interviewer should be accepting, and go on to the next adjective. Here as elsewhere the interviewer's behavior indicates that the participant's response is satisfactory.

4. Now I'd like to ask you to choose five adjectives or words that reflect your childhood relationship with your father, again starting from as far back as you can remember in early childhood--as early as you can go, but again say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me. (Interviewer repeats with probes as above).

5. Now I wonder if you could tell me, to which parent did you feel the closest, and why? Why isn't there this feeling with the other parent?

By the time you are through with the above set of questions, the answer to this one may be obvious, and you may want to remark on that ("*You've already discussed this* a bit, but I'd like to ask about it briefly anyway..."). Furthermore, while the answer to this question may indeed be obvious for many participants, some--particularly those who describe both parents as loving--may be able to use it to reflect further on the difference in these two relationships.

6. When you were upset as a child, what would you do?

This is a critical question in the interview, and variations in the interpretation of this question are important. Consequently, the participant is first encouraged to think up her own interpretations of "upset", with the interviewer pausing quietly to indicate that the question is completed, and that an answer is requested.

Once the participant has completed her own interpretation of the question, giving a first answer, begin on the following probes. Be sure to get expansions of every answer. If the participant states, for example, "I withdrew", probe to understand what this research participant means by "withdrew". For example, you might say, "And what would you do when you withdrew?"

The interviewer now goes on to ask the specific follow-up questions below. These questions may appear similar, but they vary in critical ways, so the interviewer must make sure that the participant thinks through each question separately. This is done by placing vocal stress on the changing contexts (as we have indicated by underlining).

----*When you were Upset emotionally when you were little, what would you do?* (Wait for participant's reply). *Can you think of a specific time that happened?*

----*Can you remember what would happen when you were hurt, physically?* (Wait for participant's reply). *Again, do any specific incidents (or, do any other incidents) come to mind?*

----*Were you ever M when you were little?* (Wait for participant's reply). *Do you remember what would happen?*

When the participant describes going to a parent, see first what details they can give you spontaneously. Try to

get a sense of how the parent or parents responded, and then when and if it seems appropriate you can briefly ask one or two clarifying questions.

Be sure to get expansions of every answer. Again, if the participant says "I withdrew", for example, probe to see what the participant means by this, i.e., what exactly she or he did, or how exactly they felt, and if they can elaborate on the topic.

If the participant has not spontaneously mentioned being held by the parent in response to any of the above questions, the interviewer can ask casually at the conclusion to the series, "*I was just wondering, do you remember being held by either of your parents at any of these times--I mean, when you were upset, or hurt, or ill?*"

In earlier editions of these guidelines, we suggested that if the participant answers primarily in terms of responses by one of the parents, the interviewer should go through the above queries again with respect to the remaining parent. This can take a long time and distract from the recommended pacing of the interview. Consequently, it is no longer required.

What is the first time you remember being separated from your parents?

--How did you respond? Do you remember how your parents responded?

--Are there any other separations that stand out in your mind?

Here research participants often describe first going off to nursery school, or to primary school, or going camping.

In this context, participants sometimes spontaneously compare their own responses to those of other children. This provides important information regarding the participant's own overall attitude towards attachment, so be careful not to cut any such descriptions or comparisons short.

8. *Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having rejected in childhood*

----How old were you when you first felt this way, and what did you do?

----Why do you think your parent did those things--do you think he/she realized he/she was rejecting you?

Interviewer may want to add a probe by reframing the question here, especially if no examples are forthcoming. The probe we suggest here is, *Did you ever feel pushed away or ignored?*

Many participants tend to avoid this in terms of a positive answer.

So, were you ever frightened or worried as a child?

Let the research participant respond "freely" to this question, defining the meaning for themselves. They may ask you what the question means, and if so, simply respond by saying "It's just a more general question". Do not probe heavily here. If the research participant has had traumatic experiences which they elect not to describe, or which they have difficulty remembering or thinking about, you should not insist upon hearing about them. They will have a second, brief opportunity to discuss such topics later.

9. *Were your parents ever threatening with you in any way - maybe for discipline, or even jokingly?*

----Some people have told us for example that their parents would threaten to leave them or send them away from home.

----(Note to researchers). In particular communities, some specific kind of punishment not generally

considered fully abusive is common, such as "the silent treatment", or "shaming", etc. One question regarding this one selected specific form of punishment can be inserted here, as for example, '*Some people have told us that their parents would use the silent treatment---did this ever happen with your parents?*': The question should then be treated exactly as threatening to send away from home, i.e., the participant is free to answer and expand on the topic if she or he wishes, but there are no specific probes. The researcher should not ask about more than one such specific (community) form of punishment, since queries regarding more than one common type will lead the topic away from its more general intent (below).

Some people have memories of threats or of some kind of behavior that was abusive.

----Did anything like this ever happen to you, or in your family?

----How old were you at the time? Did it happen frequently?

----Do you feel this experience affects you now as an adult?

----Does it influence your approach to your own child?

----Did you have any such experiences involving people outside your family?

If the participant indicates that something like this did happen outside the family, take the participant through the same probes (*age? frequency? affects you now as an adult? Influences your approach to your own child?*). Be careful with this question, however, as it is clinically sensitive, and by now you may have been asking the participant difficult questions for an extended period of time.

Many participants simply answer "no" to these questions. Some, however, describe abuse and may some suffer distress in the memory. When the participant is willing to discuss experiences of this kind, the interviewer must be ready to maintain a respectful silence, or to offer active sympathy, or to do whatever may be required to recognize and insofar as possible to help alleviate the distress arising with such memories.

If the interviewer suspects that abuse or other traumatic experiences occurred, it is important to attempt to ascertain the specific details of these events insofar as possible. In the coding and classification system which accompanies this interview, *distressing experiences cannot be scored for Unresolved /disorganized responses unless the researcher is able to establish that abuse (as opposed to just heavy spanking, or light hitting with a spoon that was not frightening) occurred.*

Where the nature of a potentially physically abusive (belting, whipping, or hitting) experience is ambiguous, then, the interviewer should try to establish the nature of the experience in a light, matter-of-fact manner, without excessive prodding. If, for example, the participant says "I got the belt" and stops, the interviewer asks, "And what did getting the belt mean?". After encouraging as much spontaneous expansion as possible, the interviewer may still need to ask, again in a matter-of-fact tone, how the participant responded or felt at the time. "Getting the belt" *in itself* will not qualify as abuse within the adult attachment scoring and classification systems, since in some households and communities this is a common, systematically but not harshly imposed experience. Being belted heavily enough to overwhelmingly frighten the child for her physical welfare at the time, being belted heavily enough to cause lingering pain, and/or being belted heavily enough to leave welts or bruises will qualify.

In the case of sexual abuse as opposed to battering, the interviewer will seldom need to press for details, and should be very careful to follow the participant's lead. Whereas on most occasions in which a participant describes themselves as sexually abused the interviewer and transcript judge will have little need to probe further, occasionally a remark is ambiguous enough to require at least mild elaboration. If, for example, the participant states 'and I just thought he could be pretty sexually abusive', the interviewer will ideally follow-up with a

query such as, 'well, could you tell me a little about what was happening to make you see him as sexually abusive?'. Should the participant reply that the parent repeatedly told off-color jokes in her company, or made un-toward remarks about her attractiveness, the parent's behavior, though insensitive, will not qualify as sexually abusive within the accompanying coding system. Before seeking elaboration of any kind, however, the interviewer should endeavor to determine whether the participant seems comfortable in discussing the incident or incidents.

All querying regarding abuse incidents must be conducted in a matter-of-fact, professional manner. The interviewer must use good judgment in deciding whether to bring querying to a close if the participant is becoming uncomfortable. At the same time, the interviewer *must not avoid the topic or give the participant the impression that discussion of such experiences is unusual*. Interviewers sometimes involuntarily close the topic of abuse experiences and their effects, in part as a well-intentioned and protective response towards participants who in point of fact would have found the discussion welcome.

Participants who seem to be either thinking about or revealing abuse experiences for the first time-- "No, nothing ...no... well, I, I haven't thought, remembered this for, oh, years, but ...maybe they used to... tie me..."-- must be handled with special care, and should not be probed unless they clearly and actively seem to want to discuss the topic. If you sense that the participant has told you things they have not previously discussed or remembered, special care must be taken at the end of the interview to ensure that the participant does not still suffer distress, and feels able to contact the interviewer or project director should feelings of distress arise in the future.

In such cases the participant's welfare must be placed above that of the researcher. While matter-of-fact, professional and tactful handling of abuse-related questions usually makes it possible to obtain sufficient information for scoring, the interviewer must be alert to indications of marked distress, and ready to tactfully abandon this line of questioning where necessary. Where the complete sequence of probes must be abandoned, the interviewer should move gracefully and smoothly to the next question, as though the participant had in fact answered fully.

10. *In general, how do you think your overall experiences with your parents have affected your adult personality?*

The interviewer should pause to indicate she or he expects the participant to be thoughtful regarding this question, and is aware that answering may require some time.

Are there any aspects to your early experiences that you feel were a set-back in your development?

In some cases, the participant will already have discussed this question. Indicate, as usual, that you would just like some verbal response again anyway, "for the record".

It is quite important to know whether or not a participant sees their experiences as having had a negative effect on them, so the interviewer will follow-up with one of the two probes provided directly below. The interviewer must stay alert to the participant's exact response to the question, since the phrasing of the probe differs according to the participant's original response.

If the participant has named one or two setbacks, the follow-up probe used is:

---Are there any other aspects of your early experiences, that you think might have held your development back, or had a negative effect on the way you turned out?

If the participant has understood the question, but has not considered anything about early experiences a setback, the follow-up probe used is:

---Is there any thin about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

Although the word **anything** receives some vocal stress, the interviewer must be careful not to seem to be expressing impatience with the participant's previous answer. The stress simply implies that the participant is being given another chance to think of something else she or he might have forgotten a moment ago.

RE: PARTICIPANTS WHO DON'T SEEM TO UNDERSTAND THE TERM, SETBACK. A few participants aren't familiar with the term, **set-back**. If after a considerable wait for the participant to reflect, the participant seems simply puzzled by the question, the interviewer says,

*"Well, not everybody uses terms like **set-back** for what I mean here. I mean, was there anything about your early experiences, or any parts of your early experiences, that you think might have held your development back, or had a negative effect on the way you turned out?"*

In this case, this becomes the main question, and the probe becomes

-Is there anything else about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

11. *Why do you think your parents behaved as they did during your childhood?*

This question is relevant even if the participant feels childhood experiences were entirely positive. For participants reporting negative experiences, this question is particularly important.

12. *Were there any other adults with whom you were close, like parents, as a child?*

--- Or any other adults who were especially important to you, even though not parental?

Give the participant time to reflect on this question. This is the point at which some participants will mention housekeepers, au pairs, or nannies, and some will mention other family members, teachers, or neighbors.

Be sure to find out ages at which these persons were close with the participant, whether they had lived with the family, and whether they had had any caregiving responsibilities. In general, attempt to determine the significance and nature of the relationship.

13. *Did you experience the loss of a parent or other close loved one while you were a young child--for example, a sibling, or a close family member?*

(A few participants understand the term "loss" to cover brief or long-term separations from living persons, as, "I lost my mom when she moved South to stay with her mother". If necessary, clarify that you are referring to death only, i.e. specifically to loved ones who had died).

----Could you tell me about the circumstances, and how old you were at the time?

----How did you respond at the time?

----Was this death sudden or was it expected?

----Can you recall your feelings at that time?

----Have your feelings regarding this death changed much over time?

If not volunteered earlier. *Did you attend the funeral, and what was this like for you?*

If loss of a parent or *sibling*. *What would you say was the effect on your (other parent) and on your household, and how did this change over the years?*

----*Would you say this loss has had an effect on your adult personality?*

----Were relevant *How does it affect your approach to your own child?*

13a. Did you lose any other important persons during your childhood?

(Same queries--again, this refers to people who have died rather than separation experiences).

13b. Have you lost other close persons, in adult years? (Same queries).

Be sure that the response to these questions covers loss of any siblings, whether older or younger, loss of grandparents, and loss of any person who seemed a "substitute parent" or who lived with the family for a time. Some individuals will have been deeply affected by.

Probe any loss which seems important to the participant, including loss of friends, distant relatives, and neighbors or neighbor's children. Rarely, the research participant will seem distressed by the death of someone who they did not personally know (often, a person in the family, but sometimes someone as removed as the friend of a friend).

If a participant brings up the suicide of a friend of a friend and seems distressed by it, the loss *should be fully* probed. The interviewer should be aware, then, that speakers may be assigned to the unresolved/disorganized adult attachment classification as readily for lapses in monitoring occurring during the discussion of the death of a neighbor's child *experienced during the adult years* as for loss of a parent in childhood.

Interviewing research participants regarding loss obviously requires good clinical judgment. At maximum, only four to five losses are usually fully probed. In the case of older research participants or those with traumatic histories, there may be many losses, and the interviewer will have to decide on the spot which losses to probe. No hard and fast rules can be laid out for determining which losses to skip, and the interviewer must to the best of his or her ability determine which losses--if there are many--are in fact of personal significance to the participant. Roughly, in the case of a participant who has lost both parents, spouse, and many other friends and relatives by the time of the interview, the interviewer might elect to probe the loss of the parents, the spouse, and "any other loss which you feel may have been especially important to you". If, however, these queries seem to be becoming wearying or distressing for the participant, the interviewer should acknowledge the excessive length of the querying, and offer to cut it short.

14. Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic?

Let the participant free-associate to this question, then clarify if necessary with a phrase such as, *I mean, any experience which was overwhelmingly and immediately terrifying.*

This question is a recent addition to the interview. It permits participants to bring up experiences which may otherwise be missed, such as scenes of violence which they have observed, war experiences, violent separation, or rape.

Some researchers may elect not to use this question, since it is new to the 1996 protocol. If you do elect to use it, it must of course be used with all subjects in a given study.

The advantage of adding this question is that it may reveal lapses in reasoning or discourse specific to traumatic experiences other than loss or abuse.

Be very careful, however, not to permit this question to open up the interview to all stressful, sad, lonely or upsetting experiences which may have occurred in the subject's lifetime, or the purpose of the interview and of the question may be diverted. It will help if your tone indicates that these are rare experiences.

Follow up on such experiences with probes only where the participant seems at relative ease in discussing the event, and/or seems clearly to have discussed and thought about it before.

Answers to this question will be varied. Consequently, exact follow-up probes cannot be given in advance, although the probes succeeding the abuse and loss questions may serve as a partial guide. In general, the same cautions should be taken with respect to this question as with respect to queries regarding frightening or worrisome incidents in childhood, and experiences of physical or sexual abuse. Many researchers may elect to treat this question lightly, since the interview is coming to a close and it is not desirable to leave the participant reviewing too many difficult experiences just prior to leave taking.

15. Now I'd like to ask you a few more questions about your relationship with your parents. Were there many changes in your relationship with your parents (or remaining parent) after childhood? We'll get to the present in a moment, but right now I mean changes occurring roughly between your childhood and your adulthood?

Here we are in part trying to find out, *indirectly* (1) whether there has been a period of rebellion from the parents, and (2) also indirectly, whether the participant may have rethought early unfortunate relationships and "forgiven" the parents. Do not ask anything about forgiveness directly, however--this will need to come up spontaneously. This question also gives the participant the chance to describe any changes in the parents behavior, favorable or unfavorable, which occurred at that time.

16. Now I'd like to ask you, what is your relationship with your parents (or remaining parent) like for you now as an adult? Here I am asking about your current relationship.

---Do you have much contact with your parents at present?

---What would you say the relationship with your parents is like currently?

---Could you tell me about any (or any other) sources of dissatisfaction in your current relationship with your parents? any special (or any other) sources of special satisfaction?

This has become a critical question within the Adult Attachment Interview, since a few participants who had taken a positive stance towards their parents earlier suddenly take a negative stance when asked to describe current relationships. As always, the interviewer should express a genuine interest in the participant's response to this question, with sufficient pause to indicate that a reflective response is welcome.

17. I'd like to move now to a different sort of question--it's not about your relationship with your parents, instead it's about an aspect of your current relationship with (specific child of special interest to the researcher, or all the participant's children considered together). How do you respond now, in terms of feelings, when you separate from your child / children? (For adolescents or individuals without children, see below).

Ask this question exactly as it is, without elaboration, and be sure to give the participant enough time to respond. Participants may respond in terms of leaving child at school, leaving child for vacations, etc., and this is encouraged. What we want here are the participant's feelings about the separation. This question has been very helpful in interview analysis, for two reasons. In some cases it highlights a kind of role-reversal between parents and child, i.e., the participant may in fact respond as though it were the child who was leaving the parent alone, as though the parent was the child. In other cases, the research participant may speak of a fear of loss of the child, or a fear of death in general. When you are certain you have given enough time (or repeated or clarified the question enough) for the participant's natural ly-occurring response, then (and only then) add the following probe:

----Do you ever feel worried about (child)?

For individuals without children, you will pose this question as a hypothetical one, and continue through the remaining questions in the same manner. For example, you can say, now I'd like you to imagine that you have a one-year-old child, and I wonder how you think you might respond, in terms of feelings, if you had to separate from this child?" Do you think you would ever feel worried about this child?"

18. If you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child I'll give you a minute or two to think about this one.

This question is primarily intended to help the participant begin to look to the future, and to lift any negative mood which previous questions may have imposed.

For individuals without children, you again pose this question in hypothetical terms. For example, you can say, "Now I'd like you to continue to imagine that you have a one-year-old child for just another minute. This time, I'd like to ask, if you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your imagined child I'll give you a minute or two to think about this one':

19. Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.

Give the participant plenty of time to respond to this question. Like the previous and succeeding questions, it is intended to help integrate whatever untoward events or feelings he or she has experienced or remembered within this interview, and to bring the interview down to a light close.

20. We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a ways into the future. We've just talked about what you think you may have learned from your own childhood experiences. I'd like to end by asking you what would you hope your child (or, your imagined child) might have learned from his/her experiences of being parented by you?

The interviewer now begins helping the participant to turn his or her attention to other topics and tasks. Participants are given a contact number for the interviewer and/or project director, and encouraged to feel free to call if they have any questions.

Appendix C

Edinburgh Postnatal Depression Scale (EPDS)

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

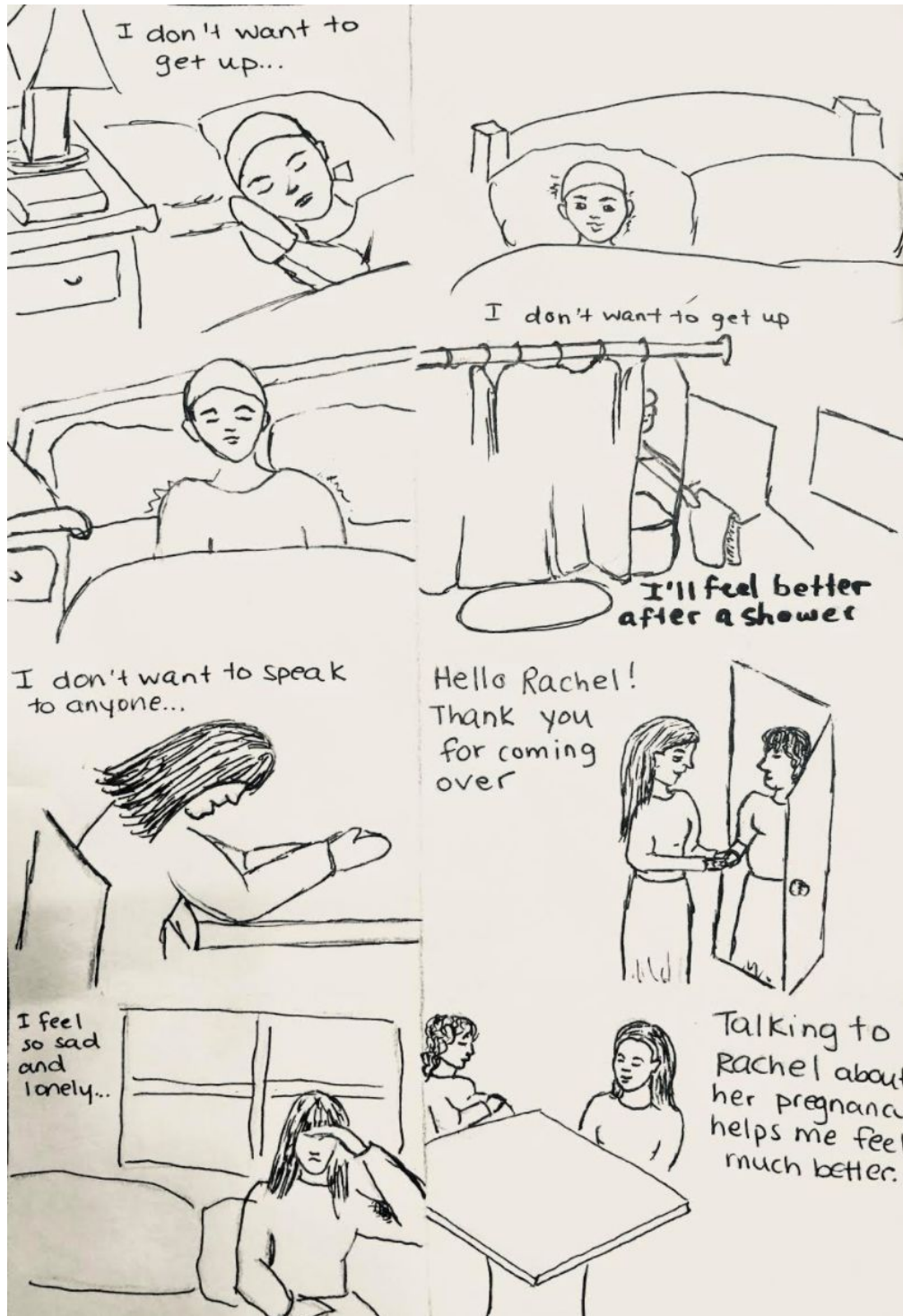
- | | |
|---|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I always could <input type="checkbox"/> Not quite so much now <input type="checkbox"/> Definitely not so much now <input type="checkbox"/> Not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual <input type="checkbox"/> No, most of the time I have coped quite well <input type="checkbox"/> No, I have been coping as well as ever |
| <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I ever did <input type="checkbox"/> Rather less than I used to <input type="checkbox"/> Definitely less than I used to <input type="checkbox"/> Hardly at all | <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> Not very often <input type="checkbox"/> No, never | <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> No, not at all <input type="checkbox"/> Hardly ever <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, very often | <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Only occasionally <input type="checkbox"/> No, never |
| <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite a lot <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No, not much <input type="checkbox"/> No, not at all | <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Hardly ever <input type="checkbox"/> Never |

Appendix D

1) Sarah and Rebecca's Day 1



2) Sarah and Rebecca's Day 2



3) Sarah and Rebecca's Day 3



4) Sarah and Rebecca's Day 4



5) Sarah and Rebecca's Day 5



Appendix E

Mothers and Babies Course Instructor Manual

This manual can be found in the electronic copy of this senior project. See the Bard College Digital Commons for more information.

Appendix F

Mothers and Babies Course Participant Manual (Original)

This manual can be found in the electronic copy of this senior project. See the Bard College Digital Commons for more information.

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Class #1:

INTRODUCTION TO THE MOTHERS AND BABIES COURSE

CLASS OUTLINE

Welcome & Purpose of the Course (10 min)

- I. Group Introductions (15 min)
- II. Purpose and Overview
 - A. Purpose of the Course (10 min)
 - B. Overview of the Course (5 min)
- III. Class Guidelines (5 min)
- IV. Video “My Parents, My Teachers” & Discussion (35 min)
- V. Stressors and the Mother-Baby Relationship (10 min)
- VI. Common Mood Problems After Birth (10 min)
- VII. How Can This Course Help You (5 min)
- VIII. Managing My Personal Reality (10 min)
- IX. Personal Project: Quick Mood Scale (10 min)

Goals for instructors:

- Establish rapport and motivate participants to come to the course.
- Present rationale and purpose of the course.
- Administer the CES-D or another mood questionnaire (optional).
- Introduce the idea that we can improve our physical and emotional health by shaping our behaviors, thoughts, and social relationships.
- Go over class guidelines, including confidentiality.
- Discuss the mother-baby relationship (i.e., attachment and bonding).
- Give an overview of the 6 classes of the course.

Materials needed:

1. Participant manuals; instructors will create and include 2 calendars describing the days and times of the MB course)
2. Nametags
3. Pens, dry erase board, or chalkboard to present material to class
4. Video: “My Parents, My Teachers” and brochures (see <http://www.elvalor.org/programs/mispadres.html>)
5. Copies of CES-D or another mood questionnaire (optional)

WELCOME TO THE CLASS (20 MINUTES)



Overview

Begin by introducing yourself to the participants as they arrive, and give each participant a nametag and a manual. When you are ready, welcome group members and provide a brief orientation to the class.



Key Points

- Welcome participants to the class.
- Reinforce their coming to the group.
- Give a brief introduction of the course instructors and additional staff (e.g., camera person if the class is being filmed).
- Emphasize the reciprocal nature of the group, meaning, we learn from them, they learn from us, and they learn from each other.
- Emphasize that they will be the experts of their own pregnancy and of their children, and we will contribute our professional knowledge. This may be especially important if none of the leaders have been parents.
- Provide very general rationale for course: to focus on the baby's arrival and how we can raise physically and emotionally healthy children.
- Be attentive to the participants' needs and remind them that they can excuse themselves at any time to use the restroom or if they are experiencing normal pregnancy symptoms (e.g., nausea).



Information

From the beginning, group leaders should keep track of time, especially because participants will notice and follow leaders' expectations regarding keeping to the allotted time.

Open Group Option. At times new group members may be rotating into the class. This can occur at the first class of each module (e.g., thoughts and mood). In this case, instructors will want to review the Welcome, and sections I (Introductions), II (Course Purpose), and III (Class Guidelines) of this class. In addition, when there is a class composed of “veteran” members and new group members, encourage the “veteran” members to share the purpose of the group with the new members and to talk about what they have learned thus far from the group. You will also want to let new members know that this is a rotating group and that there are “veteran” members.

To create a warm, welcoming atmosphere leaders may choose to provide small snacks (e.g., tea and cookies) at this and other meetings.

If the class is being taped, be prepared to discuss the role of videotaping because some group members may feel uncomfortable being videotaped at first.



Step by Step

Step 1: Introduce yourself to group members when they arrive. Give each group member a name tag and a manual.

Step 2: When enough group members have arrived, begin by giving a general overview to the course.

Suggested Wording:

We would like to welcome you to the Mothers and Babies Course. Today we will talk about the purpose of the course, introduce ourselves, and then begin to talk about how this course can help you. First, thank you for coming. We realize that you had to give up many things and change your schedules to come. The fact that you are here shows that you are committed to becoming the best mother you can be for your baby.

The manuals that we have given you are for you to keep. That way, you will be able to review things later when you most need to remember them. They contain handouts for each class.

In the front, you will find two copies of a calendar. One copy is for you to keep at home. The other one is for your manual, so we can mark down important group activities each week.

Refer to the calendar.

As you can see, we will meet once a week for the next 8 weeks. If there are days when you cannot make these meetings, either because you have another appointment or are sick, please let us know as soon as you can. In other groups that we have led, we have found that group members worry about each other when they're not there.

Step 3: Put phone numbers on the board where each of the group leaders can be reached (or have them prewritten in their manuals). Also, if you have them, hand out business cards.

Step 4: Elicit and answer questions.

Suggested Wording:

Are there any questions about this or anything else we've talked about so far?

STEP 5: (OPTIONAL) Introduce and administer the CES-D to group members

Suggested Wording:

Before we begin, we would like to have you fill out a brief questionnaire about how you have been feeling during the past week.

Answer any questions and collect and score questionnaires at the end.



I. GROUP INTRODUCTIONS (15 MINUTES)



Overview

Help everyone begin to get to know each other and feel comfortable talking in the group, and gather relevant information about the participants' backgrounds.



Key Points

- Instructors should introduce themselves first (having instructors go first provides a model for the group introductions).
- If group leaders are not pregnant or not mothers themselves, they may instead share their interest and previous experience working with pregnant women, mothers, and children or relevant and appropriate personal information.
- Each group member should introduce herself (refer participants to page # 1.2 of their manuals).
- Conclude this section by emphasizing common characteristics among participants (e.g., how many of them are first time mothers).



Participant Manual

p. 1.2



Rationale

If group members feel heard or are able to establish a connection with other group members and/or the group leaders, they are more likely to return next week.



Information

Leaders should look for opportunities to increase rapport. This is everyone's first chance to speak in the class and their experience (e.g., how you and the rest of the group responds) may set the stage for future participation. Rogerian interviewing techniques are most useful for this purpose, including:

- Paraphrasing: repeating what the participant said in your own words, to ensure you understood what she meant.
- Reflection of feelings: saying what you think the participant felt during the situation she described, to ensure you understood what she felt.
- Summarizing: saying in a nutshell the main point of a participant's contribution, to ensure that you and the group get the point she wanted to make.

These techniques should be done in the context of empathy, genuineness, and unconditional positive regard, as Carl Rogers intended.

Group cohesion can also be increased via comments that highlight areas of commonality between the participants and the instructors and among the participants.

Some people may have difficulty speaking. You can handle this by acknowledging that it is often hard to talk in a group of people you don't know and by giving them permission to not talk if they don't want to. Let them know that we generally find it easier for people to talk as they get to know each other better and that we respect individual differences with regard to their desire to self disclose.

Group leaders who do not have children may want to highlight their experience with children, both professionally (through research and clinical work) and personally (having contact with children of family or friends). Doing so may help build rapport with group members and may make the information they provide seem more valid.

Some participants may have trauma histories and may be unable to contain their affect when invited to speak. When a group member begins to talk about her trauma history, it is important to be sensitive to her feelings and to the feelings of other group members. The individual speaking needs to feel heard and supported emotionally; however, other group members may be overwhelmed by her story. After letting her speak briefly, you may choose to do some of the following things:

- Empathize with how hard the experience has been.
- Focus on how wonderful it is that she is coming to the group, and how you hope that this group helps her to have a better understanding of how to manage her life in a healthier way.
- Let her know that as we get to know each other better there will be more time to share these things.
- Acknowledge that other group members may have also experienced difficult events.
- Suggest that you may set up a separate meeting to talk with them more about what they are bringing up and then, perhaps, in those meetings determine if individual therapy is warranted.
- Remind the group member that she is safe in this environment.



Step by Step

Step 1: Let the participants know that we would like to begin to get to know each other better. It is often good for a group leader to introduce him/herself first, using the outline provided in the participant manual so that the group leader serves as a model.

Suggested Wording:

We would like to begin to get to know each other. Please turn to page 1.2 in your books. There are a few questions for you to answer that will help all of us get to know each other better. We will all have to remember to try to keep our comments brief so that everyone will get some time to share. I will go first. Introduce yourself.

Step 2: After the group leader has introduced him/herself, go around and ask other members to introduce themselves. Let them know how much time each person has (which will depend on the size of the group).

Step 3: After all the introductions are done, group leaders should make some summary comments regarding similarities and differences among people (e.g., cultural background, hobbies, importance of family, first time pregnancy).



Alternative Exercises

Depending on the characteristics of the group (i.e., size, how comfortable the women are speaking), you may choose to have the women break up into pairs, introduce themselves, and then introduce their partners to the group.

Suggested Wording:

In a little while, we will begin talking more about the class and what you will be learning but first let's get into pairs and introduce ourselves to our partners. If you turn to page 1.2 in your books, we have written down some of the things you might tell your partner when you introduce yourself. Later, you will each introduce your partner to the group.

Make sure to monitor the time to ensure that both people have a chance to speak. After they have introduced themselves to each other, have them return to the group and introduce their partner to the group. After everyone has introduced their partner, a few remarks about the similarities among the participants, as well as the variety of backgrounds might be indicated.



II. A. PURPOSE OF THE COURSE (10 MINUTES)



Overview

Begin a discussion about the class content and connect it to the participants' desires and goals.



Key Points

Discuss how the course will focus on the following topics:

- Relevant information about pregnancy and infant/child development
- Ways to manage life stress, improve mood, and avoid mood problems
- Healthy interactions help create a healthy reality for the mother and her baby
- Healthy, positive ways that we can think about babies and interact with them
- The group as support



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Rationale

The modal (most common) number of therapy sessions that people attend is one. It is key in the first session to motivate people to want to attend by helping them to see how this class will be useful and fun for them.



Information

We underscore how the class will be useful by repeating the goal of the course: to teach mothers and mothers-to-be how mood works, so they can teach their own children. But you can't teach what you don't know well. So, the mothers need to learn how their own moods work and how to increase the frequency of positive moods and decrease the frequency of negative moods. Doing this will also help them enjoy becoming mothers and being the kinds of mothers they want to be.

It is important to emphasize that the women in the course will learn healthy, positive ways to think about and interact with their babies so that they can help their babies develop in an emotionally and physically healthy manner. Women may be entering the course not to help themselves but to be good mothers for their children and help them develop normally. This is the "hook" for many group members.

One of the course goals is to prevent serious depression. However, never feeling down or depressed is not a realistic goal. It is as normal to have a sad reaction to a negative event as it is to feel pain when we hit our hand on something. The goal of the course is to reduce 1) the frequency, 2) the duration, and 3) the intensity of depressed moods, that is "How often we get depressed," "How long our depressed moods last," and "How deeply our depressed mood hurts us."

Women enrolled in the course may also be participating in prenatal classes. Emphasize that even though the Mothers and Babies Course is not intended to replace a prenatal class, the class may be a place where they can share ideas and suggestions on how to make their pregnancy enjoyable and help each other prepare for the birth.

It is important to emphasize that the materials for this course were developed by researchers with expertise in the areas of attachment and mood management as this legitimizes the materials.



Step by Step

Step 1: Go over the purpose of the course.

Suggested Wording:

I'd like to begin talking about the purpose of the course. As the name of the course suggests, all of you who are here are about to become mothers. During your pregnancy, you attend prenatal care visits to take care of your physical health and your babies' physical health. This is wonderful! We also believe that it is important to take care of your emotional health during and after pregnancy because this will affect both you and your baby. We know that parents are the most important people in babies' lives. You are their first teachers. You teach your children not only how to walk, talk, and eat, but also how to be healthy emotionally and how to relate to other people. This class was developed to support you as you become a mother and to share ways that we can be emotionally healthy and that we can pass on these skills to our children.

We will be looking not only at how we can help babies but how we can help ourselves. Mothers are the foundation of the family, and the foundation needs to be strong so it can support the family. If the foundation crumbles, the family, in a way, also crumbles. During the class we will talk about ways to build a strong foundation and we will provide support around doing so. During the class we will talk about becoming a mother, how you can be the kind of mother you want to be, and how you can raise healthy babies. The class will focus on you, your baby, and on your relationship. We will all share what we know about raising babies to be physically and emotionally healthy, and we hope that we will all learn from each other. The course contains materials that are based on research and years of working with mothers and babies. Other women have found it to be helpful, and we hope you will too.

Step 2: Elicit participants' reactions to the purpose.

Suggested Wording:

Before continuing, I want to check and see what you think about this. Is this the type of course that you think might be helpful to you?

Support and listen to participants as they talk. Reinforce comments regarding the utility of the class. Be responsive and sensitive to doubts participants may have regarding the utility of the class.



Alternative Exercise

Ask the mothers (first time or again) what they would like to learn that they think would help them and their babies, including what they might learn that might help them raise emotionally healthy babies. After you have written down their answers, discuss how the Mothers and Babies Course will address these needs.

Suggested Wording:

As you all become mothers, what kinds of things do you think you would like to learn? In other words, babies don't come with manuals, but if they did, what would you hope the manual would teach you?

Elicit participants' responses. If they don't give responses that match with the course content, you may choose to ask the following question:

Do you think maybe it would be useful if the manual included some things about how to help babies be emotionally healthy? If so, what do you think it might include on this topic?

At the end, discuss how the course will address these topics.



II. B.OVERVIEW OF THE COURSE (5 MINUTES)



Overview

Provide an overview of the Mothers and Babies Course and its three parts (modules).



Key Points

- The course is composed of 6 classes.
- The course is divided into three parts/modules: activities, thoughts, and contacts with others, each of which can help us shape our mood.
- Three classes will be devoted to the first and third module, and two classes for the second module.
- Because activities, thoughts and contacts with others are interrelated, we will discuss all of them during the course, but we will focus on one for each module.
- Relevant information about pregnancy, motherhood and infant/child development are incorporated throughout the course.



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Information

To make this section relatively brief, we recommend you focus on the three parts of the course (thoughts, activities, and people) rather than each class.



Step by Step

Step 1: Go over the basic structure of the class.

Suggested Wording:

As we mentioned before, the course has 6 classes. These classes are broken down into three parts. In each part, we talk about managing stress by making changes in a different area.

The first area is our thoughts. We will be looking at how our reactions, or the way we think, affect us. We will talk about ways of thinking that are flexible, balanced, and healthy. Thinking in this way will help us feel better and reach our goals. We will also talk about how you can help your children think in ways that will help them get ahead in life.

The second area is our activities, or what we do. We will be talking about how doing pleasant activities gives us the emotional strength to deal with stressful life events. What you do shapes your lives and will shape your babies' lives. We will talk about what we can do to reduce life stress, how to continue our lives and reach our goals in spite of stressors, and how to engage babies in activities that will help them develop.

Finally, we will be looking at our relationships with others. We will talk about the importance of social support in handling stress, ways to increase our social support, and ways to decrease conflict with others. We will also talk about ways to build good, healthy relationships with your children and about the types of support you may want around you.

During the classes, we will be asking you how your pregnancy or early motherhood is going, and we will talk about managing mood and stressful life events during this time period. We will also be giving you information about child development, and we will talk about ways you can help your baby be healthy, both physically and emotionally.

Step 2: Elicit participants' reactions to the class outline and answer any questions they may have.



III. CLASS GUIDELINES (5 MINUTES)



Overview

Go over the class guidelines and discuss confidentiality in order to create an environment where everyone feels safe and comfortable talking.



Key Points

- Give participants your phone numbers or the clinic number, so they can call if they cannot make it.
- Let participants know that leaders also need to respect the group rules.
- Make sure you go over confidentiality discussing that as group leaders you are not able to maintain confidentiality if you hear about any of the following:
 - Child abuse
 - Elder abuse (abuse or neglect of a dependant adult older than 65 yrs of age)
 - Abuse of disabled person
 - If a participant is going to hurt themselves or anyone else in the future
 - Stress that the rationale for this rule is to maintain safety.
- Let group members come up with their own rules if they wish.



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Rationale

The guidelines set the stage for the class. They help create a safe, consistent environment that will maximize people's ability to benefit from the course.

Having participants actively create guidelines gives them ownership of the class and may increase their motivation to participate.



Information

Class guidelines are the rules of the class. Some women may react negatively when the word "rules" is used, especially those who did not have positive experiences while going to school. This is one of the reasons "class rules" are presented as "class guidelines."

It is important to convey that these guidelines are intended to make the course more useful for everyone. For example, coming on time helps everyone make use of the full two-hour period, so the group doesn't have to rush through the material, and so they have more time to talk, ask questions, and give each other advice. Confidentiality and respecting each other's point of view is intended to make the course an island of safety and support during the week, a place where they know they will not be attacked or criticized, and where everyone is on their side.

It is important to communicate to class participants that we welcome them to share these materials with their spouses, family members, and friends if they wish. However, the content of what we discuss in the course remains in the room to protect the confidentiality of each class participant and to make everyone feel safe in sharing their experiences.

It is a good idea to distribute your business cards to the class members as a way to facilitate communication between participants and instructors.

Some participants, particularly those who are recent undocumented U.S. immigrants, may worry where the information they share in group goes, particularly if the sessions are being video or audio taped. You can reduce these fears by addressing these issues when you talk about confidentiality.



Step by Step

Step 1: Orient group members to the task and begin discussing the group rules.

Suggested Wording:

We want this class to be a place where you feel safe and comfortable talking. To do this, we have often found that it is useful to have some group guidelines. If you turn to page 1.4 in your books, there are some guidelines that group members have found useful in the past. Let's go over them.

If you choose, you can have group members read the guidelines.

Step 2: Highlight key aspects or provide the rationale for the guidelines. We have provided the key aspects for some of the guidelines below. You may choose not to cover all of them.

Suggested Wording:

Try to come to every class – In each class, we will talk about a new topic related to improving mood and being a mother. We hope that each week you will learn something new that will be helpful to you and to your baby. I know that each week, I will learn something new by being with you.

Come on time - We understand that it is often hard to get to class because of transportation problems or other things, but we only have a certain amount of time together, and we really want to get the most out of it. Starting on time with everyone here will help us do that.

Confidentiality - see Step 3

Complete your personal project for the week - Each week we will be asking you to do a personal project. Hopefully it will be something you want to do to see if what you learn in class can help you create positive changes in your lives. When you complete the project, you will be able to tell the group how it went and get useful feedback.

Tell us if you are unhappy with the classes - We really want this to be a good and helpful experience for everyone. Let us know how we can help you. We would be very sad if you left because of a problem and we didn't have a chance to try to make it better for you.

You don't have to do anything you don't want to do - In class, we will be asking you to participate in exercises. If anything makes you feel uncomfortable or if you simply don't want to do something, that is your right.

Share only what you wish to share, and remember that you have the right to keep some things private - As we talk in class, we may all find that there are some things that we are happy talking about and other things we would prefer to keep to ourselves or talk about only with people we are very close to.

Step 3: Cover confidentiality in full detail. This confidentiality guideline must be covered.

Suggested Wording:

Respect confidentiality - In order for people to feel safe talking in the group, it is important that we all agree that what is said in the group stays in the group. This means that when people talk about themselves in the group, we do not share what they have said with others. You can, of course, talk to other people about what you are learning or what you have said in the group.

Pause and verify that all group members agree to this guideline.

I also want to let you know that there are some situations when group leaders cannot maintain confidentiality. The first is if we hear that a child has been hurt by an adult in any way that was not an accident, that a child has been abused or neglected. The second is if we hear that someone older than 65 or someone who is disabled or dependent is being abused, not taken care of, or taken advantage of financially. The third is if we hear that someone is in imminent danger of hurting himself or herself or someone else.

In each of these situations, class leaders would need to break confidentiality in order to protect safety.

You can let them know that in general, your policy would be to discuss your concerns with them and involve them in the reporting process if you determined a report were necessary and they were willing to participate in making the report. In other words, you won't be doing things behind their backs and once they leave class, they don't have to worry that you will be breaking their confidence.

I also want to let you know that group leaders may be consulting with other members of the Mothers and Babies team about the class and ways that we can help each of you. However, all the Mothers and Babies team members will also maintain confidentiality.

Pause and elicit any questions about this guideline.

Step 4: Answer any questions from participants.

Step 5: Ask participants if they have any guidelines they would like to add to the list. If so, go over them and add them.



Alternative Exercises

Depending on the characteristics of the group (e.g., how talkative they are) you may choose to have the group come up with guidelines on their own before covering the guidelines in the manual. Make sure that confidentiality is included and that you have covered all the key points regarding times when you would need to break confidentiality.

Suggested Wording:

We want this class to be a place where you feel safe and comfortable talking. To do this, we have often found that it is useful to have some guidelines. What are some guidelines that would make you feel comfortable talking in class?

Write their guidelines on the board and discuss each one. At the end, you can have group members write down their guidelines or you can indicate that the majority of these guidelines are covered on page 1.4 in their books.



IV. VIDEO: “My Parents, My Teachers” AND DISCUSSION OF VIDEO (Video length approximately 20 minutes: 35 minutes total)



Overview

Present the idea that parents are the first teachers of their children, highlight the importance of the first 3 years of life, and provide concrete examples of how children learn and how parents can become actively involved in their learning process. It is important to keep track of time when you reach this section. You want to have at least 15 to 20 minutes, after watching the video, for discussion.



Key Points

- The first three years are critical to a child’s development as they affect future learning.
 - Babies learn through play, communication, reading, and music.
 - Sometimes these simple activities seem basic, but they are the foundation for healthy development.
 - The best way to help children learn is to make it fun.
 - Parents are not only teaching their baby skills for school, but also skills for life, such as:
 - how to behave in relationships
 - how to regulate their own emotions
 - how they view themselves (i.e., as loved, confident, competent)
 - Teaching a baby something new makes her neurons grow and make connections.
 - Point out the “Start now” brochures and let participants know that the brochure has a chart that describes different things that you can do with your baby as she grows up.
- Suggest that participants read through the chart as an optional personal project.



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Rationale

Emphasizing the importance of the first 3 years of life in terms of cognitive, social, emotional, and biological development helps mothers recognize how important they are to their children’s development and may motivate them to make positive changes in their and their babies’ lives.



Information

Participants who have older children may be hearing for the first time about the importance of the first three years of a child’s life. They may express feelings of guilt or disappointment in themselves about not raising their children in an ideal manner, especially if they feel they were not able to provide an environment that fostered early learning. You can handle this by letting them know that even when situations are less than ideal, children continue to develop and learn from new experiences and interactions in their lives, so it is never too late. Most of us were raised in less than ideal circumstances, and we were not damaged by this. However, now that there is more scientific knowledge about how human beings develop, it makes sense to use that knowledge to benefit children from now on.

Participants may ask about how other people in the home may play a role in childrens' development (e.g., father of baby, grandmother, child's sibling). You can help them think about how and to what extent they would like others to be involved in teaching their babies. For example, one class member spoke of practicing the relaxation exercises with her 7-year old because that way they would both learn how to soothe the baby.

Obtaining the video: The video was developed by El Valor, an early childhood public awareness campaign created for Latino parents with infants and toddlers. The videotape has Spanish and English versions of the same material, with the same actors. The actors are all Latino. The Spanish version is the first version on the tape. New copies of the video can be requested by writing: El Valor, 1850 West 21st Street, Chicago, IL 60608 or calling (312) 666-4511, or see: http://www.elvalor.org/creating_public_awareness



Step by Step

Step 1: Show the video: “My Parents, My Teachers.”

Suggested Wording:

We'd like to show you a video called “My Parents, My Teachers” that talks about the changes children make in the first three years of life and emphasizes how important you are as your children's first teachers.

Step 2: Elicit participants' reactions to the video.

Suggested Wording:

- *What did you hear that was new to you?*
- *What did you already know?*
- *What did you like the most?*
- *What do you remember the most?*
- *What do you think about the idea that the human brain develops most during the first three years of life? What does this mean to you?*

Highlight the following points. These points are tied to the notes about the video that are on page 1.5 of the participant manual.

- The first 3 years are among the most important because this is when children learn to walk, to talk, to think, to love you, and to feel good about themselves.
- Learning all of this means their brain is developing connections at an amazing rate. We think learning takes place when the connections between neurons become strong.
- Children learn at different speeds and may need different environments to help them maximize their learning ability. For example, some children may learn better by doing (running around and seeing the world) whereas other children may learn by quietly sitting and watching.
- Children's work is to play. They just need the space and encouragement. And they really need to learn that playing and having fun is a good thing. When you play a lot with them, they will see you as someone who is fun. They will not feel they need to hide from you to have fun. And when you have to discipline them, it will be easier for them to accept discipline because they won't see you as someone who just wants them to stop having fun. They will know you like to have fun, too.
- When we say every mother is capable of giving what her child needs, we mean that every mother can give her child love, attention, and encouragement.

Step 3: Point out the “Empieza ya” or “Start Now” brochures and encourage the participants to take one home to read. Let the participants know the brochure has a chart that describes different things that you can do with your baby as your baby grows up. To order this brochures contact CIVI-TAS at: 312-226-6700 or go to the web page: www.civitas.org



Alternative Exercises

If you do not have the “My Parents, My Teachers” videotape, we recommend using another videotape that covers similar material. Alternately, you can do the following activity with the group.

Step 1: Brainstorm as a group all the things babies learn in the first 3 years of life and write participants answers on the board.

Sample answers are listed below:

- Walk
- Talk
- Soothe themselves (regulate emotions, how to calm down when they’re upset)
- About relationships (by using their relationship with their parents as a model)
- Eat by themselves
- Figure out how things work (by putting them in their mouths, using them)

Step 2: Highlight that babies are learning how to think, to move, and to relate to others and that while they are doing this, their brains are actually growing and strengthening and building important connections. For example, the first time the baby is held by his/her mother, he/she will learn what the mother’s embrace feels like.

Step 3: Have parents discuss how babies learn all these things and highlight the importance of parents as teachers and role models.



V. STRESSORS AND THE MOTHER-BABY RELATIONSHIP (10 MINUTES)



Overview

Discuss how life stressors affect us and the mother-baby relationship. Highlight that identifying the stressors and understanding how they affect women and the mother-baby relationship is the first step in developing a plan to manage stress and avoid problems.



Key Points

- Highlight that life stressors affect how we feel emotionally and physically.
- Discuss how specific stressors (e.g., those shown on page 1.6) might affect:
 - the mother's emotional health and physical well-being
 - the mother-baby relationship
 - the baby
- Identify common life stressors following birth.
- Identify stressors in their lives.



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Rationale

This program was written to help people cope with real life problems. The heart of the course is a healthy management of reality approach. To build a healthy reality for ourselves and our children, we first have to face reality. This is why we need to learn to recognize the stressors that affect us. This activity also allows group leaders to assess the types of stressors that individual group members are facing. Group leaders may want to take notes on the types of stressors each participant endorses. This will help leaders develop ecologically valid interventions that help participants manage their reality.



Information

Prior to talking about how stress can impact the mother-baby relationship, we recommend discussing the impact of stress on our bodies, behaviors, and mood.

Women may get overwhelmed discussing every example on page 1.6. Pick one stressor that can potentially affect the women, and ask for their physical and emotional reactions. There is not enough time to cover all the stressors.

If the women are unable to come up with reactions, give an example that most of the women can relate to, such as what happens when one watches a scary movie. It is helpful to write the women's reactions on the board so you can refer back to them when discussing this section.

When group members include immigrant women, leaders should be aware that immigrant status creates another level of stress (i.e., language problems, social support issues such as lack of extended families, and environmental stressors such as neighborhood violence).

Also make note of the women that endorse domestic violence or substance use in the home or community setting as stressful, as managing these life issues will be part of shaping their reality. You may want to have a list of possible referrals to share with them.

The father of the baby or a family member may serve as a source of stress. It is important to make note of this. This area will be heavily focused upon in the People's Module (last 2 sessions).



Step by Step

Step 1: Begin a discussion about how stress affects our physical and emotional health.

Suggested Wording:

We've been talking about the mother-baby relationship, but sometimes things in our lives make it difficult to focus on that relationship. Let's look at page 1.6 in our books and think about how these different stressors might affect how we feel.

Select one stressor and talk as a group about how it would affect the mother, physically and emotionally.

Step 2: Discuss how the stressor would affect the mother-baby relationship and the baby.

Suggested Wording:

How do you think feeling (tired, angry, sad, in pain) would affect the mother-baby relationship and the baby?

Step 3: Help the women identify stressors in their lives.

As a group, think about all the different stressors the women are experiencing as they become mothers. Write them down on the board. Women can also identify stressors unique to their lives. They can choose to share them, or they can write them in their books in the blank boxes.

Suggested Wording:

- *What stressors are in your life?*
- *Are there other stressors that might affect the mother-baby relationship that aren't on page 1.6?*



Alternative Exercises

Interactive Role Play

Step 1: Select one group member to play the role of the mother. Alternately, you can have all the members of the group do this exercise.

Step 2: Give the participant something to carry that represents the baby (e.g., a doll, a heavy book).

Step 3: Ask her to interact with the "baby." Ask her how she feels about and thinks about the baby. Ask her what kinds of things she thinks she might like to do with the baby.

Step 4: Introduce various stressors. You can have group members identify the stressors they “carry.” You can either have the participant playing the role of mother imagine that she is experiencing the stressor, or you can give her heavy items (like books or more cumbersome irregularly shaped items) that would represent the stressors.

Step 5: As you add on the stressors, ask her how she feels, physically and emotionally. Ask her how she thinks and feels about her “baby.” Ask her about the types of things she would like to do with her “baby.” Talk as a group about how the stressors are affecting the mother, the mother-baby relationship, and the baby.

Facilitating the Link Between Stress and Health

Step 1: Ask the women in the group about what they first notice when they are stressed. As they respond, write their responses on the board. Responses will typically fall into 3 areas: behavioral reactions (e.g., become socially isolated), physiological reactions (e.g., headaches), and emotional reactions (e.g., anger).

Step 2: As you write their responses, under these 3 categories, you may begin asking the women how these are related to one’s emotional and physical health.

Step 3: Finally, begin asking the women how babies communicate that they are stressed from a very early age (e.g., crying if hungry or needs his/her diaper changed) to early childhood (e.g., acting out).

Highlight how important it is that they be able to recognize how stress affects them and learn how to manage it because their children are likely to experience stress and will look to them for guidance. The only way to teach someone, such as a child, ways to manage stress is for the teacher, in this case the mother, to learn them and try them out herself.



VI. COMMON MOOD PROBLEMS AFTER BIRTH (10 MINUTES)



Overview

Discuss the different mood problems that women may experience during pregnancy and after birth, and identify the different symptoms associated with each mood problem.



Key Points

- Assess what participants know about postpartum depression, baby blues, and depression.
- Provide clear definitions of each.
- Ensure that participants understand the difference between the different types of mood problems and can recognize each type.



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Rationale

One of the goals of the course is to prevent clinical depression. It is important, therefore, that participants be able to recognize the characteristics of common types of depression that are prevalent during pregnancy, postpartum, and beyond and to understand the differences among these types.



Information

This exercise can generate multiple reactions from participants. It may help some women feel less alone to understand that others have symptoms similar to those they have experienced in the past or are currently experiencing. Other women may worry about the future and the possibility of developing a significant mood disorder. Still others may have a history of major depression or postpartum depression and may worry about how you and other group members will react if they share this information.

The idea here is not to scare participants, but to educate them. As you cover each disorder, highlight that there are things you can do to try to prevent a mood disorder, and if you discover you have one, there are things you can do to treat it. Emphasize that they are decreasing the likelihood that they will have a mood disorder by learning the skills taught in the course. They are also learning to identify mood disorders, which will help them get treatment as soon as possible should they develop a mood disorder.



Step by Step

Step 1: Introduce the Activity.

Suggested Wording:

As we talked about, stress affects our emotional and physical health. One potential effect of experiencing stress during pregnancy and the postpartum period is problems with your mood. However, there are things you can do to prevent mood problems. For example, if you use the stress management skills that you will learn in this course, the chance that you will have a mood disorder will go down. Now I want give you some information about the most common mood problems that women experience during and after giving birth, so that if they happen to you, you will be able to recognize them and know how to handle them.

Step 2: Assess the women's current knowledge about different mood problems.

Suggested Wording:

Many women say that they experience mood changes during and after pregnancy. Has this happened to any of you either recently or before when you were pregnant with your other children? Or have any of you heard other pregnant women or new mothers talking about mood changes?

Elicit answers from the participants about what they have either experienced or heard. If no one has heard of anything like this, you may want to ask specifically whether they have heard of postpartum blues, postpartum depression, or depression.

Questions to stimulate discussion are listed below:

- Have you heard about _____ before? (How or from where?)
- Do you know anyone who has had _____?
- Have you ever experienced _____?
- What are your thoughts about _____?

Step 3: Go over the mood problems shown on the handout.

Suggested Wording:

Let's go over the different types of mood problems that women sometimes experience during pregnancy or soon after giving birth. If you turn page 1.7, you'll find descriptions of the three most common mood problems that occur during this period.

Go over the different categories of mood disorders.

Step 4: Elicit participant reactions after each category of mood disorders is presented.

Highlight the following points:

- The skills they are learning in the course will help reduce the likelihood that they will develop one of these disorders.
- It is important to know how to recognize these disorders because then you can get treatment as soon as possible.
- There are things you can do should you develop one of these disorders, including getting treatment and using the skills you learned during the course.



VII. HOW THIS COURSE CAN HELP YOU (5 min)



Overview

Introduce a cognitive behavioral model and explain to participants that by making changes in their thoughts, behaviors, and contacts with others, they can manage life stress and improve their moods.



Key Points

- Instill hope that there are good ways to manage stress and that by attending the Mothers and Babies Course they will learn helpful ways to manage stress.
- Emphasize that mood is connected to our ability to reach goals, our self-esteem, the types of relationships we form, and ultimately to the quality of our lives.
- Discuss how by making changes in the way we think, behave, and seek support from others, we can manage stress and feel better.
- Help participants understand that once they learn these skills and recognize the skills they have already developed, they can pass them on to their children.



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Rationale

This section can help participants understand that stress can produce imbalance in our lives, especially if we don't have the necessary tools (covered in the Mothers and Babies Course) to deal with it. We hope to help participants see that there are aspects of their reality that they can manage and that by doing so, they will feel better in spite of stressors by creating options and alternatives regarding how to manage them.



Information

All life involves some stress. Being a mother of a young child is a particularly stressful stage of life, although it can also be a particularly happy and fulfilling part of life. The Mothers and Babies Course is intended to help mothers experience less stress and as much happiness and fulfillment as is possible given their circumstances. A basic assumption of the course is that even if their circumstances are difficult (indeed, especially if their circumstances are difficult), shaping their personal reality is essential to gain a sense of self-efficacy and to prevent developing the helplessness and hopelessness of depression.



Step by Step

Step 1: Instill hope by emphasizing that it is possible to manage stress.

Suggested Wording:

During exercise V, we saw how stressors can affect your emotional and physical health, your relationship with your baby, and ultimately your baby's emotional and physical well being, and how we can learn to manage these stressors and minimize the effect they have on us and on our families. This is one of the primary reasons for this class. Over the years, mental health providers have learned a lot about helping people to manage their moods, and they have developed a number of skills called mood regulation skills. During this class we will be teaching you these skills and helping you to use them in your daily lives. We will also be talking about how you can pass on these skills to your children.

Step 2: Present a metaphor or visual picture to help people understand that it is possible to balance stress with other factors.

Suggested Wording:

If you look at page 1.8 in your books, you will see how stress can affect us. What do you think about this picture?

Elicit participants' reactions.

Now what do you think about the picture on the bottom of the page?

Elicit participants' reactions.

Step 3: Highlight the idea that when we have stress it is even more important to think of ways to balance that stress, and that during this course we will talk about ways to balance stress.



Alternative Exercises

We have found the use of metaphors very helpful when presenting ideas. You might draw a scale on the board or bring an actual scale to class where one side represents stress and the opposite side represents ways to counterbalance stress. Have participants discuss ways to tip the balance.



VIII. MANAGING MY PERSONAL REALITY (10 MINUTES)



Overview

Help participants understand the difference between their external and internal reality. Help participants understand the connection between thoughts, behaviors, contacts with others, and emotions, and begin to see that it's possible to make changes in these areas.



Key Points

- Explain the concepts of internal and external reality.
- Help participants understand the connection between thoughts, behaviors, contacts with others, and emotions.



Participant Manual

p. 1.9



Rationale

To help participants understand a theoretical model for managing their mood.



Information

This is the basis of the rest of the course. It is important that participants understand the concepts and see them as relevant to their lives. As you discuss these concepts, try to integrate information that participants have shared with the class and provide examples that are relevant to their lives.

We use a Healthy Management of Reality framework as a way to discuss how individuals can manage their mood. In essence, this is a simplified explanation of the cognitive-behavioral approach to mood management. We explain that people live in two worlds: 1) the world of their mind (their “Internal Reality”) and the physical world (their “External Reality”). What happens in their mind and what happens in the outside world affect their mood. Their mood, or emotions, straddle both worlds. Their face and body are affected by and express how they feel, but there are parts of their mood and emotion that only they will know.

The circle graphic on page 1.9 in the introduction shows arrows going in both directions, from emotions to thoughts and activities, and between thoughts and activities. It is important to point out that though emotions (how we feel) can affect the thoughts we have and the activities we do, thoughts and activities can also affect our emotions as well as each other. (This is the concept that Albert Bandura refers to as “reciprocal determinism,” and which allows us to learn to manage our mood by changing our thoughts and actions.)

The idea of “shaping our reality” must be presented here and repeated throughout the course. It is the key concept of the course. Changing our mood by changing how we think is an important skill to have, but it is likely to have a relatively short-term effect by itself. It is also necessary to acknowledge that our external reality has an important impact on our mood, and that, therefore, we need to shape it as well. Shaping our external reality involves considering where our activities place us in terms of space and time: Where do participants spend each hour of their days, with whom, doing what? Where will their babies spend each hour of their days, with whom, doing what? Are there places, people, and activities that will

create a healthier environment to grow and develop, and that will contribute to a more positive image of participants and their lives? Can the participants begin to think about and actually implement changes in their lives that will increase healthy internal and external environments for them now so that by the time their babies are born, they will have these skills well learned?

Part of our “External Reality” (or our physical reality) is our body. It is important to emphasize that the condition of our bodies (e.g. how much we sleep, what we eat, and our level of exercise) also has an impact on our mood and our health. Teaching this to our babies early on will have a long-lasting effect on their lives. Learning and practicing this ourselves will give us a sense of control over an important area of our lives.

Bottom line: What we do each day shapes our lives. By actively choosing what we do, we can create a healthier reality for ourselves and our babies.



Step by Step

Step 1: Introduce the concepts of internal and external reality.

Suggested Wording:

We believe that is important to understand that our moods do not change by themselves. There are many things that affect the way we feel. Some of these things are part of our external reality, and some of these things are part of our internal reality.

Diagram these concepts on the board.

Our external reality includes all the things that happen to us, our physical health, all the things we do, and the way we relate to others. It includes observable facts. For example, if you have an argument with your partner, that would be part of your external reality. If you are nauseated because of your pregnancy, that is part of your external reality. If your baby wakes up in the middle of the night, that is part of your external reality, and if you decide to take a walk to the park that is part of your external reality.

Check to ensure that participants understand the concept of external reality. It may be helpful to use tangible objects in the room that everyone can agree on to further explain this concept. For example, you might say that it is part of all of your external reality that you are all sitting in a room (describe the room) and that you are sitting on chairs (you might describe how comfortable or uncomfortable they are).

Our internal reality is made up of our thoughts. Our thoughts are not observable. Others do not know what we are thinking, and sometimes we even need to stop and figure out what we are thinking ourselves. Our thoughts influence our vision of the world and of ourselves just as much as what we actually do and what happens to us.

Again, make sure that participants understand the concept of internal reality. You can further explain the concept by saying that while we all share the same external reality, of being in the same room and sitting on the same chairs, you may have a different internal reality. Get participants to share their thoughts or reactions to the room or to sitting. Show how people’s internal realities differ, and discuss how this might affect mood.

Another example that often works is to have participants imagine that they are all eating a particular food, like chocolate or spinach. Their external reality is the same. However, they may each have a different internal reality because they may each have different thoughts about what they are doing. For example, one might think that this is really wonderful, another might worry about whether it will make her fat, another might think about how much she really does not like the food, and another might focus on how it will affect her baby.

Together, our external and internal realities affect how we feel and create our personal reality.

We think these concepts are important because when we want to make changes in our mood, we can think about whether we want to make changes in our external reality, our internal reality, or both.

Step 2: Show how internal and external reality affect mood.

Suggested Wording:

If you turn to page 1.9 of this session in your books, you will see a diagram of how our internal and external realities can affect our mood. From the diagram, you can see that our thoughts, activities, and emotions are interrelated, meaning, how we feel affects the way we think and what we do.

If possible, use examples the participants have shared earlier.

We all have examples from our lives of this. When we feel down, we are more likely to think negative, pessimistic thoughts, and we are less likely to do things that are healthy. However, as you can see, the way we think and what we do also affects how we feel. This means that if we can figure out a way to change the way we think or the things we do, we can also change our mood. Changing what we do also affects how we think and vice versa.

Make sure participants understand the diagram. If necessary, provide additional examples to personalize the connections.

Step 3: The concept of mood management.

Suggested Wording:

Stress is part of our external reality. It brings us down.

Although some things that happen to us are out of our control, there are also parts of our reality that are under our control. We can manage our external reality by choosing what we do. We can also manage our internal reality by making changes in the way we think. Sometimes it seems like we can't change the way we think, but we have found that we can make small changes that can be very helpful. You have all changed your reality by coming to this class and choosing to learn ways to help yourselves and your babies.

As we continue with the class, we will be talking a lot about how we can make changes in our internal and external realities that will help us and our children.

As mothers you will be able to pass on what you learn to your children, and you will be able to show them how they can shape their realities. For example, you will be able to help them have healthy thoughts about themselves, learn how to engage in activities that help grow their minds and their bodies, and learn how to have good relationships with other people.

Step 4: Make sure that participants understand the concepts. Do this step only if it seems necessary.

Suggested Wording:

Let's see if we can take some examples from your lives and figure out whether they are part of your external or internal reality.

Have participants volunteer to share things in their lives (for example, they are all pregnant) and determine whether they are part of their internal or external realities. Then have them discuss the how these parts of their life are related to their thoughts, emotions, and activities.



IX. PERSONAL PROJECT (10 min)



Overview

Show participants how to track their mood using the Quick Mood Scale and highlight the importance of the personal project.



Key Points

- Explain the Quick Mood Scale, and have participants rate their moods for today.
- Do a practice week on the board so participants get a chance to see how it works. You can ask for a volunteer or make up a mood scale.
- Emphasize the following information:
 - Participants should use the whole range, not just 1, 5, or 9.
 - They should do it each day and not all at once at the end of the week. We often find that it is easiest to keep it by your bed in order to remind you to complete the record before going to sleep.
 - It will feel more natural as they practice it. (There will be days when it will be hard to decide on an average for their mood. They should do the best they can.)
 - There is no right answer. Only they can determine how they have felt each day.
 - Each person is different.
- Let participants know that you will be asking them to track their moods using the Quick Mood Scale over the next week and that in future classes you will be looking at how making changes in what they do, how they think, and their contacts with others affect their moods.
- Discuss the importance of the personal project and go over the project for this week. (Quick mood scale and discussing what they learned in class today with a friend or family member).



Participant Manual

p. 1.10



Rationale

To learn to manage their moods, participants need to learn to recognize their moods. They need to learn that their moods fluctuate from moment to moment, hour to hour, and day to day. The Quick Mood Scale can give them a glimpse of this. Once the fact that mood fluctuates is clear, the next important concept to learn is which factors influence this fluctuation. The course focuses on 3 very important factors:

- 1) What we think (thoughts, or “cognitions”)
- 2) What we do (activities, or “behaviors”), and
- 3) With whom we spend time (people, of “interpersonal interactions”).

As the course proceeds, the Quick Mood Scale will include space to monitor each of these factors so participants can see the relationship between these factors and their moods. Therefore, it is important that they do the personal project.



Information

The way group leaders speak about the personal project during this first session will influence whether participants complete the project for the duration of the course. Therefore, it is important that group members and leaders take the personal project seriously and believe in its importance.

We recommend you do an example on the board with the participants. Sometimes participants use extreme numbers to rate their moods. You can handle this by saying that 9s and 1s are very rare throughout our lives. Therefore, their moods will most likely fluctuate between 2 and 8. It can be helpful to ask for examples of 1s and 9s to help them differentiate between “worst mood” and “best mood.” Good examples of 9’s include: the birth of the baby, winning the lottery, and your wedding day, although it is important to remember that for some participants some of these events may be negative. 1’s might include the death of a loved one and being told you or a loved one has a terminal illness.

Step by Step

Step 1: Provide the rationale for monitoring mood.



Suggested Wording:

One of the first steps in managing our mood is to begin to really notice our mood and understand what affects it. When we know what makes us feel better or worse, we can make changes to improve our mood. For example, we can do more of what makes us feel better. Even though some things that affect our mood may be out of our control, other things can be changed, and we may find that even small changes really help our mood.

Step 2: Explain the Quick Mood Scale.

It can be helpful to draw the scale on the board.

Suggested Wording:



If you turn to page 1.10 in your books, there is a copy of the Quick Mood Scale. We can use this scale to track our mood for a week.

The scale goes from a 1 to a 9, with a 1 being the worst you might feel, a 5 being average, and a 9 being the best you might feel. When we rate our mood, it’s important to try to use the whole scale. For example, if I were feeling bad, but I knew that it wasn’t the worst mood I’d ever had, I would figure out how bad I was feeling, and I would pick maybe a two or a three. There are no right or wrong answers. It’s just how I think I’m feeling.

Pause and ask group members to rate their current moods. Use active listening skills to show you understand what they’re saying and how they’re feeling.

By using the scale, I can track my mood for a week and see how it changes.

Demonstrate using the board or holding a book.

I put the dates of the week here, and then each day I rate my mood. At first, it might feel strange to track your mood, but after a while it becomes natural, kind of a daily self check, so you can say to yourself, “overall, how was today for me?”

It’s important to do it every day and not at the end of the week, because sometimes we remember things differently than they really happened. We recommend putting the scale by your bed and then filling it in every night before going to sleep.

If there are veteran members in the group, you may choose to have them share their experiences of using the scale. They can also graph their moods for the week on the board.

Step 4: Elicit group member reactions to tracking their mood. Empathize with both positive and negative reactions.

Suggested Wording:

What do you think about the idea of measuring and keeping track of your mood?

How could tracking our mood help us?

Step 5: Explain the rationale for the Personal Project.

Suggested Wording:

The Quick Mood Scale is one part of a Personal Project that we’d like you to do each week. When we meet together we’ll learn lots of new things, including ways to help us improve our mood and help our children. We’ll be talking about these things in the class, but it is very important that you try some of them at home, so you can tell us whether or not they were helpful. We only meet for 2 hours every week; if we want to make lasting changes, we need to start making them when we’re not here.

In order to help us try things we learned in class, each week we’ll be doing a personal project. The project will include tracking our mood and then doing something related to what we learned in class. We also have a list of optional projects that you can pick from. We believe that the more you do the optional projects, the more you will learn from this class.

Step 6: Obtain participants’ reactions to the idea of doing personal projects.

Step 7: Highlight that for next week, you would like them to practice using the mood scale. The optional project is to talk to a friend or family member about what they learned in today’s class.



Class #2: THOUGHTS AND MY MOOD

CLASS OUTLINE

- I. A. Announcements and Agenda (5 min)
B. General Review (5 min)
- II. Personal Project Review (10 min)
- III. Relaxation Exercise (10 min)
- IV. Violet and Mary (5 min)
- V. New Material (75 min)
 - A. The Path That Leads to a Healthy Mood (10 min)
 - B. What are Thoughts? (10 min)
 - C. Helpful and Harmful Thoughts (10 min)
 - D. Types of Harmful Thought Patterns and Talking Back (10 min)
 - E. How to Give Myself Good Advice (10 min)
- VI. Take Home Message (5 min)
- VII. Personal Project (5 min)
- VIII. Feedback and Preview (10 min)

Goals for instructors:

- Review main concepts from last class.
- Continue to build rapport and encourage group process.
- Introduce the new thoughts module, which addresses our internal reality.
- Learn and identify what thoughts are.
- Identify harmful and helpful thoughts, and their relationship to mood.
- Identify different categories of thoughts, and their relationship to mood.

Materials needed:

- Participant manuals
- Pens, dry erase board, or chalkboard to present material to class
- Ramos et al. (2007). The MB Course: Relaxation Methods for Managing Stress.
- Copies of CES-D or other mood questionnaires (optional)
- Evaluation/feedback forms (optional)



I. A. AGENDA & ANNOUNCEMENTS (5 MINUTES)



Overview

Go over the agenda for today's class and elicit agenda items from class members. Make announcements and invite class members to share announcements they have.



Key Points

- Briefly review the agenda for the course (shown on the first page of this session).
- Ask participants if they have additional agenda items.
- Make announcements.
- Ask participants if they have announcements they'd like to share.



Rationale

By setting an agenda, you help structure the session and let class members know what to expect, and you provide class members with an opportunity to actively participate in the class by contributing to the agenda. It is important to encourage participants to share important events from their weeks. By doing so: 1) you get a glimpse of their state of mind, which may make their reactions (or lack thereof) more understandable during the class, and 2) you obtain stories from their lives that you can use to illustrate and personalize course material.



Information

Setting the agenda sets the tone for future sessions. You want to set a balance between providing the structure necessary to cover all the class material and giving participants an opportunity to bring up topics that are important to them. Often participants will share information regarding their pregnancy, such as the gender of their child, what they learned at their last doctor's appointment, pictures of their baby or of other children.



Step by Step

Step 1: Review today's agenda.

Suggested Wording:

Now I'd like to review today's agenda (point to the board). As you can see we have a lot to cover. We'll begin by sharing announcements, and then we will talk about the importance of thoughts and how they influence our mood. Does anyone have something they would like to add to the agenda?

If participants contribute suggestions, write them on the board, and schedule time for them.

Step 2: Announcements.

Make announcements and ask participants if there is anything they would like to share with the group.

Step 3: Brief Check-in.

For pregnant women, ask participants to briefly mention how they are feeling and how their pregnancy is going.

For mothers with young infants, ask participants to briefly mention how they are feeling, how their baby is doing, and any changes that they noticed about their baby this week.

There may also be women who have more than one child. In this case, also ask about their other children's well-being, if applicable.



I. B. GENERAL REVIEW (10 MINUTES)



Overview

Briefly review the material covered in the previous class.



Key Points

- Parents are their children's first teachers. These are some of the things your baby needs from you: good communication, reading, music, play.
- Stress can affect your relationship with your baby. You can learn to manage stress by making certain changes in your life. We will talk more about these changes in this course.
- There are common mood problems in the postpartum period. It's important to talk to someone if you experience postpartum depression.
- Your mood and your personal reality: Your thoughts, activities, and mood all affect how you view the world.
- You can learn more about how to manage your personal reality, which has two parts: an internal and external reality. Your personal reality can affect your mood, and your mood can affect your personal reality.



Participant Manual

p. 2.2



Rationale

Reviewing what was covered during the last class will help you determine what participants remember from last session, reinforce key points, and share information with group members who were absent last session.



Information

It is important to reinforce class members' participation and validate their points of view. In essence, there are no wrong answers. Participants are sharing what they remember from last week.



Step by Step

Step 1: Ask participants to share what they remember most from the last class.

Suggested Wording:

- *What are some of the things that you remember most from the last class?*
- *Do you have any questions about what we talked about during the last class?*

Elicit responses from participants and answer any questions they may have.

Step 2: Reinforce participants' responses.

You can do this by writing down their words, highlighting what they have said, and/or praising their responses.

Step 3: If it seems appropriate, highlight key points that participants did not cover.

Suggested Wording:

So basically, we learned that life stress affects us and the people around us, like our babies. We talked about how we can manage stress by looking at what we do and how we think, and by having good support from others.

When we watched the video we saw how important parents are to their children. They are their baby's first teachers. We teach them by talking with them, reading, singing or playing music, and playing with them. We are also their role models. They follow us and for that reason, when we learn to manage our moods, they also learn how to do this. This is important because we want our children to be emotionally and physically healthy.

We discussed common mood problems that women sometimes experience during or after pregnancy, and that it is important to talk to someone if you are experiencing postpartum depression.

Finally, we talked about how we have two parts to our personal reality: our internal reality, or our thoughts and inner world, and our external reality, or the world that exists around us and that others can see. We saw that our personal reality can affect our mood, and our mood can affect our personal reality.

Highlight key points that the women made during the last class, including examples that are relevant to the module and details regarding their families and children. Instructors can also review the relevant/selected activities from the introduction, as applicable.

Today, we will be talking about how our mood is affected by what we think, but first let's go over the personal project.



II. PERSONAL PROJECT REVIEW (15 MINUTES)



Overview

Review the personal project and optional projects from the previous class.



Key Points

- Review participants' Quick Mood Scales.
- Discuss how participants felt about completing the Quick Mood Scale.
- Discuss what participants learned from tracking their mood (or tracking their activities, thoughts, and interactions with others in future classes).
- Optional Project: Discuss whether participants shared what they learned in the first class with others and how they felt about doing so.



Participant Manual

p. 2.3



Rationale

Participants are more likely to benefit from the course if they complete the personal project. They are more likely to complete the project if they know leaders will be devoting class time to reviewing the project. Reviewing the personal project also provides the class with an opportunity to see how what they do outside the class affects them. Those who did not complete the project can benefit from and be motivated by those who did complete it.



Information

Participants are more likely to complete the project if leaders take the projects seriously and set a routine expectation that personal projects will be done and reviewed at the beginning of each class. Those who complete the personal project should be reinforced with attention. They can volunteer to go up to the board, draw their mood graphs, and engage in an analysis of the things that affected their moods positively or negatively. Reinforcing completion of the project increases the likelihood that participants will complete the project in the future.

If participants did not complete the project, leaders can bring them gently into the discussion by asking them about specific events and their reactions to them. If they are willing, they can complete the project verbally, or take a few minutes to write their answers from the past week in their manuals, and/or recreate their answers on the board. It is important that you help them see how completing the project is important. For example, by tracking your mood each day, you can begin to understand how what happened during the day affected your mood. You can also lead the class in a discussion of ways to increase the chances that participants will do their projects. You may help participants identify obstacles to completing the personal project and develop a plan for overcoming these obstacles.

Participants may need emotional support as they talk about days when their moods were low. It is important to empathize with their feelings and normalize their reactions to difficult situations. We want to highlight that we cannot always be happy. Certain things will make us feel sad or angry, and that is normal; but we don't want to be sad or angry all the time. When life is difficult, it is especially important to learn ways to manage our moods.

As you review participants' mood scales, be aware that pregnancy related symptoms are likely to influence how they are feeling. Help participants empathize with and support each other as they are all undergoing a similar experience. Listen for possible thoughts or behaviors that may be helpful or harmful given what the women are undergoing, acknowledge and empathize with difficult realities, and help participants arrive at a balanced view of their situation (e.g., my baby kicks me, and it's hard to sleep. It's also exciting to know I have a baby). Help them see that they can hold two opposing, equally valid positions in their minds.

When a participant has a particularly difficult personal reality (e.g., significant trauma history, single mother with no social support network, tough economic situation, immigration problems), it may be important, and at times necessary, to stay at the feeling level and empathize with the situation and the accompanying feelings of sadness, anger, fear, etc. When appropriate, you can highlight how wonderful it is that she is attending the group as this affords her one way to change her personal reality.



Step by Step

Step 1: Review participants' Quick Mood Scales. We typically write the Quick Mood Scale on the board. We then ask for volunteers to share their mood scales. Participants either go to the board to graph their moods, or they call out numbers for each day and a group leader graphs them. At the end, we discuss what they have learned from the mood scales.

Suggested Wording:

Last week, we asked you to track your mood by using the Quick Mood Scale. [Refer to board]: We would like to go over your Quick Mood Scales. Who would like to share their Quick Mood Scale?

Help the volunteer graph her mood scale on the board. Then elicit the participant's and the class' reactions. Possible questions to elicit discussion include:

- *How was it for you to complete the Quick Mood Scale?*
- *What did you learn by tracking your mood?*
- *What happened on the days when you had a really low mood?*
- *What happened on the days when you had a really good mood?*

Depending on what module you are covering, highlight the area of focus for the module. For example, in the activities module, highlight how what participants did affected their mood. Similarly, highlight how the participant's thoughts (thoughts module) and interactions with others (people module) affected their moods.

Facilitate other participants' sharing of their mood scale.

Step 2: If applicable, help participants identify obstacles to completing the personal project.

Suggested Wording:

If you did not have a chance to complete your personal project, were there any obstacles (anything that got in the way) of you not finishing the personal project?

Step 3: Review the Optional Project.

Ask participants whether they talked to other people about the class and inquire about that experience.

Suggested Wording:

The optional project for last week was to talk to someone about the Mothers and Babies Course. Did anyone do this?

Discuss who they talked to and how it felt for them to share what they have learned so far. Reinforce their completing the optional project.



III. RELAXATION EXERCISE (20 MINUTES)



Overview

Conduct a relaxation exercise with participants.



Key Points

- Provide a brief rationale for doing relaxation exercises.
- Have each participant rate her current mood.
- Ask participants to rate their moods at the end of the exercise.
- Discuss how using their breath to relax affected their moods.



Participant Manual

pp. 2.4, 2.5



Rationale

Relaxation is a useful tool that can help the women manage stress during pregnancy and delivery and after the baby is born.



Information

Relaxation skills appear to be useful and important for women taking this course. The women in our first groups often remarked about how helpful it was to learn relaxation exercises.

After completing the relaxation exercise, it is important to allow time to talk about participants' reactions to the exercise. Participants may report mixed reactions, including feeling worse following the relaxation activity. For this reason, we have included an inoculation technique, which helps prepare participants for the possibility and utility of negative reactions (refer to Step-by-Step section below).

Some pregnant women may report that their baby begins to kick more during the exercise. If this happens, it will be important to discuss how the women understand this (e.g., this baby never lets me relax, she is healthy and is perhaps showing how much she enjoys the exercise).

Some instructors may feel uncomfortable or "hokey" conducting the exercise. They may worry that their voice is not relaxing, or they feel uncomfortable relaxing. We encourage instructors to practice the exercise by audio-taping themselves and then practice relaxing by listening to the audiotapes. Instructors can try the exercise with others and see how they respond to help them gain information about the benefits and potential pitfalls. Relaxation is an important skill, but not all exercises will help all individuals. The goal of doing relaxation exercises is to give participants an opportunity to learn different relaxation strategies and decide which ones are effective in managing their stress.



Step by Step: Breathing Exercise

Step 1: Introduce the exercise and provide the rationale.

Suggested Wording:

Now we're going to talk about one way of dealing with stress, relaxation. Relaxation is a key tool in managing stress. When we relax, we are doing something pleasant. Relaxation can be an enjoyable and pleasant activity for you and for your baby. Relaxation is also good for our physical health and gives us a break from our thoughts. This is one way that we can shift our inner reality. Today we are going to use our breath to learn to relax.

A FEW THINGS TO KEEP IN MIND ABOUT LEARNING TO RELAX

1. Practice, Practice, Practice:

Learning to relax is similar to learning any new skill— like knitting, cooking, or painting. It takes regular practice, patience and time. With consistent practice, you will soon be able to control your bodily tension and experience a greater degree of relaxation.

2. The goal: to relax without doing the exercise:

Once you have mastered the ability to achieve a relaxed state, you can try to reach this state without doing the exercise, just by simply telling yourself to relax. In this manner, you can begin to apply this new skill in your daily living. We recommend that you start with a relatively simple activity. For example, try relaxing while you are reading the newspaper. Then try it in more challenging situations, such as when you are in a hurry, or when you feel you are about to get angry with someone. Even after you get to this point, it is still useful to occasionally run through the actual exercises to keep in practice and remind yourself how powerful relaxation can be.

3. As you prepare to relax:

- *Choose a quiet, comfortable environment where there are few distractions.*
- *Choose a time of day when you are least likely to be disturbed, and not too soon after a meal. For example, try relaxing upon awakening or when you are ready to go to sleep. Also, try relaxing during the middle of the day, particularly just before you have to do something difficult or just after you have had to face a stressful situation.*
- *Select a comfortable position.*
- *Try not to worry about how well you are doing. If you begin to experience distracting thoughts, slowly return your mind to the task of relaxing.*

Step 2: Inoculate participants against possible negative reactions.

Suggested Wording:

In a moment, I am going to ask you to close your eyes, relax your body, and become aware of your breathing. As you do this, pay attention to how you are feeling. You may experience positive or negative feelings. Either type of feeling is fine. It will be important for both you and us to understand your reactions.

Step 3: Lead a relaxation exercise where participants use deep breathing techniques. Specific instructions for this exercise can be found on page 8 of the Relaxation Manual (Ramos, Diaz, Muñoz, & Urizar, 2007) and page 2.5 of the participant manual.

Step 4: Process with participants what it was like to do the relaxation exercise.

Suggested Wording:

Did your mood change? What aspects of the exercise may have contributed to your mood changing if it did?

If someone had a negative reaction to the activity, explore the thoughts she had during the exercise. Talk about how our thoughts can affect how we behave and how we feel.



Alternative Exercises

We have included a relaxation exercise; however, you may use any relaxation exercise or technique that you wish. For this section, we recommend that you select an exercise that focuses on doing something or thinking about what you do as a way to relax. A number of optional relaxation exercises are listed in the English version of the Relaxation Manual (Ramos, Diaz, Muñoz, & Urizar, 2007).

You may also choose to have class members actually do something pleasant and relaxing, such as having a cup of tea or playing a game and then discussing how this was.



IV. VIOLET AND MARY'S DAYS (5 MINUTES)



Overview

Conduct an interactive activity that highlights the connection between what we think and how we feel.



Key Points

- Engage the group in an active discussion about Violet and Mary's days and highlight the following points:
- What you do affects how you think and feel about yourself, others, and the world.
- You can choose to do things that make you feel better.
- Thinking pleasant thoughts can actually create energy.
- Thinking pleasant thoughts helps make our lives more balanced. We realize there is more in our lives than just problems and things we have to do.



Rationale

To help participants understand the link between what they do and their moods and to motivate them to engage in more healthy thoughts.



Participant Manual

p. 2.6



Information

Each module will have a cartoon about Violet and Mary as a way to serve as models for how individuals can make changes in their moods. This exercise has been very well received by participants, and some participants talk about how this is one of the exercises that they remember most.

When you present the vignettes, allow time for group members to discuss these characters, to make them real, as this will increase the likelihood that group members will keep them in their minds and will learn from their experiences. However, it is important not to “vilify” Violet because inevitably some of the women may have days similar to Violet’s. Hopefully, if they can learn to empathize with and help Violet, they will be able to do the same for themselves.

If you conduct the exercise as a role-play, some of the women may prefer not to play the role of Violet because of her outcome. Group leaders can discuss the group’s reaction to Violet and talk about how the primary difference between the two women is that Mary engaged in pleasant thoughts.



Step by Step

Step 1: Introduce the vignettes.

Suggested Wording:

Let's look at the cartoons on page 2.6 in your books to see another example of how what we think can affect how we feel. This morning, Violet and Mary get a phone call from a friend asking them to go shopping. Violet does not answer the phone. She doesn't feel like getting out of bed and stays home. Mary decides to go out with her friend and they spend the afternoon together shopping, looking at baby clothes, and talking about the upcoming baby.

Step 2: Elicit participants' reactions to the cartoons and help them flesh out the characters. Questions to stimulate discussion are listed below:

- *Who are Violet and Mary?*
- *Why do we think they are feeling down? (What are their external realities?)*
- *What are they thinking? (What are their internal realities?)*
- *What does each character do? (How do they change their external realities and their internal realities?)*
- *How does what they do affect their mood?*

To make the exercise more interactive, you may choose to have one woman act as Violet and another woman act as Mary. As the women act out their roles, other group members can participate by indicating where each woman is on the mood scale as they go from scene to scene.

Step 3: Graph the characters' mood scales on the board. Have participants determine how Violet's mood changed with each picture. Then do the same for Mary.

Step 4: Facilitate a discussion about how what we do affects how we feel. Help participants discuss how this example is relevant to their lives.

You may choose to highlight the following points:

- Healthy thoughts help to balance our lives (balance beam), especially when they are stressful.
- Healthy thoughts tend to chain, meaning when you have one thought you often start a chain so that you are more likely to have more positive thoughts and do more pleasant or positive activities.
- Even when life is stressful, we can choose to think healthy thoughts. By doing so, we change our mood and at least a small part of our lives.

Step 5: Connect this exercise to the explanation of mood and your personal reality.

Highlight that Mary made choices and did activities that changed her external reality and affected both her thoughts (internal reality) and her mood. Remind participants about the relationship between our internal and external reality and our mood.



V. NEW MATERIAL

V. A. THE PATH THAT LEADS TO A HEALTHY MOOD (10 MINUTES)



Overview

Conduct an exercise or provide a metaphor that helps group members see that they have choices and that even seemingly small choices can have significant impacts on their moods.



Key Points

- Your personal reality is shaped from moment to moment.
- We can choose what we will do and how we will think.
- Even seemingly unimportant choices affect mood directly and indirectly by making it more likely that another event or thought will occur.
- Conduct an exercise to help participants visually or metaphorically understand these concepts (to provide them with an “a ha” experience).



Participant Manual

p. 2.7



Rationale

This section reinforces the message that one’s actions and thoughts continually shape one’s reality. The intent of this exercise is to illustrate that, at each moment, we have choices regarding how we react to the current situation and that we can go up or down. We choose:

- What we think.
- What we do.
- How we interact with others.



These choices can have a positive or a negative impact on how we feel and what will happen next. The graphics on page 2.7 are intended to illustrate this process.

Information

Because concepts in this section may be hard to grasp, it may helpful to use one of the “Violet and Mary’s Days” scenarios to illustrate how decisions made from moment to moment can affect one’s mood. Drawing the paths of these decisions over time on a blackboard or eraser board may help participants visually realize that by choosing what we do, we all have some control over our mood. We shape our personal reality each day with each choice we make.

Note that this is not a “positive thinking” course in which we assume everything is great and everything is going to turn out fine. Our message is that, no matter from where one starts, it is possible to gradually shape one’s life on a moment-to-moment basis so that the next moment can be slightly better than the last. And, if life deals us some bad experiences, we can make choices to try to surmount these experiences rather than letting our reactions sink us even further.



Step by Step

Step 1: Introduce the exercise.

Suggested Wording:

We talked in class 1 about your mood and your personal reality. Today, we'll talk about how each of us can shape our personal reality. Let's talk about what we mean by shaping our personal reality. Have you heard the saying "Rome was not built in a day"? What does this saying mean to you when you think about building your personal reality?

Elicit participants' responses. Highlight key points participants make regarding shaping their reality. They may talk about how when you build a building or a city, you do it brick by brick. Our mood is also constructed brick by brick, but the "bricks" are thoughts and activities. Each thought and each activity can lead us either up or down.

Step 2: Discuss the diagrams shown on pages 2.7.

Suggested Wording:

Let's look at a diagram that shows us how we shape our mood through a series of seemingly small choices. Please turn to page 2.7 in your books. On this page we have a series of dots. Each dot represents a single moment in time. Let's say that we start at the first circle on the left. Each thought or action we have from that point onwards can move us up, down, or sideways. Going up would mean that it improves our mood; sideways would mean it has little or no effect on our mood; and down would mean it has a negative effect on our mood. At first, the moves we make will not take us far away from where we began, but imagine where we could be 10 moves later.

Step 3: Talk about how the choices Violet and Mary made affected their mood.

Suggested Wording:

Let's look at a specific example. Think back to Violet and Mary from earlier in this class.

Let's draw how each choice they made affected their mood.

Group leaders can either complete the diagram or they can have a group member lead the group and discuss how each step Violet and Mary made affected their moods. We recommend beginning with Violet and showing how each choice she made caused her to feel a tiny bit worse. Then discuss how the small choices Mary made led her to engage in more activities and to gradually feel much better. This is a good example of how activities chain, so that one pleasant activity is more likely to lead to another pleasant activity.

Step 4: Process what group members think about shaping their reality. Possible questions to stimulate discussion are listed below:

- What does this diagram mean to you?
- Does this diagram help you to think about how you might shape your reality?
- What might you do to shape your own reality?
- What choices did you make recently that affected your mood? (If they are willing, they can diagram these choices on the board)



Alternative Exercises

1. Instructors can use any illustration or metaphor that shows that people can make choices that affect how they feel. For example, an image of a stairway with people going up or down steps represents a thought or action that participants engage in.

2. Instructors can ask a participant to diagram how the activities she did over the past week affected her mood, which she may have discussed during the personal projects review.



V. B. WHAT ARE THOUGHTS? (10 MINUTES) DO DIFFERENT THOUGHTS AFFECT OUR MOOD?



Overview

Identify thoughts and discuss how thoughts are related to mood.



Key Points

- Discuss the reciprocal relationship between thoughts and mood.
- Thoughts = self talk, as if we were having a conversation in our mind.
- Our thoughts can affect the way we feel.
- Thoughts can affect our bodies (e.g., negative thoughts can cause tension).
- Thoughts can affect what we do.
- It is possible to change the way we think. In many ways, it is like learning a new language; a new way of talking! The first thing we need to do is to be able to identify (hear) our own thoughts.



Participant Manual

pp. 2.8



Rationale

Increase participants' understanding of what thoughts are and how they affect their mood.



Information

For additional reading about thoughts, see Chapters 9, 10, and 11 in Lewinsohn, P.M., Muñoz, R. F., Youngren, M.A. & Zeiss, A. (1986), *Control Your Depression*. New York: Simon & Schuster. You can also review this book: Burns, D.B. (1980). *Feeling Good: The new mood therapy*. New York: Avon Publishing.



Step by Step

Step 1: Define thoughts.

Suggested Wording:

What are thoughts?

Elicit responses from participants and make sure that it is clear that thoughts are things we tell ourselves. If participants share thoughts they are having, you can write them on the board.

Step 2: Help identify thoughts related to their pregnancies

Suggested Wording:

Please turn to page 2.8 in your books. Here is a woman who is pregnant, just like some of you, and she has a lot of thoughts about being pregnant. What kinds of things do you think she is telling herself?

Elicit responses from the participants. Make sure to allow space for women to talk about both positive and negative thoughts. Highlight the idea that we can have many thoughts at the same moment and that we pay more attention to some thoughts than to others.

How do you think these thoughts affect her mood?

Highlight the connection the participants see between thoughts and mood.

If we pay attention to burdensome thoughts, our mood tends to get worse. If we pay attention to the positive aspects of our lives, our mood tends to improve.



V. C. HELPFUL THOUGHTS AND HARMFUL THOUGHTS (10 MINUTES)



Overview

Talk about the difference between helpful and harmful thoughts and how they affect mood.



Key Points

- Helpful thoughts help improve mood.
- Harmful thoughts worsen mood.
- Both helpful and harmful thoughts affect us emotionally and physically.
- It is important to understand how the different thoughts we have can affect our mood.



Participant Manual

p. 2.9



Rationale

To help participants begin to categorize thoughts as helpful, harmful, or burdensome.



Information

It may be helpful to ask participants to give examples of thoughts they are currently having as a segue to talking about “Helpful vs. Harmful Thoughts.” During pregnancy, it is common for women to have a variety of thoughts. We cannot assume that they all view this as a joyous event. Pregnancy and childbirth can be very stressful, and we need to create a safe environment where women can bring up concerns they have regarding pregnancy, childbirth, and being a mother. Similarly, motherhood can elicit a variety of thoughts that can be shared in the group.

Here are some of the thoughts women have shared with us:

- “I’m getting fat and ugly.”
- “I just found out I’m going to have a boy. I’m not sure if I want a boy.”
- “The world is so unsafe, how can I bring up a child in this world?”
- “I don’t enjoy sex, but my partner keeps pressuring me.”
- “I’m afraid I’m going to hurt the baby if we have sex.”
- “It’s so amazing to have a baby who is half me and half my partner.”
- “How can I be a good mother when I had such a bad childhood?”
- “The baby keeps me from sleeping.”
- “I’m afraid to give birth, but I worry that if use the drugs I will be a bad mother.”
- “Will my body ever be the same?”
- “Who is going to take care of my other child when I give birth?”
- “Having a baby wasn’t what I expected. It’s a lot harder.”
- “My husband was not there for me when the baby was born.”
- “My husband has been so helpful with this baby and the kids.”

Typically, we talk about helpful and harmful thoughts. There are also thoughts that are factual. Sometimes these factual thoughts relate to some negative aspect of our lives, such as “I don’t have a lot of money,” “it hurts when my baby kicks me,” or “I’m bloated.” These thoughts can be categorized as burdensome because they are true and difficult to change. But if we only focus on this aspect of our lives, our mood will get worse.

Women and Trauma. When you ask participants to share their thoughts, some of them may begin talking at length about negative life experiences. For participants with significant trauma histories, it may be important to gently summarize what they are saying. You can do this by saying something like, “Let me see if I understand; one of the thoughts you are having is _____” or “It seems like it was very difficult for you when you were younger, and it leads you to believe _____. Let’s see if we can help with that thought.” You can then write the thought on the board and talk generally with the whole group about how earlier experiences affect our lives and the way we think about ourselves, other people, and the world. Also, emphasize to the group how important it is to understand the way these thoughts affect us so that now we can make changes in our lives and in our children’s lives.

In some cases, you may suggest to a participant that it seems very important that she speak more about her experience, and that perhaps you can meet with her after class to figure out how to best help her. Later you will decide whether you can provide support through a brief meeting or whether a referral is more appropriate.



Step by Step

Step 1: Help participants begin to think about different thoughts. Because this exercise may lead participants to talk at length about difficult experiences they are having, group leaders may want to provide structure to prevent flooding (individuals becoming emotionally aroused when sharing prior traumatic experiences, resulting in their discussion of the trauma in length and in a disorganized way—see “Information” section should this occur).

Suggested Wording:

Now that we have talked about what thoughts are, let’s begin to categorize some of the thoughts you may be having. Before we start, we want to share some of the thoughts other participants have had. For example:

- “My body hurts, pregnancy sucks.”
- “I can’t believe there’s a life inside me.”
- “I don’t know if we can afford another child.”
- “I’m not sure if we’re ready to become parents.”
- “Being a parent is harder than I thought.”

So, as you can see, it’s normal and natural to have different types of thoughts during pregnancy or motherhood. It is a time that can be both joyful and stressful because of the changes you are experiencing physically and emotionally.

Step 2: Introduce the activity.

Suggested Wording:

On page 2.8 we talked about what thoughts are, and how different thoughts can affect our mood. Now we would like you to imagine some of the thoughts that you or someone else may have related to being pregnant or being a mother. Below are two columns. One column is labeled “helpful thoughts.” Under that column, write down thoughts you are having that make you feel good, happy, or hopeful. The other column is labeled “harmful thoughts.” Write down thoughts in this column that make you feel stressed, drained, worried, sad, scared, or angry. Do you have any questions?

Answer any questions. Give the participants approximately 5 minutes to write down 2-3 thoughts under each category. We recommend that instructors walk around the room to see how the participants are doing and to answer any questions.

Step 3: Process the activity.

Ask participants to share the thoughts they wrote down and the reason(s) they categorized them as helpful vs. harmful thoughts. Remind participants to share only those thoughts that they feel comfortable sharing. You can write those thoughts on the board. Talk about what makes the thoughts helpful, harmful, or burdensome. The key here is just to focus on how the participants identified and categorized thoughts. Later we will talk about how those thoughts affect mood.



V. D. TYPES OF HARMFUL THOUGHT PATTERNS AND TALKING BACK (10 MINUTES)



Overview

For participants to become aware of their harmful thought patterns, specifically those that affect their mood states.



Key Points

- Different types of harmful thought patterns exist.
- These harmful thought patterns affect our mood in a negative way.
- It's important to recognize these harmful thoughts and be aware of how they affect us.
- By learning what types of thoughts we have, we can better understand how to modify them in a helpful way.



Participant Manual

p. 2.10



Rationale

To learn to recognize harmful thought patterns.



Information

It may be useful for group leaders to use props when reviewing the different types of harmful thought patterns. For example, a coffee mug and filter can be brought in to illustrate the concept of a negative filter; dice can be used to illustrate pessimism; and a sticker label can be used to illustrate labeling. Leaders can point to a picture in the room and explain how some people may only focus on the imperfections (negative filtering) instead of seeing the entire picture. This is similar to being in any situation and focusing only on the negative aspects of the situation. As a result, they are blind to the positive aspects that exist.



Step by Step

Step 1: Review the harmful thought patterns.

Suggested Wording:

We've been talking about how thoughts affect mood. Next week, we will talk about skills we can use to can change the way we think to improve our mood, but before we do that, it is helpful for us to learn more about different types of harmful thoughts. Harmful thoughts fall into different categories.

If you look on page 2.10 of your books, we have listed some of the common categories. Let's go over a few of them.

Pick the categories that you think are most pertinent for group members and review these categories.

Step 2: Have group members identify which category their thoughts fall into. If you have written group members' thoughts on the board, pick a few and then ask participants which category each thought falls into. Otherwise, you can have group members share thoughts from page 2.9 in their books and figure out which categories they fall into. Sometimes, a given thought will fall into more than one category.



V. E. HOW TO GIVE MYSELF GOOD ADVICE (10 MINUTES)



Overview

To help participants increase positive self talk.



Key Points

- We can learn ways to talk back to harmful thoughts to improve our mood.
- We give good advice to others; we can also give good advice to ourselves.



Participant Manual

p. 2.11



Rationale

Learn ways to talk back to harmful/burdensome thoughts.



Step by Step

Step 1: Reinforce participants' ability to identify their thoughts.

Suggested Wording:

Beginning to really focus on what it is you are telling yourselves is the first step in learning how to change the way you think.

Give specific examples of thoughts participants have identified in class.

Step 2: Introduce the “Giving Advice” Metaphor.

Suggested Wording:

Look at page 2.11 in your books. Imagine the woman in this picture is your friend, and imagine she tells you “I’m not going to be a good mother. I won’t be able to take good care of my baby.” What do you think you would say to her?

Facilitate a group discussion about all the things the group may say to her. Make sure to ask how they think her thoughts would affect her mood.

When they are done, ask them this question:

Now imagine that you are this woman and you had this thought. What do you think you would tell yourself?

Begin a group discussion about how even though we know how to help others it is sometimes difficult for us to help ourselves. We often know the right things to say, but don’t say them to ourselves. Talk about why this might be.

Some key issues to discuss:

- Women are socialized to be caretakers, helpers, to listen to others.
- We learn these skills from a young age. However, we are not taught to apply these skills to ourselves. Part of this may be cultural.
- Another part may be in the way we were raised. Many women are raised to pay attention to how others are doing at the expense of how they are doing. We need to realize that we need to also care for ourselves. Mothers are the trees of the family. If the tree is not cared for, it will not bear good fruit.

Step 3: Have women practice giving advice to themselves.

Ask participants to pair off. Take a couple of minutes and have participants write one burdensome/harmful thought on a card. Let them know they will be sharing these thoughts with their partners.

Once the cards are ready, have the participants swap cards, so now each participant has her partner's card. They will now take turns reading the cards (which are really their partner's cards), but they will pretend that it is their card. The person who does not read the card will give advice on how to handle the thought (this means that each participant will really be giving herself advice).

As this exercise is occurring, circulate among the group, clarify the exercise, and help participants who may be stuck to really focus on helping "their friend."

Step 4: Process the exercise.

Have participants talk about what it was like to "give themselves advice." Did they have the answers when they felt the problem was not theirs? If they did not have answers, you can highlight the importance of getting support from a friend when you feel "stuck." Sometimes the best advice we can give ourselves is to get help.



VI. TAKE HOME MESSAGE (5 MINUTES)



Overview

To emphasize the key points from the session.



Key Points

- Thoughts are part of my internal reality.
- Some thoughts make my mood worse.
- Some thoughts make my mood better.
- If I can find out which they are, I can use my thoughts to improve my mood.



Participant Manual

p. 2.12



Rationale

We want participants to understand the key concept or message from the session.



Step by Step

Step 1: Review the take home message.

Suggested Wording:

Each week, we will review a take home message. This take home message is a summary of the main content that you learned in today's session.

Either the facilitator or get a volunteer participant to read the take home message.

Step 2: Elicit participants' reactions to the take home message.

Suggested Wording

- What do you think of this take home message?
- Do you agree or disagree?

Step 3: Elicit participants' own take home message, if different from the one described in the session and reinforce their own take home messages.

Suggested Wording

- Do you have your own take home message? Can you share with us your take home message?
- Thank you for sharing this message, which is also important. Please feel free to add that to these other take home message on this page. [encourage participants to write their take home message on this page.]



VII. PERSONAL PROJECT (5 MINUTES)



Overview

Assign this class's personal projects



Key Points

- Assign the Quick Mood Scale
- Ask participants to practice reducing their harmful thoughts



Participant Manual

p. 2.13



Rationale

We want participants to be aware of their thoughts and to learn how to manage them in order to improve their mood.



Step by Step

Step 1: Assign the Quick Mood Scale.

If necessary, see pages Intro.28-Intro.30 of this manual. Point out to participants that again this week they should note how many helpful and harmful thoughts they had each day (at the bottom of the scale) and think about the relationship between these helpful and harmful thoughts and their moods.

Step 2: Assign the optional projects.

1. Use your cards to keep track of your helpful and harmful thoughts this week. Write your healthy thoughts on one side of the card and your harmful thoughts on the other side.
2. Talk to someone about what you learned about your thoughts and mood today.



VIII. FEEDBACK AND PREVIEW (10 MINUTES)



Overview

Give participants an opportunity to provide feedback about today's class, and give them a brief overview of next week's class.



Key Points

- Provide participants with an opportunity to comment on today's class.
- Be supportive and responsive to their comments.
- Make a plan to make changes based on feedback, if appropriate.
- Provide an overview of next week's class.



Participant Manual

p. 2.14



Step by Step

Step 1: Elicit participants' reactions to the class.

Suggested Wording:

We are almost done for today, but before we end, I want to thank you for attending the class and find out how the class went for you. Your opinion is very important to us, as we want this to be a place where you can learn useful things and where you feel comfortable talking.

Suggested Wording

- What do you think about the Mothers and Babies course so far?
- What was helpful about today's session?
- Were there things that were not helpful, and if so, what were they?
- Are there things that you wished we had talked about today that we did not talk about?

Step 2: Respond to participants' comments.

Respond empathetically and responsively, showing you understand their points of view. If the comments are negative, try not to become defensive but instead take a problem-solving stance so that you can make things better in the future.

Step 3: Provide an overview of next week's class.

Suggested Wording:

We look forward to seeing you next week. Next week, we will talk more about how to fight harmful thoughts and increase helpful thoughts so that we can improve our mood, and our babies' moods.



Class #3: **FIGHTING HARMFUL THOUGHTS AND INCREASING HELPFUL THOUGHTS THAT AFFECT ME AND MY BABY**

CLASS OUTLINE

- I. Announcements/ Agenda (5 min) and General Review (10 min)
- II. Personal Project Review (10 min)
- III. Relaxation exercise (20min)
- IV. Violet and Mary (10 min)
- V. New Material (60-75 min)
 - A. Thoughts About Becoming a Mother (10 min)
 - B. Pregnancy, Birth, and Parenting— Helpful and Harmful Thoughts (10 min)
 - C. Helpful Thoughts During Pregnancy and Motherhood (10 min)
 - D. Ways to Change Harmful Thoughts that Affect Me and My Baby (10 min)
 - E. Thoughts I want to Learn to Teach My Baby (10 min)
 - F. Thinking About Your Future (10 min)
 - G. Thinking About Your Baby's Future (10 min)
- VI. Take Home Message (5 min)
- VII. Personal Project (5 min)
- VIII. Feedback and Preview (5 min)

Goals for instructors:

- Ensure that participants understand the connection between thoughts and mood.
- Help participants see that we can, and often do, change the way we think.
- Help participants understand how our external reality (e.g., activities) and internal reality (e.g., thoughts) both contribute to our personal reality.
- Motivate participants to want to learn how to manage their thoughts (internal reality) so that they can improve the quality of their lives and their babies' lives.

Materials needed:

1. Participant manuals
2. Pens, Dry erase board, or chalkboard to present material to class
3. An enlarged reality management chart (similar to p. 3) (optional)
4. Copies of CES-D or other mood questionnaires (optional)
5. Evaluation/feedback forms (optional)

Note: In Classes 3-6, detailed descriptions (e.g., overview, step by step instructions) will be provided for the New Material section only. In each of the classes, under the sections I-III below, the content described in the Participant Manual refers to the materials specific for that module.

For additional information on sections that are common to all sections, refer to Class #2:

- I. Announcements and Agenda (pp. 2.2-2.3) and General Review (pp. 2.4-2.5)
- II. Personal Project Review (pp. 2.6-2.8)
- III. Relaxation Exercise (pp. 2.9 -2.11)



IV. VIOLET AND MARY'S DAYS (10 MINUTES)



Overview

Use this exercise to reiterate the relationship between mood and thoughts.



Key Points

- Note importance of the reciprocal relationship between thoughts and mood.
- Violet and Mary have different ways of managing their internal realities, which can affect their moods.



Participant Manual

p. 3.5



Step by Step

Step 1: Reintroduce Violet and Mary.

Suggested Wording:

On page 3.5, you can see that Violet and Mary are now 4 months pregnant. Lately, they've both been feeling down. When their stories start, both would rate their mood as a 4. Let's see how what they think and what they do affect how they feel.

Step 2: Elicit Group Discussion regarding Violet and Mary.

Suggested Wording:

Notice that Violet and Mary both start out at a level "4" in terms of their mood.

- 1) *How would you rate Violet's mood at the end of the story? (Circle number)*
- 2) *How do you think what Violet did affected how she felt?*
- 3) *How would you rate Mary's mood at the end of the story? (Circle number)*
- 4) *How do you think what Mary did affected how she felt?*

Answers: Violet ends up having a lower mood rating than Mary. Why? Due to the relationship between mood and having more harmful thoughts.

Next, ask participants to help Violet break this cycle between depressed mood and having harmful thoughts.

Mary has a better day because she decides to go to her check-up and has the helpful thought that she is taking care of her baby.

Step 3: Brainstorm possible ways to break the cycle. As participants identify different ways, write them on the board.

Suggested Wording:

- *How can we break the cycle?*
- *What did you learn in other modules that you could use to improve your mood?*
- *How do helpful thoughts affect your mood? How does having harmful thoughts affect your mood?*
- *Will improving your mood help your baby's mood?*



V. NEW MATERIAL

V.A. THOUGHTS ABOUT BECOMING A MOTHER (10 MINUTES)



Overview

Help participants understand how the way they think will affect how their children think.



Key Points

- Children learn patterns of thinking from their parents.
- The way you think about your children and yourself affects how you behave with your children, and this in turn affects the way your children think about themselves, you, and your relationship.



Participant Manual

p. 3.6



Information

In the first year of life, young children form important attachments to primary caregivers and begin to learn to regulate emotions. These are two of the primary tasks of early childhood. By “regulate emotions,” we mean that children learn how to deal with difficult feelings like hunger, anger, and fear. They learn to do these things through their interactions with their primary caregivers. The answers to the following questions shape the course of their development: Will you (caretaker) take care of me? Will you hold me when I am uncomfortable or upset? Will you come when I cry? Will you come back when you leave? Through positive interactions with caregivers, children form secure relationships and learn ways to deal with difficult feelings. These interactions also form the basis for the ways children begin to think about themselves, their relationships, and the world. For example: If someone comes to me when I am uncomfortable, then I am important, worthy. The world is not a scary place. I can turn to my mom, and she will protect me. If I am hungry, someone will give me food.

Most mothers want to be there to help their children. However, sometimes their experiences or thoughts can interfere with the way they are with their children. The goal of this session is to talk about the helpful and harmful thoughts that may influence with the mother’s ability to serve as consistent, safe attachment figures.

Young children are very attuned to their parents’ emotions. They interpret their world by the emotions attached to the words that are spoken around them. If their mothers are depressed or are experiencing a lot of harmful thoughts about being a mother or about their child, children will be exposed to a lot of negative emotions, which will affect the way they begin to think about themselves. As children develop language, they will also internalize the words that their mothers say. They will hear what their mothers say about themselves and what their mothers say about them, and over time, the mothers’ words may become the children’s words and the children’s internal realities. This process is the intergenerational transmission of harmful thinking that we are seeking to prevent.



Step by Step

Step 1: Discuss the intergenerational transmission of thought patterns.

Suggested Wording:

Last class, we talked a lot about the types of thought patterns we have and how different types of thoughts can affect our mood. But we have not yet talked about how we learned to think these ways.

How do you think we learned to think the way we do? For example, if I say “I’m stupid,” which is an example of labeling, how did I learn this?

Begin a discussion of how we learned to think the way we think. Key points to highlight include:

- *We learned by experiencing how others, like our parents or siblings, treated us.*
- *We learned by taking in the words that other people have said to us.*
- *Early experiences often shape the way we think about ourselves, others, and the world.*

Step 2: Talk about breaking the transmission of harmful thought patterns.

Suggested Wording:

As mothers, we have the opportunity to teach our children different ways to think than we were taught. What would you like your children to learn to think about themselves, your relationship, and the world?

You can write three columns on the board: 1) beliefs about themselves, 2) beliefs about their relationship with you, and 3) beliefs about the world. Then, elicit participant responses.

Step 3: Talk about how they will teach their children to think in helpful ways.

Begin a discussion about how they will teach their children the things they want them to learn. Highlight how they will serve as role models for their children in a similar way that their parents served as role models for them. So, if they want to make changes in their children’s lives and thought patterns, they may need to make changes in their own way of thinking first. Women who have children already can share their experiences of how they are teaching their children to think in helpful ways.



V.B. PREGNANCY, BIRTH, AND PARENTING—HELPFUL AND HARMFUL THOUGHTS (10 MINUTES)



Overview

Help mothers identify helpful and harmful thoughts they may have related to being a parent.



Key Points

- Identify helpful and harmful thoughts related to being a parent.
- Talk about how these thoughts are related to childhood experiences.
- Talk about how we might challenge harmful thoughts, so we can provide our children with a positive experience.



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p. 3.7



Information

It is important during this exercise to acknowledge and normalize any fears or anxiety participants may share about becoming a mother. Women in the group who are already mothers can share their own fears or anxiety, which can help normalize these feelings for first-time mothers.

As participants talk about how they want to parent their children, they begin talking about discipline strategies. Views of discipline for different cultures should be taken into account. One useful way of discussing discipline is by talking both about what participants want their children to learn and how a discipline strategy will affect their relationships with their children. In addition, you can highlight that if children have a positive and loving view of their relationships with their mothers, physical discipline is less likely to be necessary. If participants bring up using corporal punishment, it may be important to talk about the guidelines of what is considered acceptable discipline in the U.S. versus child abuse.



Step by Step

Step 1: Identify harmful and helpful thoughts related to being a mother.

Suggested Wording:

As you think about becoming a mother, a variety of thoughts may go through your head. In the previous exercise, we talked about how the way we think gets passed on to our children. We want to pass on some of the thoughts we have but not others. So, it is important that we be aware of our thoughts, so we can make changes and teach our children healthy ways of thinking.

Let's take some time and write down some of the thoughts we have related to being a mother.

Write two columns on the board, one titled “helpful thoughts” and the other titled “harmful thoughts.” Then ask participants to think of some of the thoughts that they may have related to being a pregnant, giving birth, and/or becoming a mother, and write them down. If they need an example, you can share that a harmful thought might be “my children won’t listen to me and won’t respect me” while a helpful thought might be “I can’t wait to teach them how to cook.”

Step 2: Talk about how these thoughts may affect their children. Start a discussion on how these thoughts may affect how participants interact with their children and how their children learn to think about themselves, their relationships with their mothers, and the world.

Step 3: Talk about how to challenge the harmful thoughts. Have participants “talk back” to challenge some specific harmful thoughts they have about becoming or being a mother.

Note: At the same time that you help the women challenge harmful thoughts, you should also acknowledge that becoming a mother involves many changes, not all of which are positive. Mothers do give up many things (including sleep), but they also get many things in return. Women who are already mothers can share their experiences with the changes associated with the early postpartum period.



V.C. HELPFUL THOUGHTS DURING PREGNANCY AND MOTHERHOOD (10 MINUTES)



Overview

To identify helpful thoughts related to pregnancy, motherhood, and having a new baby.



Key Points

- There are lots of helpful thoughts we can have about pregnancy, motherhood, and having a new baby.
- We can learn to notice the helpful thoughts we already have and how to have more helpful thoughts.



Participant Manual

p. 3.8



Rationale

It is important for participants to identify helpful thoughts about pregnancy and having a new baby so that they can bring more of those thoughts into their lives.



Step by Step

Step 1: Describe helpful thoughts about pregnancy and giving birth.

Suggested Wording:

There are lots of helpful thoughts you can have about pregnancy, being mothers, and having a new baby. These might be thoughts about things you are excited to teach your baby or thoughts about something in the future, like bringing your baby home from the hospital. They can also be thoughts about something you feel good about doing for you or your baby, like eating healthy food while you're pregnant and going to prenatal care check-ups. These are all helpful thoughts because they can motivate you, make you feel hopeful about the future, and make you want to take good care of your baby and yourself.

Step 2: Identify participants' helpful thoughts about pregnancy and giving birth. Have participants take turns reading out loud the helpful thoughts listed in the manual, and engage them in the process of identifying their own helpful thoughts.

Suggested Wording:

Let's turn to page 3.8. How many of you have had the thought "This is a very special time in my life"? [Have participants take turns reading the other thoughts listed. Ask how many women have had the thought after each one is read.]

What other helpful thoughts about pregnancy and being a new mom have you had? [Elicit responses.]

What is it like to read about these helpful thoughts and hear thoughts other women have had? Are you getting any "new ideas" from the list or the group? [Elicit discussion.]

If you like any of these thoughts, you can see what it's like to think them for yourself. Just like you can choose to remember a happy memory, you can choose to think a helpful thought.



V.D. WAYS TO CHANGE HARMFUL THOUGHTS THAT AFFECT MY BABY AND ME (10 MINUTES)



Overview

Teach participants strategies to help them change harmful thoughts.



Key Points

- There are a number of strategies for changing harmful thoughts.
- Each strategy can be used both to reduce our harmful thoughts and to teach our children how to have a healthy mood.



Participant Manual

p. 3.9



Rationale

Changing harmful thoughts is a key component of this intervention. It is a powerful way to improve mood and to teach children good mood management skills.



Information

This is a challenging section because there is a lot of information to be communicated and participants may not immediately understand how to use the strategies in their own lives. However, this section is extremely important because learning how to reduce harmful thoughts is a key part of the intervention. Use lots of examples to help make the material come alive and take the time to make sure that participants understand the material.



Step by Step

Step 1: Introduce the idea that we can change harmful thoughts.

Suggested Wording:

We've been talking a lot about harmful and helpful thoughts and how they affect your mood. Now I'm going to teach you a few strategies for how to reduce harmful thoughts. These strategies are really important because they are tools you can use when you feel stuck or overwhelmed by harmful thoughts. They can help give you some control over these thoughts and help improve your mood. Using these strategies will also help you teach your baby how to manage harmful thoughts and how to create a healthy mood. This way, you can use these strategies to help you AND your baby.

Step 2: Thought Interruption.

Suggested Wording:

Thought interruption is the first strategy we'll talk about. Thought interruption basically is telling your mind to STOP thinking the harmful thought. It's like holding up a big STOP sign for your mind. [Have a participant read the description in the left-hand box of the first row.]

The tricky part of this skill is that you first need to be good at catching yourself thinking the harmful thought. Sometimes, we get so caught up in our thoughts that we don't even know we're thinking them. So, you need to get good at catching yourself when you think something harmful, like "I'm a bad mother." When you catch yourself thinking you're a bad mother, instead of getting caught up in all the reasons why you're a bad mother, just think, "There's that harmful thought again. I've had that thought before, and I know it's a harmful thought. I'm going to STOP thinking that now."

Sometimes it works to think a more helpful thought instead, like “I’m not a bad mother, I’m just feeling really tired right now, and I need to try to get some rest so I have more energy for my baby.” Or you can do something helpful for yourself, a pleasant activity like drinking a cup of tea or listening to music you like. Has anyone used thought interruption before (even if you didn’t call it that)? Can you tell us about that? [Elicit responses.]

You can also teach this skill to your baby. [Have a participant read the description in the right-hand box of the first row.] When your baby is feeling frustrated and stuck, you can help get him or her “unstuck” by labeling what he or she is feeling and then helping him or her do something different.

Step 3: Worry Time.

Suggested Wording:

[Read the description in the left-hand box of the second row.] *If you find yourself overwhelmed by thoughts that make you worry, give yourself a specific time in the day to worry so that you don’t need to worry the rest of the day. You can call it your “worry time.” This strategy often works because you know you’ll have time to think about what’s on your mind, but it doesn’t need to take up ALL your time. Has anyone used this skill before?* [Elicit responses.]

[Read the description in the right-hand box of the second row.] *This skill will also help your baby because your baby won’t see you worrying, anxious, and distracted when you’re with him or her. Your baby will see that you can enjoy life and can solve life’s problems.*

Step 4: Time Projection.

Suggested Wording:

[Read the description in the left-hand box of the third row.] *This strategy reminds you to have hope for the future when you’re feeling really down. Sometimes imagining the things we want for the future can give us hope and motivate us. Has anyone used this skill before?* [Elicit responses.]

[Read the description in the right-hand box of the third row.] *Just like the other skills, this skill is something we can pass along to our babies as they grow up so that they can imagine good things for the future and work toward them.*

Step 5: Self-Instructions.

Suggested Wording:

[Read the description in the left-hand box of the last row.] *Saying things to ourselves, like giving ourselves instructions to do something well, is almost like being a good parent to ourselves. For example, my baby knows that I love her because I am doing many things to care for her, like changing her diaper, feeding her, and saying that I love her. Has anyone used this skill before?* [Elicit responses.]

[Read the description in the right-hand box of the last row.] *The things we say to our babies directly shape how they think about themselves and how they solve problems. We can have a large positive impact on our babies by talking to them with love, hope, and optimism.*

Step 6: Putting it all together. It’s often helpful to get real-life examples from the group and have group members think about how to apply the skills in their own lives.

Suggested Wording:

Has anyone been struggling with any harmful thoughts lately? Does anyone feel comfortable sharing? [Ask a group member to describe the harmful thoughts she’s been having and what situation(s) she has them in, and then have other group members suggest which of the skills she might use. Repeat this process for each participant who is willing to share with the group.]



V.E. THOUGHTS I WANT TO LEARN TO TEACH MY BABY (10 MINUTES)



Overview

Focus on thoughts the mothers want to teach their babies.



Key Points

- Review the key points of the thoughts module.
- Mothers play an important role in helping shape their babies' thoughts and internal realities,, which can have an impact on both mothers' and babies' moods.



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p. 3.10



Information

This section may be difficult for participants to understand at first, so it may be helpful to briefly review the healthy management of reality model.

Instructors may want to use an illustration of this model to convey the main point of this exercise, which is that what we say and how we talk to our children influences their perceptions of themselves and their mothers.



Step by Step

Step 1: Review the basic concepts of the thoughts module.

Suggested Wording:

This is the last class of the thoughts module. We have been talking about the kinds of thoughts we have, and we found out that some thoughts are healthy and more positive for our mood, while some thoughts are more harmful for our mood. We've also talked about some of the ways to try to get rid of these harmful thoughts, by using challenging them and thinking about what kind of life we want to have for ourselves as mothers and for our babies. Is there anything else that you remember from this module?

Elicit discussion

Step 2: Review key concepts covered covered on page 3.10. Have participants take turns reading the main points. After each main point, prompt participants to discuss what each of the points means to them. Highlight the following:

- Mothers can help shape how their babies think.
- How mothers talk to their children influences their childrens' perception of themselves and their mothers.



V.F. THINKING ABOUT YOUR FUTURE (10 MINUTES)



Overview

Help participants understand that they can actively shape their future by shaping their internal and external realities.



Key Points

- When we identify what we want in the future, we can think in ways that help us achieve our goals.
- When we identify what we want in the future, we can plan to do things that will help us achieve our goals.



Participant Manual

p. 3.11



Information/Alternative Exercise

It is important to realize that some women may be more limited in the goals they set because of social, economic, or cultural factors. It is helpful in these instances to give examples of women who faced similar challenges and were successful in their goals.



Step by Step

Step 1: Help mothers identify their ability to shape their own future and to set goals.

Suggested Wording:

Last week we talked about how thoughts can be harmful or helpful to your mood at any given moment. Do you think that the thoughts that you have can also affect your future? How?

Elicit discussion.

Step 2: Engage in an exercise to think about the “future past.”

Suggested Wording:

We want you to be able to think and plan for your future. Let’s do an exercise that helps us do this. First, close your eyes, get in a comfortable position and take a few deep breaths. [Do this for a couple of moments until participants are relaxed and focused]. Now, I want you to look into the future. Today is _____. [date & year]. I’d like for you to fast forward to your life 5 years from now, the year of _____. [Ask each question & provide about a minute for participants to visualize their answers.]

- *What do you see yourself doing 5 years from now?*
- *What kind of life do you want to have?*
- *What do you NOT want for yourself?*

After asking the questions, have participants come out of the relaxation activity and either 1) write down their goals (wants and don’t wants) on p. 3.11, or 2) verbally discuss this activity.

Step 3: Recognize that mothers can set their goals and shape their lives by changing/molding/managing their internal and external reality.

Suggested Wording:

From this activity, it's clear that we all know that we have a particular life in mind for us. You know what you want out of life and what you do not want out of life. So the question becomes, how can you make this happen?

Elicit discussion

Step 4: Recognize that one can be active in managing one's reality.

Suggested Wording:

By taking this class, you've been learning that you can shape your life. For example, in class, we've talked about how thinking helpful thoughts can help make you and your baby feel better. In the same way, to have the life that you want, you can also start by doing the things to make that future happen. Imagine that you have 5 years to make this happen. What are some of the things you need to do now? What are some of the things that you need to avoid?

Elicit discussion, and write on board relevant points.

What do you need to start doing right now to reach your desired goal? If you don't change directions, you'll wind up where you're headed.

The main thing to know is that, if you feel good about yourself and your life, then probably your baby, as he or she grows up, will also feel good and more secure in his or her life. Do you think that's true? [Briefly discuss this.]

Step 5: Identify obstacles to being active in one's life.

Suggested Wording:

There are things you think and things you do that make it more or less likely that you will act to achieve your goals. What are they?

Is there anything that would prevent you from having the life that you imagined? What are some of the roadblocks? [Answers: time, money, lack of energy, lack of partner – write these on board and problem solve with participants; this would also be a good time to review the thoughts and mood module, e.g., harmful thought patterns & antidotes].

Can anyone think of a way to overcome some of these roadblocks? [Help group to problem solve.]



V.G. THINKING ABOUT YOUR BABY'S FUTURE (10 MINUTES)



Overview

This activity is similar to Activity V.F. (Above), but it focuses on how mothers play an active role in shaping their babies' futures.



Key Points

- Thoughts can help the mother to shape her baby's life in ways that are healthier for both mother and baby.
- Identify participants' different life goals, and ways to shape their babies' future (e.g., do's and don't do's).



Participant Manual

p. 3.12



Step by Step

Step 1: Help mothers identify their ability to shape not only their own futures, but also their babies' futures.

Suggested Wording:

We just talked about the different ways that you can shape your future by doing some of the things that need to be done now and avoiding things that may not be very helpful.

Review some specific examples in previous discussion.

Because you have this important person coming into your life, you also have a role to play as a mother. As a result, you can not only shape your own reality, but also help your child to shape hers/his.

Step 2: Engage in relaxation exercise to think about the “future past.”

Suggested Wording:

Let's go through the relaxation exercise again, and this time, you're going to focus on your baby's future. First, close your eyes, get in a comfortable position and take a few deep breaths. [Do for a few moments until participants are relaxed and focused]. Now, I want you to look into the future. Today is _____ [date & year]. I'd like for you to fast forward your life to 5 years from now, the year of _____. [Ask each question & provide about a minute for participants to visualize their answers].

- *How old will your child be?*
- *What do you see her to do 5 years from now?*
- *Is she in school? Is she able to read, write?*
- *Does she enjoy school?*
- *What kind of life do you want for her to have?*
- *Who are the people in her life?*
- *What role does each of these people play in her life?*
- *What are some of the things that you want for your baby?*
- *What are some of the things that you do NOT want for your baby?*

After asking the questions, have participants come out of the relaxation activity and either 1) write down their goals (wants and don't wants) on p. 3.12, or 2) verbally discuss this activity.

Step 3: Recognize that mothers can help shape their babies' lives by helping them manage their internal and external realities.

Suggested Wording:

From this activity, it's clear that, as mothers, you want the best for your child. [Give examples from discussion]. How can you help assure or increase the likelihood that this life will happen for your baby? Elicit discussion.

In the previous activity, we talked about the things that you could do to help realize your ideal future. Now, can you think of ways that you can help to make your baby's future happen? Remember: imagine that you have 5 years to make this happen. What kinds of things do you want to teach your baby? To make this happen, what are some of the things you need to do now? What are some of the things that you need to avoid? Elicit discussion, and write on board relevant points.

Step 4: Identify obstacles to being active in shaping their babies' lives.

Suggested Wording:

Is there anything that would prevent you from having the life that you imagined for your baby? What are some of the roadblocks? Elicit answers (e.g., time, money, lack of energy, lack of partner). Write these on board and problem solve with participants.

Can anyone think of a way to overcome some of these roadblocks?

Help the group to problem solve. If support is an issue, instructors can also provide a preview of the next section on the connection between people and mood.



Alternative Exercise

An alternative to doing Activity V.F. and IV.G. separately is to do both activities together. This would help to clarify that the mother's and baby's lives are intertwined. There are ways to mold both mothers' and children's realities together. Instructors can follow one of the exercises above and add "you and your baby" instead of just "you" or "your baby."

Another way to do the exercise is to have participants stand up and begin to think about the kind of life they want for their babies and the things they can begin doing now to ensure that their babies have a promising future.

Suggested Wording:

We are now going to take one step at a time, with each step representing one year of your baby's life. Think about the things you want to do during each year to ensure your baby meets the goals you have for him or her. Before beginning, imagine that you have your baby in your arms and think about what she or he looks like."

Then, have participants take the first step, in which their baby just completed her or his first year of life. Begin to describe all the physical and emotional changes that participants can expect their babies to have. During the next step, remind the participants that their child is now walking and holding their hand. Repeat this procedure for each of the next 3 steps until the child reaches 5 years of age.



VI. TAKE HOME MESSAGE (5 MINUTES)



Overview

To emphasize the key points from the session.



Key Points

- I can help shape my internal reality and my baby's internal reality.
- My thoughts can affect both myself and my baby.
- I can change my thoughts to improve my mood and my relationship with my baby.
- If I think about how I want my baby's future to be, I can increase the chance that my baby will have a healthy and happy life.



Participant Manual

p. 3.13



VII. PERSONAL PROJECT (5 MINUTES)



Overview

Assign this class's personal projects.



Key Points

- Assign the Quick Mood Scale
- Ask participants to practice reducing their harmful thoughts



Participant Manual

p. 3.14



Rationale

We want participants to be aware of their thoughts and to learn how to manage them in order to improve their moods.



Step by Step

Step 1: Assign the Quick Mood Scale. If necessary, see pages Intro.28-Intro.30 of this manual. Point out to participants that again this week they should note how many helpful and harmful thoughts they have each day (at the bottom of the scale) and think about the relationship between the these helpful and harmful thoughts and their moods.

Step 2: Assign Optional Projects

1. Practice Reducing Harmful Thoughts Project. Ask participants to use two of the methods they learned today (thought interruption, worrying time, time projection, or self instructions) to work on reducing harmful thoughts. Ask participants to note their thoughts and the methods they used so they can talk about what worked and/or what didn't work with the group next week.

2. Talk to someone about what they learned about their thoughts and mood today.

VII. FEEDBACK AND PREVIEW (5 MINUTES)

Give participants an opportunity to provide feedback about today's class, and give them a brief overview of next week's class.



Class #4: PLEASANT ACTIVITIES HELP MAKE A HEALTHY REALITY FOR MY BABY AND MYSELF

CLASS OUTLINE

- I. Announcements and Agenda (5 min) and General Review (10 min)
- II. Personal Project Review (15 min)
- III. Relaxation Exercise (20 Min)
- IV. Violet and Mary (15 min)
- V. New Material (60-75 min)
 - A. How does what we do affect how we feel? (20 min)
 - B. What do you like to do? (20 min)
 - C. How do Babies Learn? (10min)
 - D. What Do Babies Like to Do? (10 min)
 - E. From Birth to Age 1: Some Things Babies Like To Do (10 min)
 - F. Pleasant Activities & My Baby (10 min)
 - G. Overcoming Obstacles (15 min)
- VI. Take Home Message (5 min)
- VII. Personal Project (5 min)
- VIII. Feedback and Preview (10 min)

Goals for instructors:

- Review main concepts from last class
- Continue to build rapport
- Explain the concepts of internal and external reality
- Explain that pleasant activities are part of the external reality
- Ensure that participants understand the connection between pleasant activities and mood (more pleasant activities → more positive mood; fewer pleasant activities → more depressed mood)
- Help participants identify activities that they find pleasant

Materials needed:

- Participant manuals
- Pens, dry erase board, or chalkboard to present material to class
- Ramos et al. (2007). The MB Course: Relaxation Methods for Managing Stress (optional)
- An enlarged reality management chart (similar to p. 1.9 participant manual) (optional)
- Pleasant Activity cards, 1 set for every 2 people (optional)
- Copies of CES-D or other mood questionnaires (optional)
- Evaluation/feedback forms (optional)



III. RELAXATION EXERCISE (5 minutes)

Recommended exercise: “Walking Relaxation” (p. 4.4 participant manual, or Ramos et al., 2007, p. 13). Alternatively, instructors can ask participants to choose an exercise from the participant manual. For this section, we recommend that you select an exercise that focuses on doing something or thinking about what you do as a way to relax. A number of optional relaxation exercises are listed in the English version of the Relaxation Manual (Ramos et al., 2007). You may also choose to have class members actually do something pleasant and relaxing, such as have a cup of tea or play a game and then discuss how this was.



Participant Manual
p. 4.3



IV. VIOLET AND MARY'S DAYS (15 MINUTES)



Overview

Conduct an interactive activity that highlights the connection between what we do and how we feel.



Key Points

- Engage the group in an active discussion about Violet and Mary's Days and highlight the following points:
- What you do affects how you think and feel about yourself, others, and the world.
- You can choose to do things that make you feel better.
- Doing pleasant activities can actually create energy.
- Doing pleasant activities helps make our lives more balanced; we realize there is more in our lives than just problems and things we have to do.



Rationale

To help participants understand the link between what they do and their moods and to motivate them to engage in more pleasant activities.



Participant Manual

p. 4.5



Step by Step

Step 1: Introduce the vignettes.

Suggested Wording:

Let's look at the cartoons on page 4.5 in your books to see an example of how what we do can affect how we feel. Violet and Mary are both 5 months pregnant. Lately, they've both been feeling down. When their stories start, both would rate their mood as a 4. Let's see how what they do affects how they feel.

Step 2: Elicit participants' reactions to the cartoons and help them flesh out the characters. Questions to stimulate discussion are listed below:

- *Who are Violet and Mary?*
- *Why do we think they are feeling down? (What are their external realities?)*
- *What are they thinking? (What are their internal realities?)*
- *What does each character do? (How do they change their external realities and their internal realities?)*
- *How does what they do affect their moods?*

To make the exercise more interactive, you may choose to have one woman act as Violet and another woman act as Mary. As the women act out their roles, other group members can participate by indicating where each woman is on the mood scale as they go from scene to scene.

Step 3: Graph the characters' mood scales on the board. Have participants determine how Violet's mood changed with each picture. Then do the same for Mary.

Step 4: Facilitate a discussion about how what we do affects how we feel. Help participants discuss how this example is relevant to their lives. You may choose to highlight the following points:

- Pleasant activities help to balance our lives, especially when they are stressful.
- Pleasant activities tend to chain, meaning when you do one activity you often start a chain so that you are more likely to do more activities. For example, if you go out for a walk, you may bump in to someone and then you may decide to do something with them. Then, that night you may have pleasant thoughts about what you did together. And, in the future, you are more likely to go out for a walk again.
- Even when life is stressful, we can choose to do pleasant activities. By doing so, we can change our mood and at least a small part of our lives (i.e., manage a little of our external reality).

Step 5: Connect this exercise to the explanation of mood and your personal reality.

Highlight that Mary made choices and did activities that changed her external reality and affected both her thoughts and her mood. Refer to the model diagram and explain that during this module we will be focusing on activities. We will be looking at activities we can do alone and those we can do with others that will make us feel better.

Note: Although the pictures describe Violet and Mary as pregnant, mothers with young children can also experience the same relationship between mood and activities. This model can apply to anyone (pregnant or not pregnant).



V. NEW MATERIAL: MOOD AND ACTIVITIES

V.A. HOW DOES WHAT WE DO AFFECT HOW WE FEEL? (20 MINUTES)



Overview

Formally introduce the idea that what we do affects how we feel.



Key Points

- Help participants see that what they do affects how they think and feel about themselves, others, and the world.

Highlight the following points:

- When people do pleasant activities they often feel happier, are more likely to have positive thoughts about their lives, and are more likely to have positive contacts with other people.
- It may be difficult to get the energy to do pleasant activities when we are feeling down or tired, but if we do, it may help us feel better and less tired.
- Many activities are pleasurable because they offer us the chance to experience a sense of mastery or a sense of meaning.



Rationale

To help participants understand the link between what they do and their mood and to motivate them to engage in more pleasant activities.



Participant Manual

p. 4.6



Information

Most participants will not be familiar with the phrase “pleasant activities,” so it is important to define and talk about pleasant activities in a way that makes sense to them.



Step by Step

Step 1: Introduce the phrase “pleasant activities.”

Suggested Wording:

We just saw one example of how the things we do affect how we feel. By taking a shower and going shopping with her friend Carmen, Mary was able to improve her mood. Sometimes we refer to things we do like taking a shower or going shopping as pleasant activities. What does the term pleasant activities mean to you?

Elicit responses and write them on the board. Emphasize that pleasant activities are any activities we do by ourselves or with others that we find enjoyable or satisfying.

Step 2: Discuss how pleasant activities affect how we feel.

Suggested Wording:

There is more information about pleasant activities on page 4.6 in your books. When people do pleasant activities they often feel happier, are more likely to have positive thoughts about their lives, and are more likely to have positive contacts with others. Can anyone give an example of something they did in the last week that improved their mood or lead to them having more positive thoughts?

Elicit responses. When appropriate, highlight how the activities the participants did helped them to manage their inner and outer realities.

Step 3: Point out that pleasant activities may be difficult to do if we feel down or tired but that if we do them, we may feel better.

Suggested Wording:

Has anyone ever experienced how difficult it is to get out of bed or up from the sofa and take a shower when they are sick with the flu? When I get the flu, I usually am so tired and have so little energy that the last thing I want to do is take a shower. But when I push myself and do shower, I almost always feel better. Does this happen to anyone else?

Elicit responses.

Well the same thing happens with pleasant activities. When you feel down or tired, it can be hard to do pleasant activities. But if you do them, you may feel better and be less tired. If we think about how we will feel better after doing a pleasant activity, it may make it easier for us to gather the energy to do one.



V. B. WHAT DO YOU LIKE TO DO? (20 MINUTES)



Overview

Help participants identify activities they would enjoy doing now (during pregnancy) and after their babies are born, or what mothers like to do with their babies.



Key Points

- Help each participant identify a minimum of three activities she would like to do now and three she might like to do after her baby is born, if she is pregnant.

Highlight the following points:

- We don't all like the same things.
- We don't need to do tons of pleasant activities to feel good.
- Some pleasant activities are brief and just take a second.
- There are times when we enjoy doing a particular activity and other times when we don't. It's important to figure out under what conditions an activity is likely to be enjoyable.
- When you know what you like to do, it makes it easier to do it.



Participant Manual

pp. 4.7-4.8



Rationale

Identifying pleasant activities makes it easier to do them. We want to help the women identify two types of activities that affect their mood: activities they can do on their own, and activities they can do with others. Both are important in shaping their external realities.



Information

Some women may feel that becoming a mother involves giving up many things that they used to do. This is true, and it is important to validate these feelings. Motherhood is an important transition that involves change. It is especially important to listen to and empathize with women with unwanted pregnancies. They may feel ambivalent about their babies and may need to have a chance to express their feelings and feel heard and supported. These feelings may also change as they continue throughout pregnancy.

You can also help the women reach a balanced view of the transition. Although they may be giving up some aspects of their lives, they will also discover new aspects they may have never expected. Without denying their perspective, help women who feel ambivalent about having a baby to explore what some of the positive aspects of motherhood might be.

If there are mothers in the group, it will be important to ask if these mothers experienced similar doubts and feelings during their own pregnancy and, if so, how they were able to resolve these feelings. Sharing mothers' experiences can help normalize some of the feelings that pregnant women commonly have.

During the exercise, some women may indicate that they can no longer do things they used to enjoy doing because they have less energy, no resources (e.g., money or transportation), or because they are not in their home country (e.g., language barrier, not with friends and family). The point of this exercise is to engage group members' creativity in generating alternative activities when obstacles arise. This is an important problem solving skill.

It is important to remind group members that pleasant activities can be thought of as "meaningful" activities (e.g., talking to a loved one, enjoying a meal) but do not have to be "special activities" (going to Disneyland). We cannot always do a "special" activity, but we can do "meaningful" activities.



Step by Step

Depending on the amount of time you have, you may choose to do an alternate activity. The one we have listed below takes the least time but is the least interactive.

Step 1: Introduce the activity.

Suggested Wording:

In this module, we are focusing on how the things you do can affect your mood. Activities you can do on your own give you the freedom to choose how you will spend your day without having to rely on others. Activities you do with others help create and maintain what psychologists call “a social support network,” that is, a web of people who can help you deal with the demands of life and bring healthy interactions into your life.

Now we’d like to do an exercise so that each of you can decide which activities are pleasant for you. If you turn to page 4.7 in your books, there is space for you to write down activities you would like to do right now and activities you would like to do after you have your baby. Let’s take a few moments to fill out this page.

Give participants time to complete the page.

Step 2: Help participants share what they wrote.

Suggested Wording:

So let’s see what you would like to do now and things you would like to do when your babies are born, or for the mothers in our group, what do you like to do with your babies?

Have participants volunteer to share their responses and write them down on the board. As you write the responses, highlight the following points:

- The difference between activities you do by yourself and activities you do with others and the importance of having both types of activities on your list.
- How doing the activities affects how the participants feel and how it changes their realities.
- Mothers can also do different activities with their babies that may also affect their babies’ moods.
- Both mothers and babies can learn that certain activities are fun and promote a healthy mood.

Step 3: Summarize and make comments regarding the activities that are listed on the board.

Key points to cover are listed below.

- Not everyone likes to do the same thing.
- There are lots of things to do that are free and easy.
- It’s good to have activities we can do by ourselves and activities we can do with other people.
- When you have a baby, you have to give up things you like to do, but you also get to do a lot of things you couldn’t do before.
- Knowing what you like to do gives you a roadmap and can help generate ideas to improve your mood when you are feeling stuck.
- There are different conditions that may make an activity more or less pleasant. For example, depending on how much energy you have, you might choose to do a big or a small activity. It’s important to think about this because if you pick an activity that is too big, given your level of energy, it can end up not being pleasant anymore.
- If participants cannot identify any activities, have participants review and check off some activities listed on p. 4.8 in their participant manual (also see instructions on p. 4.13 of this manual on Pleasant Activities Schedule).



Alternative Exercises

1. PLEASANT ACTIVITIES CARD

Step 1: Make the Pleasant Activities Cards (To be done prior to the session).

Instructors can create a set of Pleasant Activities Cards. Each card has a picture of a pleasant activity along with a written description of the activity. There are also some blank cards so that participants can add activities that are not on the list. Cards can be organized by color. For example, yellow cards show activities that people can do alone (yellow=yourself). Purple cards show activities that people can do with other people (purple=people). Blue cards show activities that are specifically related to the baby. White cards are blank cards on which participants can write down their own ideas of pleasant activities.

ACTIVITY CARDS:

Yellow = yourself

Purple = people

Blue = baby

White = wild (blank cards)

Step 2: Introduce the activity. Ask the participants to get together in groups of 2-3 people. Give each person a stack of Pleasant Activities Cards. Ask participants to work together in their small groups and sort through the cards. They can sort the cards into two or three piles: 1) things I like to do; 2) things I sometimes like to do; 3) things I don't like to do.

Ask them to talk to one another about the activities they each find pleasant. As they identify the activities they like, they can write them down in their books. Remind them that they will not all like the same activities, but it may be interesting to see that different people have different preferences.

Step 3: Circulate among the small groups.

Step 4: Wrap up the activity. Ask group members to share what they learned by doing the activity. You may also choose to comment on the process. Usually, participants' moods improve during this activity and it can be useful to talk about how just thinking about doing something fun is good for our mood.

2. DISCUSSING WHAT YOU LIKE TO DO IN SMALL GROUPS.

Even if you do not use the cards, it can be helpful to break participants up into small groups so they can talk about what they like to do. By doing so, members are able to talk more and to form relationships with one another. Afterwards, rejoin the group to summarize what they learned.



V.C-D HOW DO BABIES LEARN & WHAT DO BABIES LIKE TO DO? (10 MINUTES)



Overview

Engage participants in a discussion about the different activities that babies like to do. Emphasize how developmental and temperamental factors affect whether a baby will enjoy doing an activity.



Key Points

Help participants identify activities that babies enjoy doing (alone, with mom and/or dad, and with other people/babies)

Highlight the following:

- From birth there are things babies enjoy doing, so it is never too early to begin planning and doing pleasant activities with your baby.
- Doing activities with your baby will help your baby develop and will strengthen your relationship with your baby.
- Your baby's developmental level will affect whether s/he enjoys a given activity. As babies develop, different activities become pleasant.
- Your baby's temperament will affect whether s/he enjoys a given activity.
- All babies are different. We need to learn to read their signals to determine which activities are pleasant for them. We also need to learn how each baby learns best.



Participant Manual

p. 4.10



Rationale

The goal is to help the women identify healthy, developmentally appropriate pleasant activities that their babies may enjoy. This is important because if the mother has age-appropriate activities in mind before her baby is born, it will be easier for her to provide the kinds of opportunities that her baby can benefit from as s/he grows. If the baby finds a world that is full of interesting, exciting, and pleasant experiences, his or her impression of the world will be much more positive than if he or she finds a world that is boring, unpleasant, or even scary. The impression of the world the baby is creating in his or her mind will have an influence for the rest of his or her life. This is why creating a healthy reality for the baby is so important.



Information

It may be helpful to have participants first think about what their babies will like to do by themselves (e.g., playing), with their mothers (e.g., being held), and with other caregivers and family members (e.g., father, grandparents, siblings). Mothers in the group can share their babies' likes and dislikes. Page 4.10 provides space for group members to write down their ideas. When you go over what they have written, assess for the following:

- Attitudes about babies
- Thoughts about babies and how they interact with others
- Knowledge of child development

You will want to listen for strengths and also possible ways of thinking that may be risk factors for post-partum depression or for problems in the mother-baby relationship (e.g., unrealistic expectations regarding child development, lack of a support system, feelings of being overwhelmed). If you find unhelpful thoughts or attributions, you will be able to slowly work with these throughout the remainder of the class.

You may want to highlight when in a child's development s/he will enjoy the activities they listed. For example, a baby might find certain toys or activities overstimulating at one month but may really enjoy them at 3 months.

Participants sometimes are surprised to see that there are activities babies like to do shortly after child-birth. You can help them understand that from birth (and even before that) babies are ready to learn and to interact with others. It is important to acknowledge differences in preference for activities as they are related to differences in developmental ages.

Research has shown that babies prefer figures that are faces, which suggests that they are born wanting to make connections to others. Babies also recognize their mothers' voices and smells.

When you talk about monitoring the number of pleasant activities you do, it is very important to explain that pleasant activities are not just special activities. If participants only count things like going to the movies, seeing a one-hour television program, or going out to a restaurant, they will limit themselves to two or three of these a day because it is impossible to have time (or money) for more. However, if instructors point out that a pleasant activity can be really brief, they will see that they can engage in pleasant activities throughout their days.

Pleasant activities might include: Looking out your window at home; on the way to work, noting that the weather is nice, that there are nice parks or stores along the way, or that most people they see have enough to eat and a place to live; looking at a photo album and remembering memories; generating pleasant memories in your mind; humming a favorite song; relaxing while waiting in line or at a stop sign; taking the scenic route rather than the quickest route.

Pleasant activities can involve becoming conscious of things you do routinely and mindfully appreciating and enjoying them. Realizing how nice it is to be able to brush your teeth, take a shower, use a clean bathroom with hot and cold running water, turn on a light by just touching a switch, open the refrigerator and taking out fresh food. (Imagine not being able to do any of these things). Learning how to be aware of pleasant activities and engaging in them will increase the chances participants will model this for their babies. Point out how much happier their babies' lives will be if they learn to do this from the time they are small.

Once the baby comes, mothers will be able to be mindful of pleasant activities that involve the baby, such as bathing the baby, feeding him/her, changing his/her clothes, feeling the baby's warmth as s/he falls sleep on her shoulder, enjoying the total trust the baby will have of his/her mother, seeing the baby learn something as simple as grasping something with his/her fingers, or finding something with his/her eyes. These can all be pleasant activities, but only if the participant is cued to consider them as such. This is the time to begin the process, and this can be reinforced throughout the course.

For cultural and health reasons many women will be unwilling to take their babies out of the home in the beginning or even for the first few months. We want to respect these decisions and talk about looking for places to take their babies when their babies are older. For example in Latino cultures, families observe "La Cuarentena," which is a period of 40 days when new mothers don't leave the house and practice traditional self-care activities.



Step by Step

Step 1: Help participants identify what they think babies like to do. For mothers who have other children, ask them what their children liked to do as babies.

Suggested Wording:

What do you think babies like to do? For those of you who are mothers, can you remember what your child liked to do as a baby? [Elicit discussion.]

Have you ever noticed that babies are fascinated with faces? They like to reach out their hands and touch things. Babies are constantly being exposed to things for the very first time. They are learning new things every minute. We've talked earlier about how you can be your baby's teacher, and mold his/her internal reality. You can also mold your baby's external reality? How?

Key points to highlight

- *Babies learn by watching, so mothers can always have something available to stimulate babies' interests*
- *Attend to babies' needs (feed baby when crying)*
- *Give babies toys or objects that help them learn that they can use to make something happen. For example, a toy that lights up or makes noise when they touch it or move it, such as a rattle.*

Step 2: Elicit discussion of what babies like to do in the presence of others.

Suggested Wording:

What do you think that babies like to do with other people? Does she/he do things differently with her/his father, or grandparent/sibling...?

Step 3: Recognize that developmental and age differences in activities that babies engage in.

Suggested Wording:

In the first year of your baby's life, there are many changes that your baby will make, including physical, cognitive, and social changes. Because your baby is changing so rapidly, the things that he/she does or likes to do will also change. As you can see on p.410, there is a list of some of the activities that babies like to do at different ages. When your baby is young, s/he cannot move much but enjoys imitating and listening to your voice. When s/he is older, s/he has more motor ability, can move around, crawl, and maybe even learn to stand up. So s/he'll be so much more active and more interested in the things around her/him. As your baby grows, it is important to recognize that the activities s/he likes will also change.



V.E. FROM BIRTH TO AGE 1: SOME THINGS BABIES LIKE TO DO (10 MINUTES)



Overview

Provide participants with a general list of activities that babies like to do according to their ages and stages of development.



Key Points

Highlight the different activities that babies enjoy:

- Take into account the baby's temperament when planning pleasant activities.
- Plan ahead activities that babies like to do.
- Babies are able to do and enjoy different activities as they develop.
- Motor development helps babies explore their environments. For example, babies can use their hands to reach for objects and explore them.
- There are many activities that babies can do and like to do even when they have limited mobility.



Participant Manual

pp. 4.11



Rationale

Help women understand that a significant amount of learning occurs during the baby's first years of life.



Information

How to use this list. This section complements the previous activity in the participant's manual (p. 4.10). Participants may be surprised to see the types of activities babies like to do immediately after they are born. The instructor can ask participants about their reactions about what they learned. Participants will learn that it is never too early to plan and engage in pleasant activities with their babies.



Step by Step

Step 1: Discuss the list on page 4.11 of the participant's manual. The general list describes the different activities that babies usually like to do during each stage of development and at different ages.

Suggested Wording

You have mentioned activities that are great for your baby's development and, more importantly, activities that babies like to do. Let's take a look at page 4.11 in your manuals. Many of the activities that you have mentioned are included in this list. The main purpose of this list is to help us understand that likes and dislikes change as babies grow. As you can see, their likes and dislikes change from month to month and year to year. It could be that newborns are overstimulated if there are many toys in their cribs/beds or even if we stare directly at them for a long period of time. They may look away, or they may cry to show that there are many toys in their cribs or that they are getting too much attention now. However, in a few months, they will love and enjoy these same types of stimulation. A lot of new mothers have expressed that having a baby less than 3 months old is like having a new baby every day. Then, what babies like to do changes constantly from day to day and from year to year.



V.F. Pleasant Activities And My Baby (10 MINUTES)



Overview

Discuss how engaging in pleasant activities affects the mother-baby relationship. Highlight the importance of this relationship.



Key Points

Engaging in pleasant activities helps the mother-baby relationship by:

- Helping mothers have a better mood and be more emotionally strong.
- Improving the baby's mood.
- Strengthening the mother-baby relationship through shared positive activities.



Participant Manual

pp. 4.12



Rationale

This is an opportunity to discuss the importance of the mother-baby attachment relationship.



Information

The main message is that engaging in pleasant activities not only improves the mother's mood, but also strengthens the mother-baby relationship. Relationships develop over time and through shared experiences. Babies learn about the types of relationships they will have with their parents based on the type of experiences they share.

If a baby has enjoyable moments with his/her mother, s/he will have positive associations, emotions, and ideas about her and about their relationship. By beginning to do pleasant activities together when the baby is young, the mother and baby are developing an interaction pattern for the future. They are more likely to continue to do pleasant activities together as the baby grows, and they are more likely to have positive views of each other and of their relationship.

Again, when we talk about pleasant activities, it is important to remember that pleasant activities do not have to be special or time consuming. Even routine tasks, such as changing a diaper, feeding, or bathing can be enjoyable for both mother and baby. The mother can help set the tone for these interactions.

The instructor can refer to examples from the video, "My Parents, My teachers" to emphasize this point. For example, you can bring up the scene when the mother is smiling and laughing with her baby while she is changing the baby's diaper.



Step by Step

Step 1: Discuss how doing pleasant activities affects the mother.

Suggested Wording:

Now let's think about how doing pleasant activities affects the mother-baby relationship. First, why would it be good for the mother to do pleasant activities?

Elicit responses. Highlight the following:

- Doing pleasant activities keeps the mother emotionally healthy, which better enables her to take care of her child.
- You have to take care of yourself before you care for others. Doing pleasant activities is one way that we care for ourselves.
- Sometimes it is important for mothers to do pleasant activities without their babies. Even “good mothers” need breaks to recharge.

Step 2: Discuss how doing pleasant activities affects the baby.

Suggested Wording:

Why would it be good for the mother to provide her baby with pleasant activities, such as looking at mobiles or interacting with other babies?

Elicit responses. Highlight the following:

- Babies learn by playing.
- Pleasant activities improve babies' moods.
- The mother-baby relationship is bi-directional, meaning the baby also affects the mother. When the baby's mood is good, s/he is more likely to interact with his/her mother in a positive way, which will lead to a more positive mood for both.

Step 3: Discuss how doing joint pleasant activities affects the mother and baby.

Suggested Wording:

Why would it be good for the mother and baby to do pleasant activities together?

Elicit responses. If necessary, emphasize the importance of joint pleasant activities.

When the mother and baby do pleasurable activities together, they build a positive relationship. We can think about the diagram with the dots (chaining). Each activity they do makes their relationship stronger. The baby learns that his/her mother is a warm and fun person who shows him/her an interesting side of the world.



V.G. OVERCOMING OBSTACLES (15 MINUTES)



Overview

Help participants identify different ways to overcome obstacles to doing pleasant activities. In particular, discuss problem solving as one way to overcome a problem.



Key Points

- Help participants identify obstacles to doing pleasant activities.
- As a group, discuss ways they might overcome these obstacles.
- Discuss problem solving as one way to overcome a roadblock or problem.



Participant Manual

pp. 4.13



Rationale

Balancing “have to’s” and “want to’s” is often difficult. This page involves an alternative exercise for generating solutions to common obstacles when we try to engage in pleasant activities. It also includes a simple 4-step method to overcome obstacles that can be used repeatedly until a solution is found. By going through these four steps, participants will see that they have the skills and creativity to solve the obstacles they encounter.



Information

It can be useful to go over reported obstacles that participants may have brought up while discussing the personal project.



Step by Step

Step 1: Identify obstacles to doing pleasant activities.

Suggested Wording:

We just finished talking about the importance of balancing what we have to do with what we want to do. While we know that it’s important to do pleasant activities, sometimes things just seem to get in the way of doing them. For example, the things we have to do can keep us from doing the things we want to do. What are things that get in the way of doing pleasant activities?

Elicit responses and write them on the board.

Step 2: Brainstorm possible solutions to these obstacles.

Suggested Wording:

Now let’s all work together to think of all the possible ways we might overcome each obstacle. At this point, we want to come up with all possible solutions without evaluating them. We’re all different, so we may each prefer a different solution.

Go through each obstacle and have group members call out ways to overcome it. Write their answers on the board. Highlight how much they already know about overcoming obstacles.

Step 3: Discuss problem solving as a formal technique for overcoming obstacles.

Suggested Wording:

You all know a lot of ways to overcome obstacles. Now I'd like to talk about one other way. It's a formal technique called problem solving. Counselors often teach couples or parents and children this technique so that they can resolve conflicts, but we can also use it to help us figure out solutions to difficult problems. We've outlined the steps to take on the bottom of page 4.13. You already use many aspects of problem solving. For example, the first step is to identify the problem or obstacle. We've already spent time doing this together.

The second step is to think about all the possible solutions. Another word for this is brainstorming. We just did this as a group when we came up with all the possible solutions to the obstacles. As we saw, it can be useful to ask others for their input because as the saying goes, "two heads are better than one." The important part of this step is to write down all solutions without thinking about whether they are good choices. We will evaluate the solutions later.

The next step is to choose the best solution or combination of solutions. This means you pick the one that is best for you. Remember we are all different, so different solutions may work better for each of us.

The final step is to see how well the solution works for you. We try it out, and then we see how well it worked. If it doesn't work, it's time to try something else out.

Step 4: Use problem solving to tackle an obstacle a participant is facing.

Step 5: Elicit participants' reactions to this problem solving technique.



VI. TAKE HOME MESSAGE (5 MINUTES)



Overview

To emphasize the key points from the session.



Key Points

- Doing pleasant activities can improve your mood.
- You can choose pleasant activities to do alone and with your baby.
- Many of the things babies learn as they develop, they learn from us.
- It is important for us to communicate with our babies and encourage them to explore their environments and learn new things.
- Doing pleasant activities can improve your baby's mood and make the mother-baby relationship grow stronger and more positive.



Participant Manual

pp. 4.14



VIII. PERSONAL PROJECT (5 MINUTES)



Overview

Assign this class's personal projects



Key Points

- Assign the Quick Mood Scale and explain if necessary
- Ask participants to complete one of the personal projects over the next week



Participant Manual

pp. 4.15-16



Rationale

We want participants to begin consciously doing pleasant activities so they can see how doing them affects their moods.



Step by Step

Step 1: Assign the Quick Mood Scale. If necessary, see pages 1.28 - 1.30 of this manual.

Step 2: Assign the one of the Optional Projects

PLEASANT ACTIVITIES SCHEDULE

Suggested Wording:

You came up with a great list of activities. If you turn to page 4.8 you'll see a list of activities that women who have taken this course told us they enjoyed doing. Many of the activities you came up with are on this list but there are others likeÉ [point out some of the activities on the list that participants did not mention] that we didn't talk about. You can go back to this list at any time to get ideas for pleasant activities you can do.

Find out things that babies like to do

Suggested Wording:

Talk to a mother of a new baby and find out two things that babies like to do [applicable for pregnant women].

MAKE A PERSONAL COMMITMENT PROJECT.

Suggested Wording:

This week, I would like you to do one new pleasant activity. As we talked about, sometimes there are barriers to doing pleasant activities. One way to try to overcome these barriers is to set a goal for yourself and stick to it. Fill out the Personal Commitment Form and calendar on page 4.16 to help you do this. Next week we'll talk about how you felt when you completed the pleasant activity and achieved your goal and whether or not you found the Personal Commitment Form and calendar helpful.



VIII. FEEDBACK AND PREVIEW (5 MINUTES)

Give participants an opportunity to provide feedback about today's class, and give them a brief overview of next week's class.



Class #5: CONTACT WITH OTHERS AND MY MOOD HOW TO GET SUPPORT FOR ME AND MY BABY

CLASS OUTLINE

- I. Announcements and Agenda (5 min) and General Review (10 min)
- II. Personal Project Review (15 min)
- III. Relaxation Exercise (5 min)
- IV. Violet and Mary (15 min)
- V. New Material (60-75 min)
 - A. When I am with Others, I feel Better (10 min)
 - B. People in My Life and the Ways They Support Me and My Baby (10 min)
 - C. Communication Styles and Your Mood (10 min)
 - D. Getting Your Needs Met (10 min)
 - E. What Keeps You from Expressing Your Needs (10 min)
- VI. Take Home Message (5 min)
- VII. Personal Project (5 min)
- VIII. Feedback and Preview (10 min)

Goals for instructors:

- Review main concepts from last class
- Continue to build rapport and encourage group process
- Provide important developmental information about how babies learn and how activities foster development.
- Help participants begin to think about activities their babies will enjoy.
- Help participants identify problem solving as a way to overcome obstacles to doing pleasant activities.

Materials needed:

- Participant manuals
- Pens, Dry erase board, or chalkboard to present material to class
- Ramos et al. (2007). The MB Course: Relaxation Methods for Managing Stress.
- Copies of CES-D or other mood questionnaires (optional)
- Evaluation/feedback forms (optional)



III. RELAXATION EXERCISE

Recommended exercise: “Teaching Your Child to Relax with You” (Ramos et al., 2007, p. 9; reproduced in Participant manual on page 5.3).



Participant Manual

p. 5.4



IV. VIOLET AND MARY'S DAYS (15 MINUTES)



Overview

Use this exercise to introduce the relationship between mood and contacts with others.



Key Points

- Note importance of the reciprocal nature of interpersonal problems and depression.
- Violet and Mary have different ways of managing their external reality, which can affect their mood.



Rationale

To help participants understand the link between their interpersonal interactions and their mood and to motivate them to engage in more positive interactions.



Participant Manual

p. 5.5



Step by Step

Step 1: Reintroduce Violet and Mary.

Suggested Wording:

On page 5.5, you can see that Violet and Mary have recently given birth to their newborn babies. This morning, Violet and Mary wake up feeling so tired they do not want to go outside or do anything. Violet and Mary hear their babies crying. Violet feels angry with her baby and tells her baby that she can't stand her. Violet's baby does not stop crying, and Violet does not know what to do. Mary speaks soothing words to her baby and tries to figure out what her baby needs or wants. She reassures her baby that she is there for her. Mary feeds her baby, thinking that she may be hungry, and this calms her baby; the two enjoy a peaceful, intimate time together.

Step 2: Elicit participants' reactions to the cartoons and help them flesh out the characters.

Notice that Violet and Mary both start out at a level "4" in terms of their mood.

- 1) How would you rate Violet's mood at the end of the story? (Circle number)
- 2) How do you think what she (Violet) did affected how she felt?
- 3) How would you rate Mary's mood at the end of the story? (Circle number)
- 4) How do you think what she (Mary) did affected how she felt?

Answers: *Violet will have a lower mood rating than Mary. Why? Due to the relationship between mood and fewer positive contacts (negative mother-baby interaction). Next, ask participants to help Violet break this cycle between depression and less/negative contacts with others.*

Step 3: Brainstorm possible ways to break the cycle.

As they identify different ways, write them on the board. Suggested Wording:

- How can we break the cycle?
- What did you learn in other modules that you could use to improve your mood?
- Will improving your mood help your baby's mood?



V. NEW MATERIAL: CONTACT WITH OTHERS AND MOOD V.A. WHEN I AM WITH OTHERS, I FEEL BETTER (10 MINUTES)



Overview

To introduce the module on relationship between mood and contacts with others (interpersonal relationships).



Key Points

- Provide psychoeducation regarding the reciprocal nature of interpersonal problems and depression.
- Identify participants' current support systems.
- Note that people contacts are part of one's external reality.



Participant Manual

p. 5.6



Information

In this section we describe the interaction between how we feel and how we act with other people. The interaction goes both ways: How we feel affects how we act with others and how we act with others affects how we feel.



Step by Step

Step 1: Introduce the relationship between people contacts, and mood and provide overview of the next two weeks.

Suggested Wording:

Contact with others and mood is the last section of new material. We have 2 more weeks with each other, including today. Over the next 2 sessions, we will be talking about how our relationships with others affect our moods and might also affect our babies' moods. How we interact with others is part of our external realities. Let's begin by talking about the connection between mood and contacts with others.

Step 2: Begin a group discussion regarding how depression affects contacts.

Write "mood" and "contacts with others" on the board. Write their answers to the questions below on the board (see example below).

Suggested Wording:

What kinds of people contacts do you have when you are feeling down?

How does your feeling down affect your contacts with people?

Key points to address include that when people are feeling down they often:

- Have less contact with others, avoid others
- Have lower tolerance, feel more irritable
- Feel more uncomfortable around people
- Act quieter and be less talkative
- Are more sensitive to being ignored, criticized or rejected
- Trust others less

Step 3: Discuss how fewer positive contacts or negative contacts can affect mood.

Suggested Wording:

When you isolate yourself from others, how does that affect your mood?

How does having more conflict or tension with others affect your mood?

Key points to address include that when people have fewer positive contacts or more negative contacts they may:

- Feel alone
- Feel sad
- Feel angry
- Feel like no one cares
- Be more depressed

Step 4: Summarize relationship.

Suggested Wording:

So we can see that the relationship between depression and contacts with others is reciprocal, that is, it goes both ways. When we are feeling down or depressed, we often have fewer or more negative contacts because we don't feel like being around others, we may be more sensitive to others' comments, or we may be more irritable. When we have fewer positive contacts and/or more negative contacts with others, this also adds to our depression. So when we are feeling down or depressed, we can be caught in a vicious cycle. Next week, we will be talking about how we can break this pattern, and better manage our external realities.

Step 5: Have participants identify what comes first: depression or lack of people contacts.

Suggested Wording:

A lot of people wonder whether feeling down/depression causes people to be less sociable or being less sociable causes people to feel down/depression? What do you think?

Through group discussion elicit the following point:

The answer is probably both. When we feel down, we are less likely to socialize. But not having contact with people can take away from us a good source of support, and we become more depressed. When we feel more depressed, we do even fewer things with people. This cycle continues until we are so depressed that we spend much of our time feeling alone.



V.B. PEOPLE IN MY LIFE AND THE WAYS THEY SUPPORT ME AND MY BABY (10 MINUTES)



Overview

Participants are asked to identify and evaluate their current social support systems and the relationship between social support and mood.



Key Points

- Recognize the importance of social support and its relationship to mood.
- Humans by nature are social beings.
- Participants can identify and evaluate their own social support systems.
- We can make choices as to whom we spend time with.



Participant Manual

p. 5.7



Rationale

Social support is a component of interpersonal relationships, which can help decrease depressed mood.



Information

Women without partners. Some women in the group may not have partners. In this case, group leaders should acknowledge that it may be more difficult for them (but NOT impossible) than for women with partners to obtain support/help.

Alternative Exercises

PICTURE PRESENTATION OF SOCIAL SUPPORT NETWORK.

Another exercise used to identify one's social support system is to draw the participant in the center of the board with a circle around the person's name. Then ask the participant the names of the people in their lives who provide them with support (generically speaking) and whether they are close to them or not. For example, Jane is the participant, and Jane identifies that her mother, brother, and husband are supportive people in her life. The instructor would write the mother's name or relationship, brother's name or relationship, and husband's name or relationship on the board, with a circle around each name. Next, ask Jane how close she feels to each of them. For those that she identifies as close, draw a solid line attaching their circle to Jane's circle. For those that are identified as not close or conflictual, draw a dashed line from their circle to Jane's circle. In this way, the participant can identify and evaluate whether she needs to enlarge her social support network, and/or she feels that the network is adequate.

MEETING PEOPLE AND MAKING YOUR SUPPORT SYSTEM LARGER AND STRONGER.

Purpose: To discuss ways that people can make their social support system stronger.

Suggested Wording:

Depression has been associated with low social support. Therefore, encouraging the formation of new relationships and increasing social contacts is essential to reducing negative mood/depression. One way to make your social support network stronger is to meet new people, but doing this is not always easily, especially when you're feeling down, or when you are pregnant (or a mother with a young baby) and may be uncomfortable going out.

Let's talk some good ways to meet new people:

- The easiest way to meet people is to do something that you like doing and doing it in the company of other people!
- Even if you don't find anyone in particular whom you would like to get to know better, you will still have been doing something pleasant and you will be less likely to feel that you wasted your time.
- Since the main focus is the activity you are doing, and not just meeting others, there will be less pressure on you than in a setting where the whole purpose is to meet people.

ACTIVITY

As a group brainstorm to identify activities and places where you can meet people. Identify places that are in the area and activities that are free such as:

- 1) Church, temple, synagogue, place of worship
- 2) Prenatal clinics
- 3) Childcare places
- 4) Parks where other mothers/children might frequent
- 5) Volunteer activities
- 6) Cultural/ethnic events

What activity could you do this week with another person that might be helpful, supportive, pleasurable, relaxing or enjoyable?

Example:

Activity → Attend group (or Call a friend)

Mood → Less depressed

Your example:

Activity: _____

Mood: _____



V.C. COMMUNICATION STYLES AND YOUR MOOD (20 MINUTES)



Overview

The relationship between communication styles, mood, and relationships with others.



Key Points

- Identify participants' primary styles of communication (passive, assertive, aggressive) in interpersonal situations.
- There are different communication styles that may work in different situations.
- Communication styles can affect mood.
- Communication styles can affect relationships with others.



Participant Manual

p. 5.8



Rationale

Understanding communication styles can help improve mood and relationships with others. Some types of communication styles can improve or make relationships worse.



Information

Materials: a box or basket in which there are three scenarios depicted on three separate papers, folded up in the box/basket (described below). Participants will pair up with each other or one of the group leaders, pick out one of the papers, and enact the chosen situation in front of the class.

Individual and Cultural considerations. The point of this exercise is not to have participants always communicate in an assertive manner. Rather, it is to help participants feel comfortable enough doing so that they can choose how to communicate. There are individual and cultural differences in the value or importance of each of the three communication styles. There may be culturally relevant ways of expressing oneself in different situations. For example, being passive may be desired in certain situations, which may be related to culture. For some participants, including those in a relationship with domestic violence, being passive may be the best and safest way of relating to the perpetrator. In cases such as this, being passive can be viewed as respecting your own wishes and keeping yourself safe. In addition, particular cultures may value passive responses relative to assertive responses. Depending on group composition, it is important to acknowledge that there is no one “right” communication style. It depends on the particular situation.



Step by Step

Exercise: “What’s in the box?” – Identifying your personal style of communication.

Step 1: Identify participants’ primary communication style through role plays.

Suggested Wording:

In order to communicate our needs to others, we need to be able to talk about how we feel and what we need from others. We’d like to do a few role plays to figure out how you usually act or communicate in different situations. How do we actually talk in different social situations? Here, I have a basket that describes different everyday situations (like asking the grocery owner where a product is).

_____ (co-instructor’s name) and I will do one for you to see, and afterwards, you can think about what you would do in the same situation. Then we’ll take turns acting out these situations.

Instructors model the first one, by reading out loud the situation, and decide who will play which role. Typically, the participant should play the role ascribed to “what would you do in this situation?” The role plays should take a few minutes per situation. The options following each of the scenarios are intended for group leaders to elicit discussion following each of the role plays. Group leaders can ask participants what they would have done in that situation. It’s also possible to have the same situation and another person (or group leader) model another style of communication.

Possible scenarios [these are written on separate papers ahead of time and put into the box; see end of this section for these items]:

Situation 1: You went to a doctor and didn’t understand what the doctor said. What do you do in this situation?

2 roles: 1) doctor; 2) patient

[Possible options: would you: a) ask questions; b) just pretend to understand; c) not say anything.]

Situation 2: You are in a clothing store and you cannot find the salesperson. Finally, after half an hour, you find the salesperson, but she does not want to help. What do you do in this situation?

2 roles: 1) salesperson; 2) customer

[Possible options: would you: a) go to the manager; b) ask the salesperson to help; c) leave the store.

Situation 3: You were taking a class and the teacher said something you strongly disagreed with. What do you do in this situation?

2 roles: 1) teacher; 2) student

[Possible options: would you: a) tell the teacher your opinion in a respectful manner; b) stay quiet; c) pretend to agree to please the teacher]

Situation 4: You are angry at a very close friend about a comment that she made last week but have not said anything. She is coming over to your house today. What do you do in this situation?

2 roles: 1) friend; 2) you.

[Possible options: would you: a) talk to friend about the situation; b) say nothing and pretend that everything is fine; c) ignore friend/stop calling].

Step 2: Introduce the concept of communication styles.

Suggested Wording:

From this exercise, you can see that there are different ways of communicating our needs. In general, there are three main ways that we communicate what we want. We can do it in a passive way, an aggressive way, or an assertive way.

Write the words on the board.

What do these words mean to you? For example, who was passive in the role plays? Who do you think was aggressive or assertive in the role plays?

Step 3: Elicit a discussion regarding how they view these communication styles and how they think they might affect their mood and their interpersonal relationships.

Suggested Wording:

How do you think that your communication style affects your mood?

How does your communication style affect your relationships with others?

Step 4: Acknowledge cultural or individual differences. There is no one “right” way to communicate.

Suggested Wording:

There is no right or wrong communication style. Sometimes, you may choose to act passively because that is what is expected of us by our families or our cultural upbringing. Sometimes, we change our usual style to fit whatever works best in a given situation. For example, an assertive person might choose to be passive because this is what is expected in this situation, or that is best for the situation. What is important is that you choose how you will act!

Alternative Exercises

Instructors can introduce the three communication styles by putting the grid (communication styles and respecting wishes) on the board. Refer to p. 5.8 in participant manual.

At first, just put the bolded, underlined parts of the table on the board and ask group members to complete the rest.

Ask participants:

- *Which style do you tend to use?*
- *How do you think using that style affects your mood?*

Proceed to Steps 3-4 above.

Explaining passive-aggressive Style:

Suggested Wording:

What does it mean to be passive-aggressive? As can be seen on p. 5.8, passive-aggressive can mean that you are not respecting your own wishes and not respecting others' wishes. In this way, you are not clearly communicating your needs to others.



V.D. GETTING YOUR NEEDS MET (10 MINUTES)



Overview

You usually have a better chance of getting your needs met by being assertive (making positive, clear, and direct requests).



Key Points

- It's OK to ask for help.
- Asking for help in a positive, clear, and direct way can increase the chance that your needs will be met (but not always).
- Being assertive can help increase the chance that your needs will be met.
- One way to ask for help is to do it systematically (step by step approach).
- By being assertive and expressing what you want and how you feel in a respectful way, you can improve relationships with others.



Participant Manual

p. 5.9



Rationale

Getting your needs met can improve relationships with others.



Information

For suspected domestic violence cases: Emphasize the fact that individuals have the right to feel safe! When a relationship appears to be non-reciprocal, abusive, or violent, the relationship may be headed toward dissolution or towards significant limits. The instructor can explore with the specific group participant how she evaluates the status of the relationship in dispute. (Instructors should have a list of referrals of agencies that support women who are victims of domestic violence that are particular to their geographical areas.) The instructor may also elicit input from the group regarding the stage of the relationship to provide additional feedback and/or support to the participant.



Step by Step

Step 1: Being assertive can help to get one's needs met.

Suggested Wording:

Part of being assertive is being able to make requests in a clear and positive way. When we do this, we are able to ask for what we want and need, others know how they can help us, and it increases the chance that we will get support. Of course, it does not guarantee that we will get what we want. The other person may agree to a different compromise, or they may simply refuse, but at least we'll know the answer. Why is it useful to make a request even when the answer might be no?

Elicit answers from group members.

Points to emphasize are listed below:

- They might say yes.
- At least you know.
- You can move on and think about what else you can do.

Step 2: Identify steps to being assertive. Put the 5 steps on the board (p. 5.9).

Suggested Wording:

There are 5 steps that can help you to become more assertive, to communicate in a way that might increase your chances of getting our needs met.

1) Identify what you want.

2) Pick whom you should ask for help.

3) Figure out a way to say it in a way that is clear and direct. Discuss the difference between indirect and direct requests. For example, “Boy, the trash can is full” and “I wonder when you’ll be taking out the trash” are both indirect requests. “Could you please take out the trash in the next half hour” is a direct, specific request. “I sure am worried about my sugar level” versus “Doctor can you check my sugar level?”

4) Respect the other person’s right to say no. (e.g., “I know you’re really busy.”) Talk about how this sets the stage for making a request.

5) Be willing to compromise.

Have each group member think of someone they would like to request something from this week (e.g., friend, family member, doctor). Help them to decide what they would like to request from this person and think about how they would like to make the request.

Have them practice making the request in group, and then have group members give them feedback.



V.E. WHAT KEEPS YOU FROM EXPRESSING YOUR NEEDS? (10 MINUTES)



Overview

Identify obstacles to the ability to communicate one's needs, and teach problem solving to overcome these obstacles.



Key Points

- Identifying obstacles to being assertive or expressing your needs is the first step to overcoming them.
- There are different ways to overcome these obstacles.
- Overcoming these obstacles improves your external reality.



Participant Manual

p. 5.10



Step by Step

Step 1: Explore with participants the roadblocks to being assertive.

Suggested Wording:

We all have times when we don't say what is on our minds. We often have a lot of excuses for not doing so. Sometimes the excuses are really good, and in some cases it might not be the right time to share our thoughts, feelings, or desires; but, sometimes we fall into a non-speaking trap. Let's talk about some of the things that might prevent us from speaking our minds when it's a good idea for us to do so.

Brainstorm with the group some of the things that might keep them from being assertive and speaking their minds. Some of the common obstacles are listed below. After you have brainstormed with the group discuss each obstacle, clearly defining what thought or thoughts are linked to the obstacle, obtaining opinions from different group members, and talking about how to overcome the obstacle.

Be respectful of cultural differences (e.g. age, gender, family positions, and structure) that may contribute to the difficulty being assertive and/or to valuing other forms/styles of communication.

Common Obstacles:

- *Fear*
- *Habit/routine – not used to doing it*
- *Low energy – too tired to do it*
- *Don't believe it would change things (why bother)*
- *Don't want to show disrespect to another person*

Other questions to stimulate discussion are listed below.

- Does assertiveness mean danger for you?
E.g., “If I’m assertive, then, I’ll be rejected.” Or “If I speak up for myself then, I’ll be humiliated or hit.”
- Do you feel like your disagreement can be resolved?
- Is the relationship headed for dissolution?
- Do you have evidence that the relationship is not reciprocal, not mutually respectful and caring of each other’s needs?

Step 2: Review questions to ask if it feels dangerous to speak your thoughts and feelings in a relationship.

Suggested wording:

In some relationships, we may feel that it is dangerous to freely speak our thoughts and feelings. In this case, it is important to examine the relationship and think about whether this relationship is safe. Some questions you may ask yourself to determine this are listed on page 5.10.

Read the questions on page 5.10, or ask participants to read them aloud:

- Do you feel that you have the same right as your spouse/partner to speak up about problems in your relationship?
- Do you feel that your needs are as important as the needs of your spouse/partner or other people in your life?
- Do you feel safe expressing your needs?

Emphasize the fact that individuals have the right to feel safe! When a relationship appears to be non-reciprocal, abusive, or violent, the relationship may be headed toward dissolution or towards significant limits. The instructor can explore with the specific group participant how she evaluates the status of the relationship in dispute. (Instructors should have a list of referrals of agencies that support women who are victims of domestic violence that are particular to their geographical areas.) The instructor may also elicit input from the group regarding the stage of the relationship to provide additional feedback and/or support to the participant.

Additionally, inform the group that you will be discussing safety in relationships in more detail next week. Also assure group members that if they have questions or want to talk, they can approach you at the end of class, and you can provide them with support, guidance, and/or referrals.



VI. TAKE HOME MESSAGE (5 MINUTES)



Overview

To emphasize the key points from the session.



Key Points

- Negative mood can cause people to have fewer positive contacts with others, and/or more negative contacts with people, and having fewer positive contacts with people can lead to negative moods.
- I can help manage my external reality by choosing to interact with different people in my life.
- There are people who can provide support for me and my baby.
- Being assertive can increase the chance that I can get my needs met.



Participant Manual

pp. 5.11



VII. PERSONAL PROJECT: QUICK MOOD SCALE (10 MINUTES)



Overview

Assign this class's personal projects.



Key Points

- Assign the Quick Mood Scale.
- Ask participants to do a pleasant activity with someone who provides them with support.



Participant Manual

pp. 5.12



Rationale

We want participants to be aware of how their contacts with others affect their mood.

Step by Step



Step 1: Assign the Quick Mood Scale. If necessary, see pages 1.28-1.30 of this manual. Point out to participants that this week they should note the number of positive and negative contacts they had each day (at the bottom of the scale) and think about the relationship between the number of positive and negative contacts they had and their mood each day.

Step 2: Assign one of the Optional Projects

1. Keep track of the number of positive and negative contacts.
2. Engage in a pleasant activity with someone who gives you support.

IX. FEEDBACK AND PREVIEW (10 MINUTES)



Overview

Give participants an opportunity to provide feedback about today's class, and give them a brief overview of next week's class.



Class #6: INTERPERSONAL RELATIONSHIPS AND MY MOOD GRADUATION

CLASS OUTLINE

- I. Announcements and Agenda (5 min) and General Review (10 min)
- II. Personal Project Review (10 min)
- III. Relaxation Exercise (10 min)
- IV. Violet and Mary (10 min)
- V. New material (60-75 min)
 - A. Can We Break this Vicious Cycle? (10 min)
 - B. Interpersonal Relationships and Depression: Role Change or Transition (15 min)
 - C. Interpersonal Relationships and Depression: Role Disagreements of Dispute (15 min)
 - D. Safety in Relationships is the #1 Priority (10 min)
 - E. Role Models for Me and My Baby (10 min)
- VI. Course Review (5 min)
- VII. Personal Project Review (5 min)
- VIII. Final Activity
- IX. Graduation Ceremony and Celebration

Goals for instructors:

- Review the reciprocal nature between mood and interpersonal relationships.
- Identify ways to increase support for one's baby.
- Discuss the effect of role changes or transitions on mood and relationships with others.

Materials needed:

- Participant manuals
- Pens, Dry erase board, or chalkboard to present material to class
- Ramos et al. (2007). The MB Course: Relaxation Methods for Managing Stress.
- Copies of CES-D or other mood questionnaires (optional)
- Evaluation/feedback forms (optional)
- A Referrals list of domestic violence and crisis hotlines for organization, if available.



IV. VIOLET AND MARY'S DAYS (10 MINUTES)



Overview

Use this exercise to introduce the relationship between mood and contacts with others.



Key Points

- Note importance of the reciprocal nature of interpersonal problems and depression.
- Violet and Mary have different ways of managing their external reality, which can affect their mood.



Participant Manual

p. 6.5



Step by Step

Step 1: Reintroduce Violet and Mary.

Suggested Wording:

On page 6.5, you can see that Violet and Mary's babies are now 1 year old. They both wake up feeling down and not wanting to get out of bed. Violet stays home alone. Mary calls her friend Carmen, who also has a young child. Mary and Carmen spend the afternoon talking about being new mothers while their babies enjoy each other's company.

Step 2: Elicit group discussion regarding Violet and Mary.

Suggested Wording:

Notice that Violet and Mary both start out at a level "4" in terms of their mood.

- 1) How would you rate Violet's mood at the end of the story? (Circle number)*
- 2) How do you think what she (Violet) did affected how she felt?*
- 3) How would you rate Mary's mood at the end of the story? (Circle number)*
- 4) How do you think what she (Mary) did affected how she felt?*

Answers: Violet will have a lower mood rating than Mary. Why? Due to the relationship between mood and fewer positive contacts (isolation). Next, ask participants to help Violet break this cycle between depression and less/negative contacts with others.

Step 3: Brainstorm possible ways to break the cycle. As they identify different ways, write them on the board.

Suggested Wording:

- *How can we break the cycle?*
- *What did you learn in other modules that you could use to improve your mood?*
- *How does having a good talk or a good time with someone help your mood?*
- *Will improving your mood help your baby's mood?*



V. NEW MATERIAL: CONTACT WITH OTHERS AND MOOD V.A. CAN WE BREAK THIS VICIOUS CYCLE? (10 MINUTES)



Overview

To introduce the topic of breaking the relationship between negative mood and few/negative contacts with others (interpersonal relationships).



Key Points

- Review the reciprocal nature of interpersonal problems and depression.
- Identify participants' current support system.
- People contacts are part of one's external reality.



Participant Manual

p. 6.6



Information

In this section we describe the interaction between how we feel and how we act with other people. The interaction goes both ways: How we feel affects how we act with others and how we act with others affects how we feel.



Step by Step

Step 1: : Review the relationship between people contacts and mood.

Suggested Wording:

Today will continue to talk about how our relationships with others affect our mood, and how relationships with others might also affect your baby's mood. How we interact with others is part of our external reality. Let's review the connection between mood and contacts with others.

Step 2: Summarize relationship.

Suggested Wording:

So we can see that the relationship between depression and contacts with others is reciprocal, that is, it goes both ways. When we are feeling down or depressed, we often have fewer or more negative contacts because we don't feel like being around others, we may be more sensitive to others' comments, or we may be more irritable. When we have fewer positive contacts and/or more negative contacts with others, this also adds to our depression. So when we are feeling down or depressed, we can be caught in a vicious circle. We will be talking about how we can break this pattern, and better manage our external reality.

Step 3: Have participants identified how to break the cycle between negative mood and fewer positive contacts (or more negative contacts) with others (refer to p. 6.6 of the participant's manual).

Suggested Wording:

Now that we know about the cycle between negative mood and lack of positive people contacts, how can we break the cycle? [Elicit group discussion.]

Some group members may indicate that they have difficulty finding people with whom they have positive contacts. Others may talk about how their relationships with family members or their babies' fathers are not positive relationships. Participants should feel free to discuss negative contacts. Let the group brainstorm ways for them to identify people in their lives who are positive contacts or to expand their social support networks.

Now I'd like for you to look at p. 6.6 of your manual. We can see here that to improve our moods, we can increase our pleasant activities, change the way that we think (our internal realities), and also by either reducing negative or harmful contacts with people or increasing positive or helpful contacts with others. Can anyone give an example of using any of these strategies to improve your mood? [Elicit responses.]



V.B. INTERPERSONAL RELATIONSHIPS AND DEPRESSION: ROLE CHANGE OR TRANSITION (15 MINUTES)



Overview

Explore the role change associated with having a new baby and how it can affect your mood.



Key Points

- A role change or transition—like becoming a new mother or having another baby—can affect your mood.
- Sometimes even positive role changes can make you feel depressed because taking on a new role can be stressful.
- Understanding how a role change is affecting you can help you feel less helpless and can improve your mood.



Participant Manual

pp. 6.7-6.8



Rationale

Role changes can affect our relationships with the people in our lives and can create stress that affects mood.



Information

This topic gives participants a chance to reflect on how their relationships may change in both positive and negative ways as a result of having a new baby. Group members may be able to see common themes across their experiences, empathize with one another, and provide support to one another around the relationship changes occurring with this role change. Role change or transition is one of the four interpersonal problems areas that is part of the Interpersonal Psychotherapy (IPT) model, which posits that depression results from having difficulties in relationships. The other three interpersonal problem areas include: interpersonal disputes, grief/loss, and deficits in interpersonal skills. In this session, we focus on two of these areas that are more common to experiences of perinatal women, including role change and role disagreements (or interpersonal disputes). IPT has been found to be an effective intervention to prevent or treat perinatal depression. For more information, see Segre, L., Stuart, S., & O'Hara, M.W. (2004). Interpersonal psychotherapy for antenatal and postpartum depression. *Primary Psychiatry*, 11(3), 52-56.



Step by Step

Step 1: Define role changes and transitions.

Suggested Wording:

Does anyone know what a role change is? [Elicit responses] A role change is when you shift into a different position in some aspect of your life. It could be starting a job when you haven't been working in a while. It could be leaving a job you've been in. It could be getting married. Or it could be losing someone close to you.

Can you guess which role change we're going to focus on? Having a new baby! Of course having a new baby is a big role change. Maybe this is your first baby, and you are now in the role of a mother for the first time. Maybe you already have one or more kids, and you are now adding another child to the family, which changes your role too.

No matter what the role is, your relationships with other people change when your role changes. For example, when you have a new baby, you start a new relationship with that child. Your relationships with your other children, your partner, your friends, and your family are also likely to go through some changes. For one thing, you probably won't have as much time for those other people as you did before the baby was born, right? Other people in your life may feel sad or frustrated if you don't have as much time for them as you used to. Those changes affect your relationships, and they can also affect your level of stress and your mood. Anytime we go through changes, there is usually stress—even when the changes are positive and happy.

Take a few minutes to fill out pages 6.75 and 6.8 in your manual. This exercise will help you think through how having a new baby changes your role and can affect your mood.

Step 2: Discuss group members' experiences of role changes as a result of becoming pregnant and having a new baby.

Suggested Wording:

So what do you think, do people treat you differently with a new baby? How so? [Elicit responses.] How does becoming a mother affect you and your mood? [Ask group members who feel comfortable to share what they wrote.]

Are there other role changes in your life right now that are helping or hurting your mood? For instance, is anyone going through a role change in terms of having lost someone close to you or having a change in your employment or some other transition? (Have group members who feel comfortable share.)

What are your feelings about these changes? Remember that you might have positive and negative feelings about the same role change. [Ask group members who feel comfortable to share what they wrote.]

Step 3: Discuss how to handle the role change effectively.

Suggested Wording:

Are you hearing some common themes in the group? What do think is helpful to you as you're transitioning into your new role as the mother of a new baby? (Allow some time for women to brainstorm about ways to work on their relationships during their role changes to make this time less stressful. You can also make suggestions about how group members can reach out to others to find support in their relationships or negotiate for what they need.)

Can you talk to people in your life about the role change and the fact that everyone needs to make some changes and adjustments when a new baby is born? [Elicit responses] Sometimes it helps to keep in mind that it can take some time to become comfortable in a new role, but it's also an exciting change that opens up a new chapter in your life.

Step 4: Discuss role transition and reality management model as it relates to the thoughts, behaviors, and people.

Suggested Wording:

We have talked a lot in this class about our personal reality, including our internal reality (our private thoughts, beliefs, memories, etc.) and our external reality. How can we use what we know about our personal reality to manage the role change of becoming the mother of a new baby? [Elicit responses].

To build a healthy new reality, you can make changes to your thoughts, behaviors, and contacts with others. For example, how can you make changes to your thoughts regarding the role change? [Elicit responses]. What can you do to adapt to the role change in terms of your behaviors? [Elicit responses.] Finally, who can help you adapt to the role change? [Elicit responses.]

Emphasize how making changes to your internal and external reality helps you adapt to the stress that can come from a role transition like becoming the mother of a new baby.



V.C. INTERPERSONAL RELATIONSHIPS AND DEPRESSION: ROLE DISAGREEMENTS OR DISPUTES (15 MINUTES)



Overview

Identify role disagreements or disputes and how they affect mood.



Key Points

- Having a baby sometimes creates conflicts or disagreements with others.
- Those disagreements can affect your mood.
- It is important to learn how to identify your thoughts, feelings, and behaviors about those disagreements so that you can improve your mood.



Participant Manual

p. 6.9



Rationale

Disagreements with other people that result from having a new baby can be a powerful source of stress and can put participants at risk for depression.



Information

This section allows group members to identify role disagreements and their thoughts, feelings, and behaviors about those disagreements so that they can make positive choices about how to handle them. This section can be challenging because group members may get into venting about their relationship problems. It is important that you keep the discussion focused on how participants can make positive changes, rather than simply allowing them to vent about their relationship problems. Instructors can also refer to section V.E below regarding safety in interpersonal relationships.



Step by Step

Step 1: Identifying role disagreements.

Suggested Wording:

So we talked about how pregnancy or having a new baby can change your relationships with others and that it can put stress on relationships with friends, family, partners, or other children. For example, maybe your mother doesn't agree with how you're parenting your baby, and the two of you keep arguing about it. Or maybe you don't think your partner is helping out enough, and you're angry about it. Is anyone having a disagreement with someone related to your pregnancy or new baby? Would you like to tell the group about it? [Allow group members to give examples and share their experiences with role disagreements.]

Step 2: Understanding your feelings, thoughts, and behaviors. Have group members take some time to fill out p. 6.9 on their own and then discuss what they wrote as a group.

Suggested Wording:

Take a few minutes and answer the questions on page 6.9 of your manuals. This exercise will help you identify your feelings, thoughts, and behaviors about a disagreement.

[Give participants 3-4 minutes to complete page 6.9.] Who wants to share?

Elicit examples from the group for the different categories on the worksheet. There may be a tendency for group members to “vent” about people they are angry with or adopt a blaming attitude. It’s important to allow members to express themselves but also to keep the conversation focused on members’ own responses and actions and how they can make positive choices in the situations. It’s helpful for group members to understand their feelings, thoughts, and behaviors, but you should also encourage them to understand the feelings, thoughts, and behaviors of the other people in the disagreements.

As participants share, ask:

- Is there a solution where you can both get what you want?
- Could you do anything to make this situation healthier or more positive for you?
- Does anyone have suggestions for _____ [participant’s name]?

[Elicit discussion.]



V.D. SAFETY IN RELATIONSHIPS IS THE #1 PRIORITY (10 MINUTES)



Overview

Assess possible exposure to relationship violence or abuse.



Key Points

- Safety is a #1 priority for you and your baby.
- If you are being exposed to violence or abuse in a relationship, it's very important to change that situation so that you and your baby are safe.
- There are always options for getting out of an unsafe relationship.



Participant Manual

p. 6.10



Rationale

Participants' safety is critical for their own well-being and their babies' well-being.



Information

This is a sensitive and important topic. Although not much time is spent on this topic, you should be prepared to assist participants who have questions by providing resources or referrals as needed. Crisis hotline information should be distributed to all group members. Instructors can also refer to this section while discussing interpersonal disputes (section V.D above).



Step by Step

Step 1: Safety in relationships is the #1 priority

Suggested Wording:

What does it mean to be safe in a relationship? What does it mean NOT to be safe? [Elicit responses. Summarize what group members say.]

Physical violence is a definite threat to your safety and to your baby's safety. Pushing, shoving, kicking, and hitting are all aspects of physical violence. When someone in a relationship consistently says threatening or humiliating things to you, that's also a threat to your safety and your baby's safety. We often call that "emotional abuse." Babies sense when there is screaming, hitting, and fighting around them. These situations scare them, and they can react with crying, not being able to sleep, feeling afraid, and other behaviors that show they are anxious and stressed.

It's important to identify whether you are in a relationship that threatens your physical or emotional safety and take steps to get out of the situation. Violence and emotional abuse can happen in many different kinds of relationships. It might be a relationship with a partner, a family member, or a friend.

It's also important to identify whether you are engaging in violent behavior toward anyone and to change your behavior.

Step 2: Assessing safety**Suggested Wording:**

Take a moment to answer the 4 questions on page 6.10 that ask about your safety. I won't ask you to share this information with the group; these are personal questions to help you identify physical and emotional abuse in your relationships.

I'm going to pass around the number of a crisis hotline you can use if you need it and can also share with other people you know who may need it. If you have questions or want other information about how to get out of an unsafe relationship, please talk to me at the end of the group today.



V.E. THE ATTACHMENT or BONDING RELATIONSHIP BETWEEN PARENTS AND BABIES



Overview

Introduce the relationship between mothers and babies (attachment, bonding), and how these are related to identifying babies' needs and temperament.



Key Points

Bonding between mother and child occurs during pregnancy and when the baby is born. Bonding or attachment refers to the close emotional tie that develops between the mother and baby.

- Bonding or attachment can help strengthen the parent-child relationship.
- Bonding or attachment in the early years lays the foundation for the parent-child relationship in later years.
- There are numerous ways to promote the parent-child relationship.
- Recognizing babies' different needs can help promote the parent-child relationship.



Participant Manual

p. 6.11



Step by Step

Step 1: Define bonding and attachment.

Suggested Wording:

We've talked about your needs. Now we will talk more about your baby's needs. One of the most important relationships is the one that you will have with your baby, at birth and beyond. During pregnancy, you are already bonding with your baby. You know that your baby is growing inside of you -- when your baby is kicking, is restless, is sleeping. So really bonding continues from the relationship that you already have with your baby during pregnancy. When you give birth, this bond becomes more of a reality for you. Now you can see, feel, and talk to the little person whom you knew only by feeling, or from the movements and heartbeat that you heard during pregnancy.

Bonding refers to the close emotional tie that develops between you and your baby. Some people also call this attachment.

Step 2: Elicit participants' understanding of attachment in their lives.

Suggested Wording:

How can you form an attachment with your baby? Are you doing this already? How?

Step 3: Identify ways to promote bonding and attachment. One way is to recognize and learn about baby's needs.

Suggested Wording:

What can you do to promote the bonding experience with your baby? Just like you have needs, your baby will also have needs. Some parenting books talk about 3 goals that are important to be a helpful parent or mother: 1) know your child; 2) help your child feel right; 3) enjoy parenting.

Write 3 goals on board.

Remember, you are your child's first and favorite role model. You can send a positive message to her or him - that s/he is capable of doing many things. Start by being supportive. Take pleasure in your child's accomplishments and let her or him know it.

Part of attending to your baby is to recognize her or his needs. For example, if s/he is hungry, you want to feed her or him. When s/he is tired, put her or him to sleep. This will teach her or him that s/he can find love in the world.

Babies also have emotional needs. They want to know that they are loved. You can love your child and show your affection for her or him. Hug her or him, cuddle with her or him, read to her or him, talk to her or him throughout the day. This will teach her or him that s/he is important to you, and that therefore s/he can be important to others. Her or his internal reality will begin to form the idea that s/he is a valuable being. If s/he thinks of herself or himself as valuable, s/he will be more likely to treat herself or himself well, and expect that others treat her or him well, too.

You can establish daily routines so your child will feel secure within a schedule. Don't be afraid to alter the schedule occasionally for special activities. Predictability is good. But so is teaching your child to be flexible.

From the moment s/he is born, your child is developing a sense of self. S/he is working toward being attached to, but separate from you. The first step in this development is learning to trust. When you meet your baby's physical and emotional needs, you are helping her or him trust herself or himself and feel secure in the world.



V.F. ROLE MODELS FOR ME AND MY BABY (10 MINUTES)



Overview

Introduce role models as a way of thinking about one's interpersonal relationships, and how role models can inspire people to behave in a healthier and happier way.



Key Points

- Identify role models.
- Role models can be different people whom we admire.
- Parents are babies' first role models.
- By being role models, parents can help their babies and children behave in ways that make their lives healthier and happier.



Participant Manual

p. 6.12



Rationale

Role models can help to improve interpersonal relationships and mood. We often pick up ways of doing things from other people. Some are good and some are not.



Information

This discussion of role models may increase anxiety for some participants, especially those who felt that they did not have positive role models in their lives. In this case, instructors should point out that it's not too late to find role models for themselves and to start thinking about possible people to be role models for their babies.



Step by Step

Step 1: Introduce this week's material, linking it to material taught in previous sessions.

Instructors can elicit a general discussion and/or have participants complete four questions on p. 6.12 and then discuss their written answers.

Suggested Wording:

Let's start by talking about role models. What are role models?

Elicit participants' answers.

Points to discuss:

- Role models can be people who have qualities that make a person look up to them (e.g., honesty, friendliness, genuineness).
- Role models can be real people or fictional.
- Role models can guide a person's behavior positively (i.e., behave in ways that help make their lives healthier and happier).

Step 2: Elicit participants' role models.

Suggested Wording:

Who are your role models?

Step 3: Parents are their baby's first role models.

Suggested Wording:

As parents, you are your baby's first teacher and your baby's first role models. As a role model, what qualities do you want your baby to know about you?

Your baby can also have other role models. Who would you like your baby to have as role models?

Step 4: Parents can help to protect babies from negative role models.

Suggested Wording:

There are also role models that may have a negative influence. Some people look up to others who do not have positive qualities. For example, there is a lot of violence on TV. How do you protect yourself and your baby from these negative and unhelpful influences in your life? We learn the way we behave, the way we talk, and even the way we think from people who are around us. This happens whether we are conscious of it or not. Part of what we would like you to remember from the course is that you can consciously choose what you learn from other people and what you will teach your baby.

In terms of what you learn from other people, we suggest you focus on parents you know, see at the stores, park, or on the street.

Notice the things parents do which you would like to do with your own child. Notice also the things parents do which you want to avoid doing with your own child. If you see things that are particularly important to do or not do, you may want to jot them down, so you will remember when your child is born, and as he or she grows up.

In terms of what you will teach your baby, remember that your baby is learning all the time, not just when you intend to teach him or her something. That means that if there are things you are used to doing that you would rather your child did not learn, now is the time to break the habit. If you keep on doing them once your child is born, he or she will see you doing it, and might learn to do it himself or herself. Similarly, if there are things you want to do more often, or want to begin doing so your child will learn it, then now is the time to start, so that it has become part of the things you do by the time your child is born.

Elicit participants' answers.

Points to discuss:

- *Being aware of the negative influences.*
- *Help children to be aware that there are both positive and negative influences.*
- *Try to stay away from the negative influences e.g., select particular TV shows to watch or avoid.*
- *Increase social support in one's life.*



VI. COURSE REVIEW (10 MIN)

VI. A. MANAGING MY PERSONAL REALITY and VI.B. CREATING A HEALTHY REALITY FOR ME AND MY BABY



Overview

Review and reinforce main concepts from the 6-week class.



Key Points

- Review the main concepts: Internal and external reality.
- Review the main concepts: Relationships between mood and pleasant activities, thoughts, and contacts with others can affect one's internal and external reality.
- Thoughts can affect our internal reality.
- The activities that we do and the people in our lives can affect our external reality.
- We can make choices to have a healthier reality (both internal and external).



Participant Manual

pp. 6.13-6.14



Rationale

Reviewing the main concepts of the class will help to prevent the likelihood of a major depressive episode in the future.



Information

Because this is the last class, termination issues will be prominent. Instructors should address termination and should specifically discuss what participants can do in the short term (e.g., next week during class time) and the long term to manage their realities. The goal is to suggest and reinforce that participants should continue using the skills they learned to maintain the changes they have made to their mental health.



Step by Step

Step 1: Review of most important concepts of MB.

Suggested Wording:

Now we'd like to review what you've learned in the past 6 weeks. One of the topics we've talked a lot about is different ways of managing our reality. What do you remember the most about this? What is internal reality? What is external reality? Let's look at p. 6.13 of your book and talk about these concepts.

Points to discuss:

- *Emphasize choices that participants can make about their internal and external realities.*
- *Internal and external reality may affect mood.*
- *Mothers can help mold their babies' internal and external realities by using tools they learned in this class (go to point 2).*

Step 2: Review mood and thoughts, activities, and people contacts within the reality management approach.

Suggested Wording:

We've also talked about how your mood is related to pleasant activities, thoughts, and contacts with others. As you can see on p. 6.14, there are different ways that you can manage your internal and external reality by having more helpful thoughts, doing more pleasant activities, or spending time with people who are helpful influences in your life. How can you create a healthy reality for you and your baby?

Creating a healthy reality means shaping your and your baby's day-to-day lives so that life is more satisfying and filled with more peaceful, happy, loving moments for both of you.

Shaping your day includes both shaping what you actually do and also what you think.

Shaping what you do is what we mean by shaping external reality. This includes how you spend each hour of the day, where you spend it, with whom, and what kind of activities you build into your life.

Shaping what you think is what we mean by shaping your internal reality. This includes what goes on in your mind as you go through your day. Are you aware of the special moments as your relationship with your baby develops? Are you aware of what your baby is experiencing, so that you can have a positive influence on what he or she feels about you, about himself or herself, and about the world in general? The things your baby feels, sees, and hears shape his or her image of what life is like. So you have a real chance to help shape that image. Will it be one of being special and cared for? Of being able to get what s/he wants? Or will it be one of being ignored and not being able to stop being frustrated? The things we have discussed during this course are all relevant to these issues.

Points to discuss:

- The types of activities one does and people one interacts with can affect one's mood (here focus on external reality).
- The types of thoughts that one has can affect one's mood (here focus on internal reality).
- By changing their internal and external realities, mothers can help shape their children's internal and external realities.
- What types of activities do mothers want their babies to do?
- Who do mothers want in their babies' lives? (Reiterate importance of social support)
- Instructor can refer back to examples from Violet and Mary to illustrate the above points.



VII. PERSONAL PROJECT: QUICK MOOD SCALE & OPTIONAL PROJECTS

VIII. FINAL ACTIVITY: WHAT OTHERS LIKE ABOUT YOU (10 MIN)

IX. GRADUATION AND CELEBRATION (20 MIN)

1. Review the course materials, especially the activities that are meaningful to you.
2. Practice any of the relaxation exercises you learn in this course.



Overview

Carry out a final exercise intended to provide positive feedback for participants from their peers. Celebrate end of class with a graduation ceremony.



Key Points

- Participants have an opportunity to listen to others appreciate them.
- Celebrate end of course and graduation.



Participant Manual

pp. 6.16-6.17



Information

Depending on the group composition, group members may want to plan their graduation party. For example, some members have brought food or drinks to share with the class. Also, an optional thing is to have certificates of graduation and take pictures of the class (per participant choice).



Rationale

Provides an opportunity for each participant to recognize other participants, and to celebrate the completion of class.



Step by Step

Step 1: Positive review exercise: “What others like about you.”

This exercise provides an opportunity for each participant to recognize other participants. Each person will say something positive to another person until everyone has had a turn. Depending on class size, the number of comments may vary. If the class is small, everyone will get an opportunity to say something about another person. If the class size is larger, instructors can limit the number of comments per person.

We suggest one of the leaders start, and model giving a brief, i.e., one or two sentence description of something one of the participants does that the leader values. Then that participant picks one other member of the group and does the same, and so on until all are done.

Suggested Wording:

We’d like to do one final exercise, called “What others like about you.” The purpose of this exercise is to give you an opportunity to recognize each other, and the strengths that you each have. You’ve had an opportunity to get to know each other in the past 6 weeks. Each person will have a turn to say something nice or positive about another person. All too often, we don’t get recognized for what we already do. So this is one way of allowing all of us to do this.

Conduct the exercise as described above and then ask: How was the exercise for you?

Typically, the result of this exercise is that participants feel very good about themselves.

Points to discuss:

- You have choices about how you behave with others.
- You can change how you behave with others.
- This exercise was an example of one way to change one's internal and external reality. Have them notice how they felt at the beginning of the exercise, and how they feel at the end. What is it that people did that produced this difference, and what kinds of thoughts were triggered that made their mood better?

Step 2: Graduation ceremony and graduation. Typically, instructors have prepared certificates of completion of the Mothers and Babies Class for each participant. Instructors congratulate the participants and give participants a chance to say something about the class.

Suggested Wording:

Finally, it's graduation time! Congratulations! We want to congratulate all of you for coming to class, and hope that this was a worthwhile experience for you. We really enjoyed having you in class. Now, I'd like to call you up here for your certificate.

If you would like to say some brief comments to your fellow students, this would be a good time.

Optional things include the following:

- 1) Graduation photo
- 2) Graduation ceremony
- 3) Food and drinks
- 4) Videotape party as a way to replay at a later time.

If you have plans to keep in touch with participants, include time to schedule post-intervention interviews. Include a table/chart/separate handouts about expectations of babies during the first year post-partum.



Alternative Exercise

INVITATION TO PARTICIPATE IN A FOCUS GROUP

Purpose: In order to evaluate the impact of the group on the participants and to plan for future groups, we suggest that you invite participants to attend a focus group with non-group leaders to gain information regarding their views of the course (e.g., strengths, weaknesses).

Emphasize that this is voluntary, group leaders will not be present, and it will be videotaped. Focus group should ideally take place 1 week following the 8th session. Have a sign-up sheet or ask to get an idea of who will be present. The feedback obtained in the focus groups can be used to improve the way the course was implemented by identifying specific issues that were most important to the population you serve. Incentives can be provided for women's participation.



The Mothers & Babies Course

A Reality Management Approach

.....
PARTICIPANT MANUAL

SIX-WEEK COURSE

Huynh-Nhu Le and Ricardo F. Muñoz
*The George Washington University
Washington, DC*



Introduction to the Mothers and Babies Course

CLASS OUTLINE

- I. Group Introductions
- II. Purpose and Overview
- III. Class Guidelines
- IV. Video: “My Parents, My Teachers”
- V. Stressors and the Mother-Baby Relationship
- VI. Common Mood Problems After Birth
- VII. How this Course Can Help You
- VIII. Managing My Personal Reality
- IX. Personal Project: Quick Mood Scale



I. Group Introductions

1. What is your name?
2. Where are you from?
3. How long have you lived in this area?
4. What activities do you like to do in your free time?
5. What is your favorite food?
6. If you are pregnant, how many months are you pregnant and when are you due?
7. If you are a mother, how many children do you have? How old are they?
8. What kind of mother would you like to be?
9. What would you like to learn from this class?

NOTES:



II. Purpose and Overview

Purpose

During the course, you will learn:

1. Ways to think about and interact with your baby to create an emotionally and physically healthy reality for him or her.
2. Helpful information about your pregnancy and your baby's development.
3. Ways to manage life stress and improve your mood so:
 - you can feel better and enjoy life more.
 - you can teach your baby how to manage life stress as he or she grows up.
 - you can avoid mood problems such as depression.

You will also have the opportunity to talk with many other women. Some of them already have a baby, and others are expecting. Share with them your ideas and concerns before and after childbirth, so that you can give your baby and yourself all the support you need.

Overview

Class 1 Introduction to the Mothers and Babies Course

THOUGHTS

Class 2 Thoughts and My Mood

Class 3 Fighting Harmful Thoughts and Increasing Helpful Thoughts that Affect My Baby and Myself

ACTIVITIES

Class 4 Activities and My Mood
Pleasant Activities Help Make a Healthy Reality for My Baby and Myself

CONTACT WITH OTHERS

Class 5 Contact with Others and My Mood
How to Get Support for Me and My Baby

Class 6 Interpersonal Relationships and My Mood
Graduation



III. Class Guidelines



1. **Try to come to every class.**

If you cannot make it to the class, please call us at _____.



2. **Come on time.**



3. **Respect confidentiality** (what is said in the group stays in the group)

EXCEPTIONS: Things leaders cannot keep confidential:

- If we hear about child abuse or neglect.
 - If we hear an older adult (over 65) is being abused or neglected currently or in the future.
 - If we hear someone is in danger of hurting themselves or someone else currently or in the future.
-



4. **Listen to and support each other.**



5. **Be respectful of your classmates' viewpoints.**



6. **Share your ideas and let others share theirs.**



7. **Complete your personal project for the week.** (So you can get the most out of class).



8. **Let us know if you're unhappy or uncomfortable with any aspect of the classes.**



IV. VIDEO

“My Parents, My Teachers”

The Mother-Baby Relationship

REACTIONS: What did you like the most? What do you remember the most?

- The first 3 years of your baby’s life are the most important.

- Teaching a baby something new makes their neurons (brain cells) grow and make connections.

- Each child is different.

- Children’s “work” is to play.

- Reading, playing and singing with your baby will help your baby’s physical and emotional development.

- Every mother is capable of giving what her child needs.



V. Stressors and the Mother-Baby Relationship



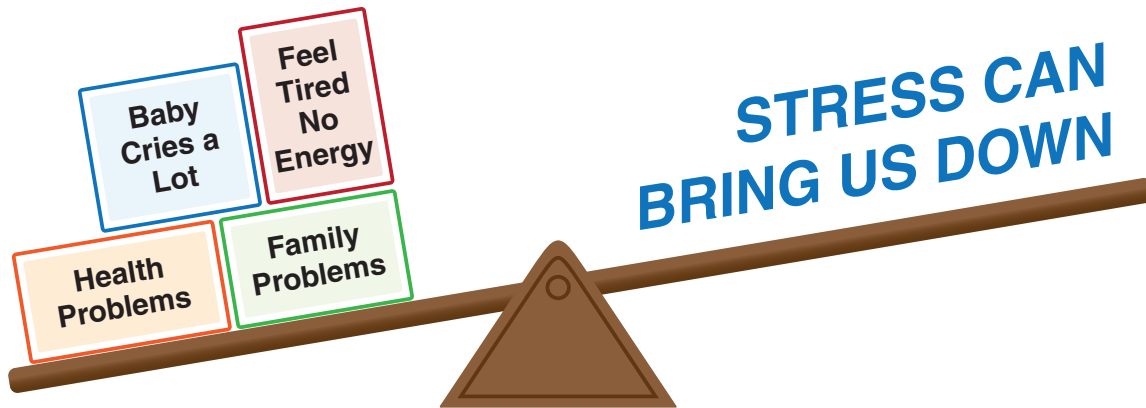


VI. Common Mood Problems After Birth

POSTPARTUM BLUES or BABY BLUES	POSTPARTUM DEPRESSION (Specific type of Major Depression)	MAJOR DEPRESSION
<p>Description:</p> <ul style="list-style-type: none"> • Mild mood shift • Occurs 3-7 days after giving birth • Symptoms last less than 2 weeks <p>Symptoms:</p> <ul style="list-style-type: none"> • Mood disturbances <ul style="list-style-type: none"> - Tearfulness - Anxiety - Sadness - Irritability - Emotional ups and downs • Poor appetite • Fatigue • Headaches • Sleep disturbances/insomnia • Low self-esteem • Negative feelings about family members (including the baby) • Miss being pregnant <p>How common is it?</p> <ul style="list-style-type: none"> • After giving birth, 3 to 8 out of 10 women will have postpartum blues <p>What to do:</p> <ul style="list-style-type: none"> • Get help and support from family members, friends, and other mothers • Try to do pleasant activities • If symptoms worsen or persist beyond 2 weeks, see your doctor 	<p>Description:</p> <ul style="list-style-type: none"> • Serious mood disorder • Occurs after pregnancy—up to 4 weeks after giving birth • Symptoms last more than 2 weeks <p>Symptoms:</p> <ul style="list-style-type: none"> • Similar symptoms as in “Baby Blues” but lasting longer • 5 or more of the symptoms listed under “Major Depression” <p>How common is it?</p> <ul style="list-style-type: none"> • After giving birth, 1 to 2 out of 10 women will have this type of depression <p>What to do:</p> <ul style="list-style-type: none"> • See a doctor, nurse, therapist, or counselor as soon as possible • Get help and support from family members, friends, and other new mothers • Try to do pleasant activities 	<p>Description:</p> <ul style="list-style-type: none"> • Serious mood disorder • Can happen at any point in our lives • Symptoms last more than 2 weeks <p>Symptoms: <i>(5 or more of these 9 symptoms)</i></p> <ul style="list-style-type: none"> • Feel depressed nearly every day • Loss of interest or pleasure in activities • Significant change in appetite • Change in sleep (too much/ too little) • Change in the way you move (restless or slowed down) • Constantly tired, fatigued • Feelings of worthlessness or excessive guilt • Hard to concentrate or make decisions • Repeated thoughts of death or suicide <p>How common is it?</p> <ul style="list-style-type: none"> • In a group of 10 women, 1 to 3 will suffer from major depression sometime during her life <p>What to do:</p> <ul style="list-style-type: none"> • See a doctor, nurse, therapist, or counselor as soon as possible • If your symptoms get serious enough that you are afraid you might hurt yourself, you may need to stay in the hospital until these symptoms are treated • Get support from others

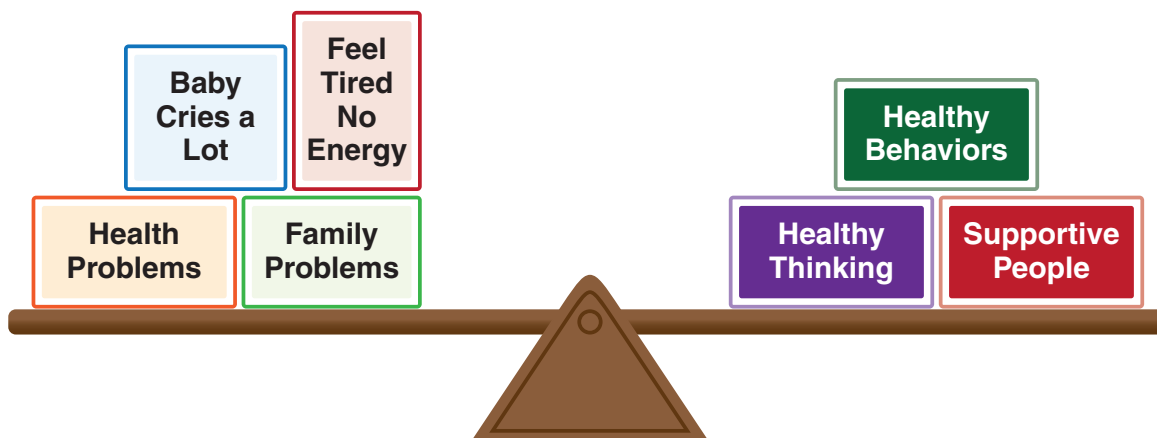


VII. How This Course Can Help You



But we can learn to manage stress and feel better and more balanced by making changes in:

- the way we **behave**
- the way we **think** about and understand the stressors
- the **support** we receive from other people





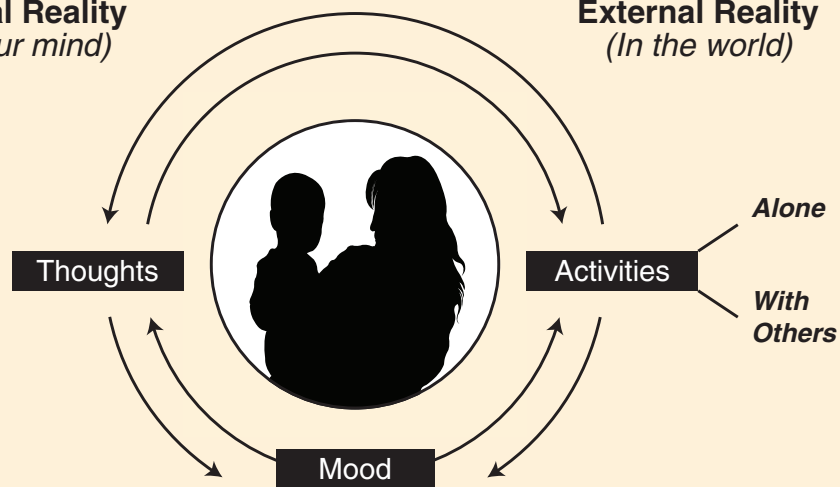
VIII. Managing My Personal Reality

- It is important to understand our moods. How do they influence our lives?
- To have a healthy mood, or positive feelings, it is important to learn to how to manage your own reality.
- Our personal reality is divided into two parts:
 1. **The reality of our mind:**
 - what we think
 - our internal reality
 2. **The reality of our world:**
 - what we do
 - with whom we relate
 - our health
 - what happens in our world
 - our external reality

MY PERSONAL REALITY

Internal Reality
(In your mind)

External Reality
(In the world)



Promote parent-infant bonding using cognitive-behavioral strategies

This drawing demonstrates how we understand the relationship between our personal reality and our mood.



IX. Personal Project: Quick Mood Scale

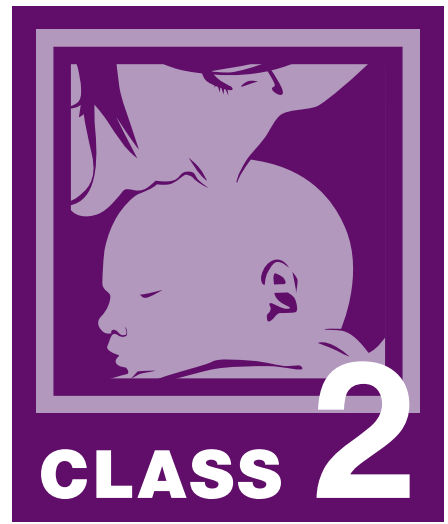
Instructions: Track your mood every day using the Quick Mood Scale. It will help you learn to be aware of how you feel, so that you can learn to have healthier moods and teach your baby to balance his/her moods.

- The seven columns represent each day of the week.
- Write down the date above each of the seven columns.
- Every night, before going to bed, circle the number (between 1-9), which indicates how you feel on that day. For example:
 - if your **mood is average**, (neither high nor low), circle **number 5**
 - if it is **better than average**, circle **a number higher than 5**
 - if it is **worse than average**, circle **a number lower than 5**
- The number you choose will only reflect how you feel that day—there is no right or wrong answer. We find that it is easiest to keep the scale by the bed, so that before you go to bed, you can think about your day and rate your mood for the day.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1

OPTIONAL PROJECT:

1. Discuss the Mothers and Babies Course with a friend or a family member. Talk about what you learned in today's class.



Thoughts and My Mood

CLASS OUTLINE

- I. Announcements/Agenda and General Review
- II. Personal Project Review
- III. Relaxation Exercise
- IV. Violet and Mary
- V. NEW MATERIAL
- VI. Take Home Message
- VII. Personal Project
- VIII. Feedback and Preview



I. Announcements/Agenda and General Review

Announcements/Agenda

General Review

What do you remember most from the last class?

- Parents are their children’s first teachers. These are some of the things your baby needs from you:
 - Good communication
 - Reading
 - Music
 - Play
- Stress can affect your relationship with your baby. You can learn to manage stress by making certain changes in your life. We will talk more about these changes in this course.
- There are common mood problems in the postpartum period. It’s important to talk to someone if you experience postpartum depression.
- Your mood and your personal reality: Your thoughts, activities, and mood all affect how you view the world.
- You can learn more about how to manage your personal reality, which has two parts: an internal and external reality. Your personal reality can affect your mood, and your mood can affect your personal reality.



III. Relaxation Exercise

What is relaxation?

Relaxation is a method we can use to manage stress and to reach a healthy balance in our lives. Relaxation exercises can help you deal with stressful situations when they occur. Relaxation is an enjoyable and pleasant activity that you can share with your baby, so that he/she will not only learn to benefit from these exercises, but will also have wonderful memories of you. Children can be taught how to do relaxation exercises from a very young age, similar to how they are taught to brush their teeth, how to pray, how to be polite, how to eat regularly, etc.



A FEW THINGS TO KEEP IN MIND ABOUT LEARNING TO RELAX

1. Practice, Practice, Practice!
2. The goal: to relax without doing the exercise.
3. As you prepare to relax:
 - Choose a quiet, comfortable environment where there are few distractions.
 - Choose a time of day when you are least likely to be disturbed, and not too soon after a meal. For example, try relaxing upon awakening or when you are ready to go to sleep. Also, try relaxing during the middle of the day, particularly *just before* you have to do something difficult or *just after* you have had to face a stressful situation.
 - Select a comfortable position.
 - Try not to worry about how well you are doing. If you begin to experience distracting thoughts, slowly return your mind to the task of relaxing.

Ramos, Diaz, Urizar, & Muñoz (2002). Relaxation Methods for Managing Stress. SFGH/UCSF.

USING YOUR BREATH TO LEARN TO RELAX



STEPS TO FOLLOW:






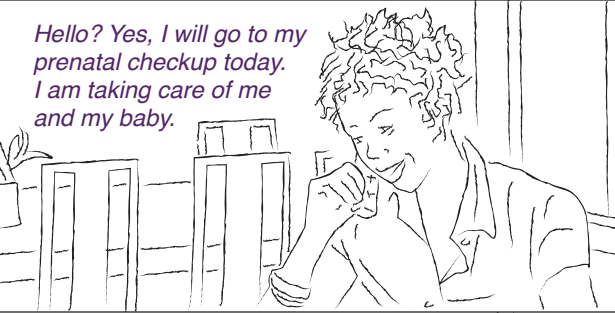


- Sit quietly in a comfortable position.
- Close your eyes.
- Relax all your muscles as fully and deeply as possible. Start with either end of the body (your feet or your head) and move systematically all the way up or down, focusing on each muscle, and relaxing each one.
- Breathe easily and naturally through your nose. Become aware of your breathing. As you breathe out, say a brief word you have chosen to repeat (for example, the word "one" or the word "relax").
- Continue for about ten minutes at first, until you get used to producing the feeling of relaxation. Your goal is to be able to produce this feeling in one minute or even less at any time you choose. This way, you can provide yourself with a moment of relaxation as often as you wish throughout your day.
- Before you open your eyes, remind yourself to retain this feeling of deep relaxation and simultaneous alertness when you return to your normal activities.

This method is nicely described in a book called *The Relaxation Response* by Herbert Benson (New York: Avon Books, 1975).



IV. Violet and Mary's Days

Instructions: Violet and Mary are both 4 months pregnant. Circle the number on each panel that represents what kind of mood you think each woman is having.

VIOLET'S DAY	MARY'S DAY
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't want to get up.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't want to get up.</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't feel like facing the day.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't feel like facing the day, but I'll feel better if I take care of myself and my pregnancy.</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I'm not a good person. I don't want to do anything.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>Hello? Yes, I will go to my prenatal checkup today. I am taking care of me and my baby.</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I feel so sad and lonely.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>It was good that I went to my checkup today. I am happy my baby is growing well.</i></p>

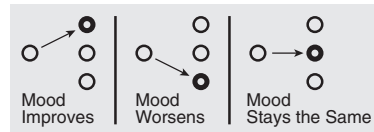
ILLUSTRATIONS BY JOSIE THOMPSON, THOMPSON DESIGN



V.A. The Path That Leads to a Healthy Mood

Your personal reality is continually being built or shaped from moment to moment.

- In each moment of our life, we decide what to think, do, say, and how to treat other people.
- Each decision we make improves or worsens our emotional well-being or keeps it the same.

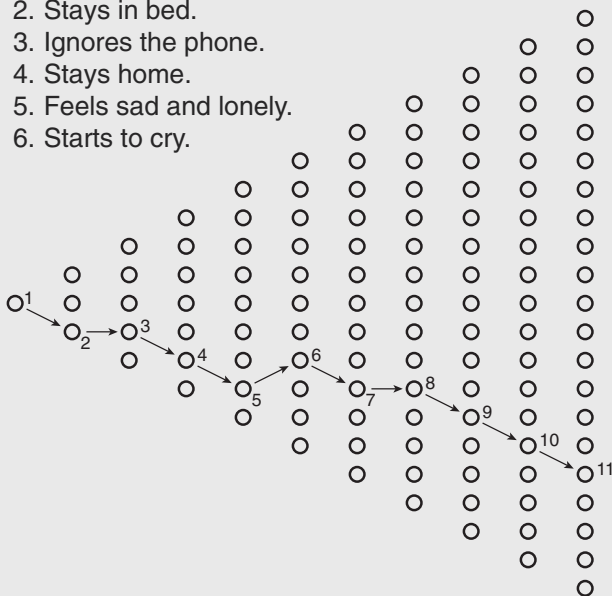


- In general, each decision we make has a minimum effect on us. However, as our decisions accumulate, they can create a strong change in our emotional well-being.

The path that leads to a NEGATIVE mood

Example: Violet's Day

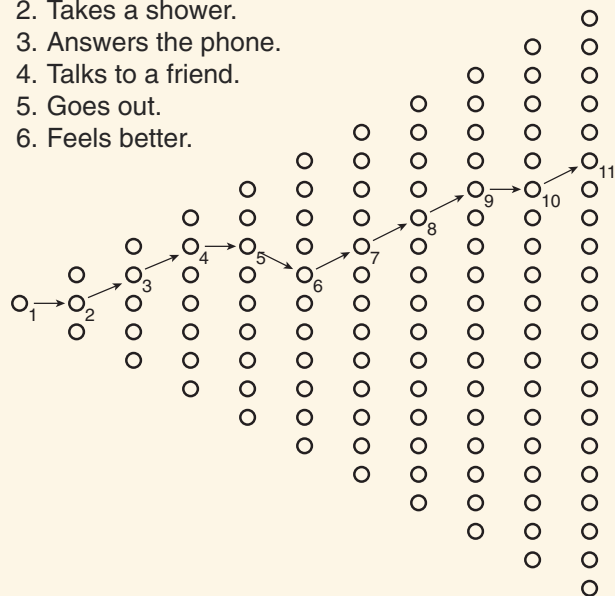
1. Wakes up.
2. Stays in bed.
3. Ignores the phone.
4. Stays home.
5. Feels sad and lonely.
6. Starts to cry.



The path that leads to a HEALTHY mood

Example: Mary's Day

1. Wakes up.
2. Takes a shower.
3. Answers the phone.
4. Talks to a friend.
5. Goes out.
6. Feels better.



The thoughts that we have each day help us shape the reality of that day!



V.B. What Are Thoughts? Do Different Thoughts Affect Our Mood?

- Thoughts are all the things we tell ourselves (as if we were having a conversation in our head).
- We can have several thoughts at any given moment.
- We are conscious of some thoughts and not of others.
- Our thoughts can help us or harm us.
- Our thoughts almost always affect our mood.
- If we become aware of the many types of thoughts we have, we can learn to use them to achieve a healthier mood.





V.C. Helpful Thoughts and Harmful Thoughts

Instructions: Some thoughts help us to feel more positive about our lives—they give us energy and hope. Other thoughts can make us feel more negative—they can make us feel depressed and tired. Try to think of some helpful and harmful thoughts that you may have and list them in the boxes below.



HELPFUL Thoughts

HARMFUL Thoughts



V.D. Types of Harmful Thought Patterns and Talking Back

Harmful Thought Patterns	Talking Back to Your Harmful Thought Patterns
<p>ALL OR NOTHING THINKING: Thinking in extremes (only at one end of the scale, top or bottom). Not balanced. All good or all bad. The best or worst. Perfect or a failure.</p>	<p>Try to engage in more balanced thinking. What's in the middle? Are there more shades of grey?</p>
<p>OVERGENERALIZATION: Taking one negative characteristic or event and seeing it as a never-ending pattern: Somebody betrayed me. I don't trust anyone. I couldn't do this one thing. I can't do anything.</p>	<p>Ask yourself: Am I assuming that every situation and every person are the same? This is just one situation, one person. Can I remember other situations and people that were different?</p>
<p>BLAMING ONESELF: Thinking that when negative things happen they are always my fault.</p>	<p>Am I to blame for everything that turns out badly? Do only bad things happen to me? Remember the good that has happened to me and that I have achieved.</p>
<p>NEGATIVE FORTUNE TELLING: Thinking that you can see how things will be in the future and that they are sure to turn out badly.</p>	<p>Can I really predict the future? Why not find out how it will turn out rather than just imagine the worst? Things could change.</p>

Adapted from David D. Burns (1980). *Feeling Good: The New Mood Therapy*, Morrow.



V.E. How to Give Myself Good Advice



- You can learn ways to decrease harmful thoughts throughout your day.
- You can learn to talk back to harmful thoughts to improve your mood.



VI. Take Home Message

- Thoughts are part of my internal reality.
- Some thoughts make my mood worse.
- Some thoughts make my mood better.
- If I can find out which they are, I can use my thoughts to improve my mood.



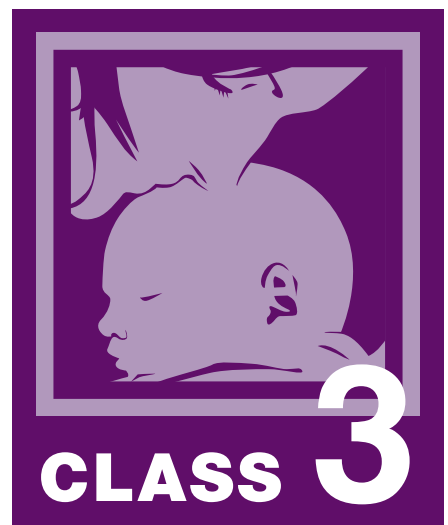
VII. Personal Project: Quick Mood Scale

Instructions: Every night, before going to bed, circle the number that best represents how you feel each day. At the bottom of each column you will find a line where you can make a note of how many helpful and harmful thoughts you have each day. See if there is a relationship between your mood and the helpful and harmful thoughts you have each day.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1
Number of HELPFUL Thoughts:	_____	_____	_____	_____	_____	_____	_____
Number of HARMFUL Thoughts:	_____	_____	_____	_____	_____	_____	_____

OPTIONAL PROJECTS (pick one of the following):

1. Use your cards to keep track of your helpful and harmful thoughts this week. Write your healthy thoughts on one side of the card and your harmful thoughts on the other side.
2. Talk to someone about what you learned about your thoughts and mood today.
3. Practice the relaxation exercise that you learned today.



Fighting Harmful Thoughts and Increasing Helpful Thoughts That Affect My Baby and Myself

CLASS OUTLINE

- I. Announcements/Agenda and General Review
- II. Personal Project Review
- III. Relaxation Exercise
- IV. Violet and Mary
- V. NEW MATERIAL
- VI. Take Home Message
- VII. Personal Project
- VIII. Feedback and Preview



I. Announcements/Agenda and General Review

Announcements/Agenda

General Review

What do you remember most from the last session?

- Relaxation can be helpful to manage stress. Relaxation takes a lot of practice!
- You can have thoughts that affect your mood at any time. Harmful thoughts are likely to make your mood more negative while helpful thoughts are likely to make your mood more positive.
- If we can learn to identify when we are having certain types of thoughts, we can learn to manage our moods and our internal reality better.



III. Relaxation Exercise: A Favorite Place



Sit in a comfortable chair with your arms at your side or lie down on your bed in a comfortable position with your arms and legs uncrossed. You can also choose any other position in which you feel totally comfortable.









- Close your eyes. This will allow you to concentrate and to keep your mind from wandering.
- Put one hand on your abdomen. Now take a deep breath and feel your abdomen rise slowly as you inhale and go down as you exhale. You can mentally say to yourself “in” with each inhalation through your nose and “out” with each exhalation through your mouth (Pause).
- Begin to focus on your breathing. Inhale deeply through your nose and exhale slowly through your mouth. Each breath you take leaves you more and more relaxed...it purifies your whole body and mind.
- Imagine being in your favorite place.
- What do you see, hear, taste, smell?
- What thoughts do you have when you are in your favorite place?
- How does being in your favorite place affect your mood?

Ramos, Diaz, Urizar, & Muñoz (2002). Relaxation Methods for Managing Stress. SFGH/UCSF.



IV. Violet and Mary's Days

Instructions: Violet and Mary are both 6 months pregnant. Circle the number on each panel that represents what kind of mood you think each woman is having.

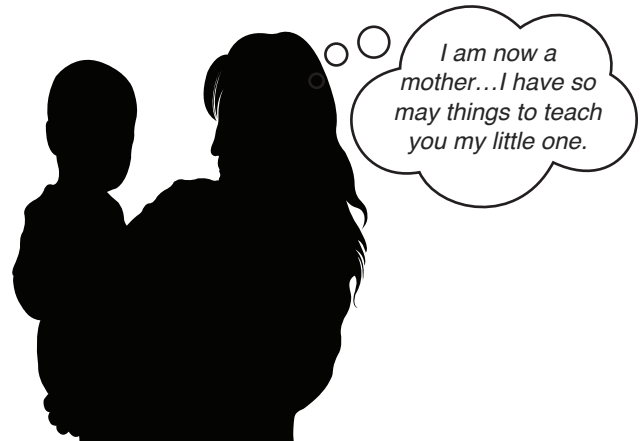
VIOLET'S DAY	MARY'S DAY
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't want to get up.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't want to get up.</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't feel like facing the day.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>After my shower I'll feel better.</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I don't want to speak to anyone.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>Hello Carmen, would you like to go for a walk with me?</i></p>
<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I feel so sad and lonely.</i></p>	<p>9 8 7 6 5 4 3 2 1</p>  <p><i>I'm glad I asked Carmen to go out with me today. I feel a lot better.</i></p>

ILLUSTRATIONS BY JOSIE THOMPSON, THOMPSON DESIGN



V.A. Thoughts About Becoming A Mother

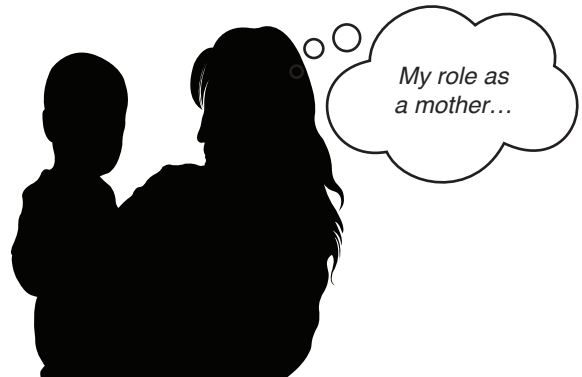
- Our thoughts affect the way we perceive life and how we will be as mothers.
- As you become a mother, you can decide what kind of mother you will be. For example, you can decide:
 - how to think about you, your baby and your relationship.
 - how you want to treat your baby and what to teach him or her.
 - what you want to feel for your baby and those emotions you like to teach him or her.
- Remember that learning to think is like learning to talk. Babies learn to think and talk by observing how their mothers think and talk.
- If the baby is raised listening to words of affection, the baby will learn to be affectionate.
- Your baby will learn from you. Remember, you are his/her first teacher!
- You can teach your baby to think in such a way that he/she will feel good about him or herself.
- As a mother, you can be an example to your baby. You can help your baby “shape” his/her thoughts so that he/she develops a healthy, internal world.





V.B. Pregnancy, Birth, and Parenting—Helpful and Harmful Thoughts

Instructions: There are different ways to think that can help you enjoy your pregnancy and your baby more. Write down some harmful and helpful thoughts that you have had about pregnancy, giving birth, and becoming a mother in the boxes below. When you find yourself having harmful thoughts, remind yourself of some of your helpful thoughts.



	HARMFUL Thoughts	HELPFUL Thoughts
About Pregnancy		
About Giving Birth		
About Becoming a Mother (For the first time or again)		



V.C. Helpful Thoughts During Pregnancy and Motherhood



HELPFUL THOUGHTS DURING PREGNANCY:

This is a very special time in my life.

I am getting ready to be a good mother.

I am so happy I am bringing a new life into this world.

I want to take good care of myself so I can have a healthy baby.

Giving birth is such a normal process; I don't need to be so nervous.

HELPFUL THOUGHTS DURING MOTHERHOOD:

I am so eager to hold my baby in my arms.

From birth, my baby will know he/she is loved.

I am a good mother.

I am taking good care of my baby.

I am so excited about all the things I am going to teach my baby.

I will teach my baby to be proud of herself, her family, and her culture.

I am going to teach my baby to be polite, respectful, and above all, to enjoy life!





V.D. Ways to Change Harmful Thoughts That Affect My Baby and Me

Just as your thoughts affect your mood, your child's thoughts affect his/her mood. You can teach your child to think in a healthy way that will make him/her happy.

Methods to reduce harmful thoughts:	How to teach your child to have a healthy mood:
<p>1. Thought Interruption: There are times when we get into a rut with a certain thought, usually a negative one, which keeps bothering us throughout the day and makes us feel bad. When this happens, try to stop this thought by distracting yourself.</p>	<p>Notice how your baby is feeling and to teach him/her what feeling s/he is having. For example, if your baby begins to feel frustrated because s/he is tired and is sleepy, ask your child, "Honey, are you tired? It's time for your nap. Once you rest, you will feel a lot better." This way, your baby learns that something can be done to feel better when s/he is upset or has negative thoughts.</p>
<p>2. Worry Time: Sometimes, it's necessary to think about the things that have an effect on your mood. Yet, it's important not to do it too often. It is possible to limit the amount of time you spend on these thoughts to 5 or 10 minutes per day. Also, try not to do it when you are with your baby.</p>	<p>Take a few minutes a day to focus on your problems and worries when your baby is asleep and when you will not be interrupted. That way the baby will be less likely to learn to worry.</p>
<p>3. Time projection: Sometimes when we get sad or depressed, it seems that things are terrible and that they will always be terrible. When this happens, it is helpful to imagine ourselves moving forward in time to a time when things will be better.</p>	<p>It's important that your baby learns that life will bring them good and bad things. They can enjoy the good things and remember that the bad moments will pass by.</p>
<p>4. Self-instructions: Talking to yourself is something that we all do. It does not mean you are crazy. It can be like giving yourself helpful directions. You can remind yourself to use these techniques. You can remind yourself how you want to handle things. Children also learn to control themselves by giving themselves instructions such as "don't touch," "hot" and so on. We also give ourselves instructions, especially when we are doing something new.</p>	<p>The way that you speak to your baby will teach him/her to understand you better as s/he grows. It's true that your baby will not understand everything you say, but it's good to start practicing now. One example is to tell yourself, "I want to raise my baby with a lot of love, so when s/he needs to be disciplined s/he won't think s/he is not loved."</p>



V.E. Thoughts I Want to Learn to Teach My Baby

Our mind is our internal reality, our inner world, and our personal environment.

- The way we think has been shaped by many influences since childhood.
- What we see, what we hear, and the way in which we are treated shape our internal reality.
- What we learn can be useful or it can be harmful. Some cause us great burdens or even pain and sorrow.
- Now that we are adults, we can decide if we want to continue thinking in the manner we were taught as children.



Now that you have a baby, you can decide how you would like to shape your baby's internal reality.

- You can choose:
 - From the things your parents and family members taught you.
 - From your culture (in your country of origin, if you were not born here).
 - From the society you live in now.

While there is no way of guaranteeing that your child will think in one way or another, there are ways of increasing the possibility that your baby will think in a certain way.

- Unfortunately, parents sometimes teach their children to think, talk, and behave in unhealthy ways without being aware that they are doing this.
- In this course, you can reflect on how you think and talk so that, even before your baby is born, you can decide what you want to teach him or her.



V.F. Thinking About Your Future

Instructions: Think about what kind of life you would like to have in the future (say 5 years from now) and what kinds of things you do and do not want for yourself. Then, think about the steps you need to take in order to have the life you really want.

EXAMPLE:

“I would like to have a great computer job”



“I will sign up for a computer class now”



MY IDEAL FUTURE (5 years from now)	
What I want:	What I need to do now:
What I don't want:	What I need to avoid doing now:



V.G. Thinking About Your Baby's Future

Instructions: Think about what kind of life you would like your baby to have. Then think about the steps you need to take now in order to help your child have an ideal future.

EXAMPLE:

"I want my child to enjoy reading"



"I will read to my child now"



MY BABY'S IDEAL FUTURE (5 years from now)	
What I want for my baby:	What I need to do now:
What I don't want for my baby:	What I need to avoid doing now:



VI. Take Home Message

- I can help shape my internal reality and my baby's internal reality.
- My thoughts can affect both myself and my baby.
- I can change my thoughts to improve my mood and my relationship with my baby.
- If I think about how I want my future and my baby's future to be, I can increase the chance that we will have a healthy and happy life.



VII. Personal Project: Quick Mood Scale

Instructions: Every night, before going to bed, circle the number from 1-9 that best represents how you feel each day. At the bottom of each column, you will find lines where you can keep track of your healthy thoughts and harmful thoughts. See if there is a relationship between how you feel each day and your thoughts.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1
Number of HEALTHY Thoughts:	_____	_____	_____	_____	_____	_____	_____
Number of HARMFUL Thoughts:	_____	_____	_____	_____	_____	_____	_____

OPTIONAL PROJECTS (pick one of the following):

1. Practice how to reduce harmful thoughts by using two of the methods we discussed in class today.
2. Talk to someone about what you learned about your thoughts and mood today.
3. Practice the relaxation exercise that you learned today.



Activities and My Mood

Pleasant Activities Help Make a Healthy Reality for My Baby and Myself

CLASS OUTLINE

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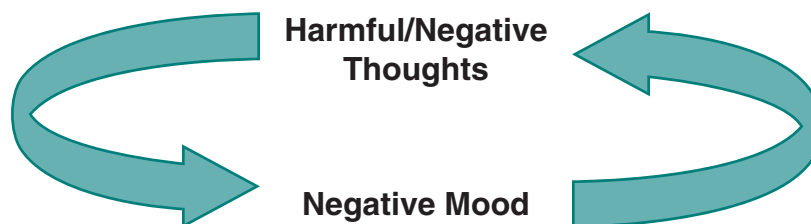
I. Announcements/Agenda and General Review

Announcements/Agenda

General Review

What do you remember most from the last class?

- You can communicate in healthy ways with your baby verbally and nonverbally to help your baby learn to think about him/herself and the world.
- By spending time now to think about how you would like your baby's future to be, you can improve your baby's chances of having a healthy life. You can also spent time thinking about how to improve your future.



- If you can learn to identify when you are having certain types of thoughts, you can learn to manage your moods better.
- There are several ways to change harmful thoughts that can affect you and your baby. Can you identify what are the 4 ways to reduce harmful thoughts?



III. Relaxation Exercise: Walking Relaxation



Most of us walk a lot throughout the course of the day. Therefore, walking can be an activity that can be used to practice relaxation. The following exercise can be done at any time. For example, when you are running an errand or when you are walking in the park with your baby in the stroller. This exercise incorporates walking, breathing, and counting.

- Focus on your breathing before or while you are walking. Take deep full breaths: inhale through your nose and exhale through your mouth.
- It is recommended you walk at a slower pace as you begin to do this exercise.
- Continue concentrating on your breathing. Breathe deeply through your nose and exhale slowly through your mouth. Repeat five times.
- Now that you are aware of your breathing, count your steps while you breathe deeply.
- Inhale while you walk and say to yourself “1...2...3...” and now exhale and take three more steps “1...2...3...” Repeat this and continue breathing deeply and slowly.

Continue counting your steps while breathing through your nose and exhaling through your mouth. This will help make you feel more relaxed.

Ramos, Diaz, Urizar, & Muñoz (2002). Relaxation Methods for Managing Stress. SFGH/UCSF.



IV. Violet and Mary's Days

Instructions: Both Violet and Mary are 8 months pregnant. Circle the number on each panel that represents what kind of mood you think each woman is having.

VIOLET'S DAY	MARY'S DAY
<p>9 8 7 6 5 4 3 2 1</p> <p><i>I don't want to get up.</i></p>	<p>9 8 7 6 5 4 3 2 1</p> <p><i>I don't want to get up.</i></p>
<p>9 8 7 6 5 4 3 2 1</p> <p><i>I don't feel like facing the day.</i></p>	<p>9 8 7 6 5 4 3 2 1</p> <p><i>I want to be the "best mom in the world." Maybe I'll visit Ana and see how things are going with her baby.</i></p>
<p>9 8 7 6 5 4 3 2 1</p> <p><i>I don't want to speak to anyone.</i></p>	<p>9 8 7 6 5 4 3 2 1</p> <p><i>Hello Ana, how are you and your baby? Can I visit you?</i></p>
<p>9 8 7 6 5 4 3 2 1</p> <p><i>I feel so sad and lonely.</i></p>	<p>9 8 7 6 5 4 3 2 1</p> <p><i>Ana, you're a great mom. I'm so happy that I can ask you for help when I have my baby.</i></p>

ILLUSTRATIONS BY JOSIE THOMPSON, THOMPSON DESIGN



V.A. How Does What We Do Affect How We Feel?

- When people do pleasant activities:
 - They often feel happier.
 - They are more likely to have positive thoughts about their lives.
 - They are more likely to have positive contacts with other people (but there are also pleasant activities that people can do alone).
- When you are feeling down or tired, it is often hard to get the energy to do pleasant activities BUT it may help you feel better and less tired.
- Many activities are pleasurable because they offer us the chance to experience a sense of mastery or a sense of meaning.



V.B. What Do You Like To Do?

Instructions: Write down things you enjoy doing. Try to think of some things you can do alone or things you can do with others. There is no right answer—only you know what you enjoy doing!

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Now write down things you enjoy doing with your baby or things you can do with your baby when he/she is born.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

PLEASANT ACTIVITIES LIST

DATE:							
1. Read a book or magazine							
2. Daydream							
3. Watch TV							
4. Prepare a new dish or a special dish							
5. Complete a puzzle or a crossword puzzle							
6. Take a shower or a warm bath							
7. Talk about old times							
8. Listen to music							
9. Spend time with friends							
10. Sing							
11. Go to church or pray							
12. Read the newspaper							
13. Go for a walk							
14. Exercise							
15. Tell stories about my country							
16. Take a nap							
17. Work outdoors (e.g., gardening)							
18. Get a manicure or pedicure							
19. Go to the library							
20. Eat in a restaurant							
21. Practice a relaxation exercise							
22. Dance							
23. Play with my baby/children							
24. Other: _____							
25. Other: _____							



V.C. How Do Babies Learn?

Babies learn by:

- Observing and imitating what their parents do.
- Communicating with their parents.
- Following what their parents teach them.
- Feeling supported when they try to do new things.

All the activities you do with your child are opportunities for learning.



V.D. What Do Babies Like to Do?



Instructions: Write down things that you think babies like to do. Think of some things babies can do alone and things babies can do with mom and with others.

THINGS BABIES LIKE TO DO ALONE	
AGE IN YEARS	ACTIVITY
0	
1	
2	
3	

WITH MOM		WITH OTHER PEOPLE OR OTHER BABIES	
AGE IN YEARS	ACTIVITY	AGE IN YEARS	ACTIVITY
0		0	
1		1	
2		2	
3		3	



V.E. From Birth to Age 1: Some Things Babies Like to Do

AGE	WHAT BABIES LIKE TO DO
Newborn	Imitate—make faces, stick out your tongue and watch your baby imitate you Rock—going for a ride in a stroller can also be calming Listen to soft music, a musical toy, or your voice Be touched—gently massage your baby
1 Month	Track objects Watch mobiles Practice exercising feet using bicycle movements
2 Months	Play with hand puppets Gently bounce up and down Hold and play with a rattle
3 Months	Shake a rattle on his/her wrist Listen to music with rhythm Play with toys that are attached with strings and practice batting
4 Months	Play peek-a-boo Practice rolling from stomach to back Watching bubbles
5 months	Looking in a mirror Play with a roly-poly toy (a toy that turns up when knocked over) Swing in an infant swing
6 Months	Play patty-cake Play with other babies Go on piggy back rides
7 Months	Play tug of war Play “look for the toy after you hide it” Looking at books with lots of pictures and colors
8 Months	Learn the sounds that animals make Play hiding games Bang on pots and pans
9 Months	Roll a ball back and forth to you Practice standing up
10 Months	Push a car or truck on the floor Tear magazines Blow bubbles
11 Months	Push things with levers Pour things from one container to another (try cereal) Play in the water
1 Year	Play with a big beach ball Toss bean bags or balls (or crumpled up paper) into a container Play with his or her shadow Explore the world around them



V.F. Pleasant Activities and My Baby

- Babies who do pleasant activities are more likely to have healthy moods.
- Babies' brains continue to develop. By doing pleasant activities babies actually learn more and make more connections among their brain cells. They actually get smarter.
- Active babies eat better, sleep better, their digestive system works better, and they grow stronger and healthier.
- Babies learn through play, and through play, they get to enjoy learning.
- When we do pleasant activities with our babies, we strengthen our relationship with them. Doing fun things together leads to enjoying each other more now and in the future.
- When our babies get used to doing pleasant activities with us, they are more likely to want to please us. They are more likely to listen to us, which means fewer discipline problems in the future.
- When mothers and babies do pleasant activities together, their relationship becomes stronger and more positive.



V.G. Overcoming Obstacles

Sometimes even after we decide to do something pleasant, our plans still fall through. We run into an obstacle or problem, and we don't do the pleasant activities that we meant to do.

- Try to think of some possible obstacles and possible solutions to overcome them.

What is keeping me from doing pleasant activities or from my baby once he or she is born? (Obstacles/Problems)	How can I overcome these obstacles? (Solutions)

Solving Problems and Overcoming Obstacles:

1. Identify the problem or obstacle.
2. Think about all the possible solutions.
3. Pick the best solution (the one that's best for you).
4. Try the solution and see how well it works.



VI. Take Home Message

- Doing pleasant activities can improve your mood and your baby's mood.
- You can choose pleasant activities to do alone and with your baby.
- Many of the things babies learn as they develop, they learn from us.
- It is important for us to communicate with our babies and encourage them to explore their environment and learn new things.
- Doing pleasant activities can improve your baby's mood and make the mother-baby relationship grow stronger and more positive.



VII. Personal Project: Quick Mood Scale

Instructions: Every night, before going to bed, circle the number from 1-9 that best represents how you feel each day. At the bottom of each column you will find a line where you can make a note of how many pleasant activities you remember doing each day. See if there is a relationship between how you feel each day and the number of pleasant activities you do each day.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1
Number of PLEASANT Activities:	_____	_____	_____	_____	_____	_____	_____

OPTIONAL PROJECTS (pick one of the following):

1. Complete the *Pleasant Activities* List and keep track of your pleasant activities.
2. Pick two new pleasant activities and do them this week. You can fill out the *Personal Commitment Form* to make sure that you schedule and do your pleasant activity.
3. Talk to a mother of a new baby and find out two things that babies like to do.

MAKE A PERSONAL COMMITMENT

1) I plan to do the following:

2) I will do it by this date:

3) I feel this is important because:

OPTIONAL: Use the calendar below to schedule the activity to which you have committed yourself.

DAY:	DAY:	DAY:	DAY:
MORNING	MORNING	MORNING	MORNING
AFTERNOON	AFTERNOON	AFTERNOON	AFTERNOON
EVENING	EVENING	EVENING	EVENING



Contact with Others and My Mood

How to Get Support for Me and My Baby

CLASS OUTLINE

- I. Announcements/Agenda and General Review
- II. Personal Project Review
- III. Relaxation Exercise
- IV. Violet and Mary
- V. NEW MATERIAL
- VI. Take Home Message
- VII. Personal Project
- VIII. Feedback and Preview



I. Announcements/Agenda and General Review

Announcements/Agenda

General Review

What do you remember most from the last class?

- Doing pleasant activities can improve your mood and your baby's mood. There are many benefits to doing pleasant activities with your baby, including the fact that they make the mother-baby relationship grow stronger.
- Many of the things babies learn as they develop, they learn from us. It is important for us to communicate with our babies and encourage them to explore their environment and learn new things.
- Do you remember some fun things that babies like to do? Have you thought of any more new activities?
- There may be obstacles to doing pleasant activities, but there are ways to overcome these obstacles.



III. Relaxation Exercise: Teaching Your Child to Relax with You



- Your child will learn to calm down and relax, when he/she is frustrated, from the example that you set.
 - We recommend that you begin to teach your child these relaxation strategies early on. That way, it becomes easier to continue practicing these exercises with your child as he/she grows older.
 - **Ways to relax with your child (1 to 4 years of age):** Sing to your infant (or put on relaxing music) when he/she cries or when he/she is ready to eat or go to bed. Enjoying a relaxation exercise with your child will result in a strong and healthy bond between the two of you.
 - **Ways to relax with your child (5 years or older):** Continue practicing these relaxation exercises together to share in these pleasant activities. These exercises will also help your child when he/she is angry. For example, your child will begin to notice when she/he is stressed and learn to breathe to calm down, with the guidance of his/her mother.
 - The most important part of learning these exercises is to praise your child when she/he chooses to use them as a way to handle stress (for example, giving them a hug or star), instead of using a more destructive form (for example, hitting other children). In this way, your child will behave in a healthy manner and she/he will have more positive experiences with other children.
- It is important that you practice these relaxation exercises first so that you can then teach these strategies to your child. It is also important to keep in mind that it will take time for you and your child to realize the benefits of these exercises.

Ramos, Diaz, Urizar, & Muñoz (2002). Relaxation Methods for Managing Stress. SFGH/UCSF.

Remember: We can reach a healthy balance in our lives by becoming aware of how we react to stress, which is related to our external reality and our internal reality, and knowing how to fight the negative effects that stress brings. Remember that relaxation only takes a few minutes of your day. Practicing these exercises will bring you many benefits so that you can enjoy life to its fullest and enjoy your role as a mother.



IV. Violet and Mary's Days

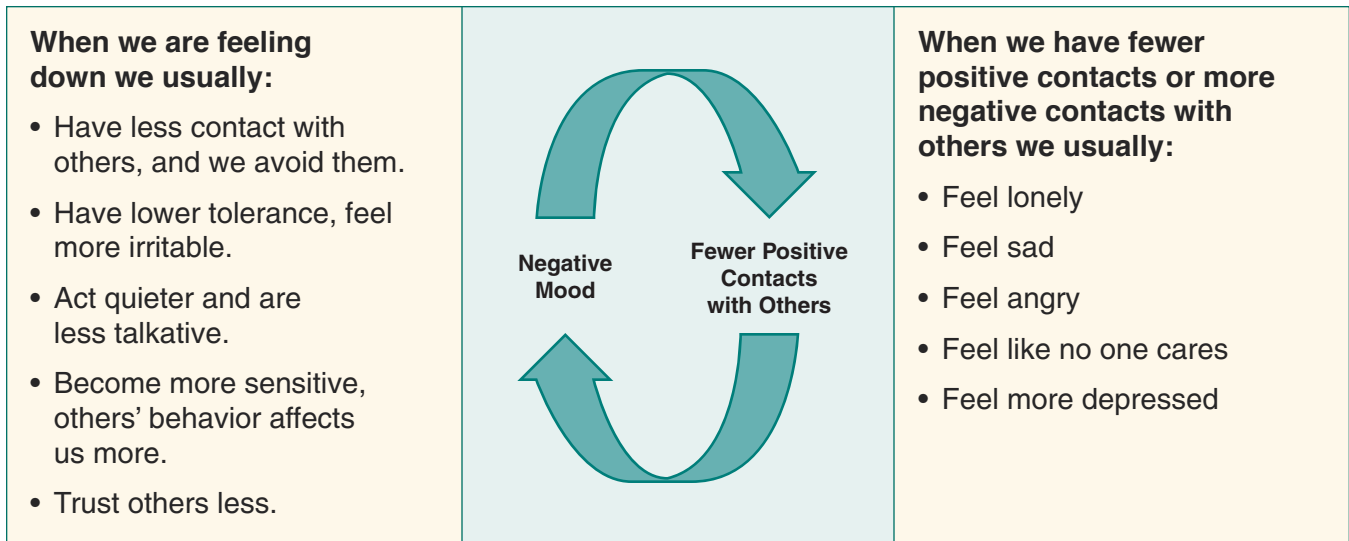
Instructions: Violet and Mary both recently gave birth, but now that their babies are born they are not sleeping well. Circle the number on each panel that represents what kind of mood you think each woman is having.

VIOLET'S DAY		MARY'S DAY	
9 8 7 6 5 4 3 2 1	<p><i>I'm so tired. I don't want to get up.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>I'm so tired. I don't want to get up.</i></p>
9 8 7 6 5 4 3 2 1	<p><i>I can't stand it. You cry too much. You're a bad baby, and I don't know what to do.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>Poor baby. What's wrong? Are you hungry? Are you hurting? Mama's here.</i></p>
9 8 7 6 5 4 3 2 1	<p></p>	9 8 7 6 5 4 3 2 1	<p></p>

ILLUSTRATIONS BY JOSIE THOMPSON, THOMPSON DESIGN



V.A. When I Am with Others, I Feel Better



Does a negative mood cause people to be less sociable OR does being less sociable cause a negative mood?

The answer is probably both. When we feel down, we are less likely to socialize. When we feel depressed, we do even fewer things with people. This continues until we are so depressed that we spend much of our time feeling alone.



V.B. People in My Life and the Ways they Support Me and My Baby

Instructions: Each square is for a different type of support that people can give you and your baby. Think about the people who fit each square and write their names in the square. The same person can be written in more than one square.

PRACTICAL SUPPORT	ADVICE OR INFORMATION
<p>Whom will you ask to:</p> <ul style="list-style-type: none">• drive you to the hospital? _____• call to lend you something you need? _____• help with babysitting if I don't feel well and need to rest? _____• would take me to the hospital if my baby gets sick? _____	<p>Whom will you ask for advice/information:</p> <ul style="list-style-type: none">• when you don't feel well? _____• when my baby is sick? _____• when you don't understand how to do something? _____• when something about my baby worries me? _____
COMPANIONSHIP	EMOTIONAL SUPPORT
<p>Who will:</p> <ul style="list-style-type: none">• walk around the park with you? _____• spend the afternoon with you? _____• help you with chores? _____• play with my baby? _____• teach my baby new things? _____	<p>Who will you look to:</p> <ul style="list-style-type: none">• for encouragement? _____• for understanding? _____• for help when you're feeling down? _____• comfort my baby? _____• make my baby feel loved? _____



V.C. Communication Styles and Your Mood

What's in the box?



3 TYPES OF COMMUNICATION STYLES		
COMMUNICATION STYLES	Respects Wishes of Others	Respects Own Wishes
Passive	Yes	No
Aggressive	No	Yes
Assertive	Yes	Yes

1. What is your main communication style?

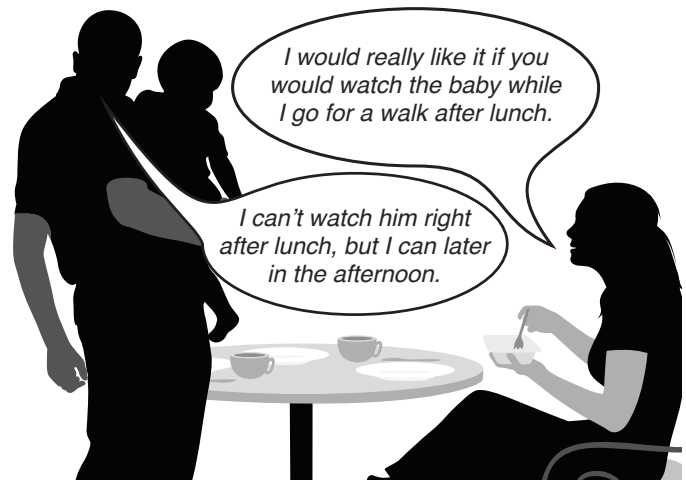
2. How does your communication style affect your mood?

3. How does your communication style affect your relationships with others?



V.D. Getting Your Needs Met

- It is okay to ask for what you need.
- To get your needs met, it is better to communicate in a positive, clear, and direct manner.
- When you ask for help from others, the more information you provide the easier it will be for others to help you. For example: “I want to attend a computer class on Wednesday from 1:00-3:00 pm.”
- There is a better chance (but no guarantee) that you will get what you want.
- The person may say “yes” or “no”. You may need to compromise.



STEPS	MY EXAMPLE
1. What do I need?	
2. Who can help me?	
3. Ask for what you need in a way that is clear and direct.	
4. Respect the other person's right not to do what you request.	
5. Be willing to compromise.	



V.E. What Keeps You from Expressing Your Needs?

1. How do you express your needs?
2. What situations prevent you from expressing your needs?
3. What would improve your ability to express your needs?
4. Do you feel that other people are able to express their needs better than you do?
5. Do you feel that other people express their needs more than you do?

If at any moment it becomes dangerous to speak your thoughts and feelings in a relationship, ask yourself:

- Do you feel that you have the same right as your spouse/partner to speak up about problems in your relationship?
- Do you feel that your needs are as important as the needs of your spouse/partner or other people in your life?
- Do you feel safe expressing your needs?

REMEMBER: YOU HAVE THE RIGHT TO FEEL SAFE!

If you or someone you know is being affected by domestic violence, there are services in the community that specialize in helping people with these problems. Tell your group leaders if you are in a relationship in which you are afraid you may be hurt physically or emotionally.



VI. Take Home Message

- Negative mood can cause people to have fewer positive contacts with others, and/or more negative contacts with people, and having fewer positive contacts with people can lead to negative moods.
- I can help manage my external reality by choosing to interact with different people in my life.
- There are people who can provide support for me and my baby.
- Being assertive can increase the chance that I can get my needs met.



VII. Personal Project: Quick Mood Scale

Instructions: Every night, before going to bed, circle the number from 1-9 that best represents how you feel each day. At the bottom of each column you will find a line where you can make a note of how many positive and negative contacts you had each day. See if there is a relationship between how you feel each day and those people you have contact with.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1
Number of POSITIVE Contacts:	_____	_____	_____	_____	_____	_____	_____
Number of NEGATIVE Contacts:	_____	_____	_____	_____	_____	_____	_____

OPTIONAL PROJECTS (pick one of the following):

1. Keep track of the number of positive and negative contacts.
2. Engage in a pleasant activity with someone who gives you support.
3. Practice the relaxation exercise that you learned today.



Interpersonal Relationships and My Mood & Graduation

CLASS OUTLINE

- I. Announcements/Agenda and General Review
- II. Personal Project Review
- III. Relaxation Exercise
- IV. Violet and Mary
- V. NEW MATERIAL
- VI. Course Review
- VII. Personal Project Review
- VIII. Final Activity
- IX. Graduation Ceremony and Celebration



I. Announcements/Agenda and General Review

Announcements/Agenda

General Review

What do you remember most from the last class?

- Negative mood can cause people to have fewer positive contacts with others, and/or more negative contacts with people.
- Having fewer positive contacts and/or more negative contacts with people can cause us to have more negative mood.
- There are different people who can provide support for you and your baby. Having support can help improve your mood and your baby's mood.
- There are three main styles of communication: passive, assertive, and aggressive. These styles can affect our relationships with other people.



III. Relaxation Exercise: Teaching Your Child to Relax with You



Let's choose one of your favorite relaxation exercises to do together today.



IV. Violet and Mary's Days

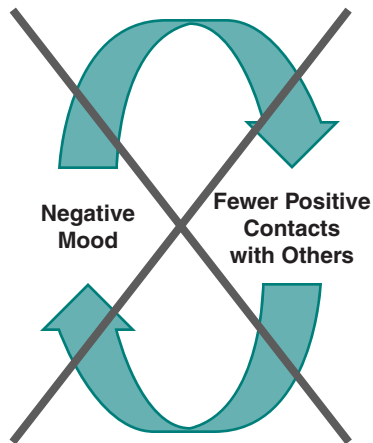
Instructions: Both Violet and Mary have a 1 year old baby. Circle the number on each panel that represents what kind of mood you think each woman is having.

VIOLET'S DAY		MARY'S DAY	
9 8 7 6 5 4 3 2 1	<p><i>I don't want to get up.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>I don't want to get up.</i></p>
9 8 7 6 5 4 3 2 1	<p><i>I don't feel like facing the day.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>My baby is acting fussy. I'll invite Carmen and her baby to see if they can come over.</i></p>
9 8 7 6 5 4 3 2 1	<p><i>I don't want to speak to anyone.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>Hello Carmen, Would you like to come over for a play date?</i></p>
9 8 7 6 5 4 3 2 1	<p><i>I feel so sad and lonely.</i></p>	9 8 7 6 5 4 3 2 1	<p><i>Carmen, I'm glad you came. The babies are having a great time playing together.</i></p>

ILLUSTRATIONS BY JOSIE THOMPSON, THOMPSON DESIGN



V.A. Can We Break this Vicious Cycle?



We are able to break this vicious cycle by:

1. Improving our mood:
 - doing pleasant activities.
 - changing the way that we think.
2. Reducing negative/harmful contacts with others.
3. Having more positive/helpful contacts with others.



V.B. Interpersonal Relationships and Depression: Role Change or

1. Having a baby can be both a joyous and stressful occasion. Having a baby can change the way you feel about yourself. Becoming a mother is a new role and can affect your mood. How does this role affect you and your mood?

2. Are there other role changes or role transitions that are helpful or harmful to your mood?

3. **Feelings:** What are your feelings about these changes?

- Write down or draw how you feel about these changes.

- Common feelings include being glad, mad, sad, anxious, and afraid.

- We often have many feelings at the same time.

A Reality Management Approach: How could you mold your reality now that your role has changed? To build a healthy new reality, you can use your thoughts, behaviors, and contacts with others.

4. **Thoughts:** What are your thoughts (helpful and harmful) about these changes?

5. **Behaviors:** What can you do to adapt to these life changes?

6. **People:** Who can help you adapt to these life changes?



V.C. Interpersonal Relationships and Depression: Role Disagreements or Disputes

Having a baby can change your relationship with other people for the better or the worse. Do you have problems with another person that affect your mood? Do you have problems/conflicts/arguments with another person that contributes to you feeling sad?

1. **Feelings:** What are your feelings about this person?

2. **Thoughts:** Think about the conflict(s) you had with this person over the past week.

- How does the conflict affect the way you view yourself?
- How does the conflict affect how you view the other person?
- How does the conflict affect the way you view the world?

3. **People:** Think about the person you are having problems with.

- What are his/her good points? What are his/her bad points?
- How do you think he/she sees the problem? (try to understand his/her point of view; even though you don't agree with it.)
- Is there a solution to the problem where you both get something important that you want?

4. **Behaviors:** When you have a problem with this person, how do you behave?

- Is this how you generally behave when you have problems with other people?
- When you have problems with this person, how does he/she behave?
- Are there things that you could do that would help shape the situation into one that is healthier for you?



V.D. Safety in Relationships is the #1 Priority

As you think about the conflict(s) you had, please evaluate your safety during the conflict.

1. Did you feel afraid or worried about your safety this past week?

Yes No

2. Did you or someone say something that was humiliating, intimidating or threatening?

Yes No

3. Did someone push, shove, kick, or hit you?

Yes No

4. Did you push, shove, kick, or hit someone?

Yes No

REMEMBER: YOU HAVE THE RIGHT TO FEEL SAFE!

If you or someone you know is being affected by domestic violence, there are services in the community that specialize in helping people with these problems. Tell your group leaders if you are in a relationship in which you are afraid you may be hurt physically or emotionally.



V.E. The Attachment or Bonding Relationship Between Parents and

Bonding or Attachment: The close emotional tie that develops between parents and babies.

See Bonus Materials for more information on your baby's development.



“Bonding allows you to transfer your life-giving love for the infant inside to caregiving love for the one outside. Inside, you gave your blood; outside, you give your milk, your eyes, your hands, your voice—your entire self.”

Sears & Sears, 1993, p. 43



V.E. Role Models for Me and My Baby

Role models have different meanings for different people. For some people, role models are people (fictional or real) who have positive qualities that make others look up to them and want to be like them. For other people, role models are people who inspire them to behave in ways that make their lives healthier and happier. As a parent, you are your baby's first teacher and your baby's first role model!

1. What are role models?

2. Who are your role models?

3. Who would you like your baby to have as role models?

4. How do you protect yourself and your baby from negative or unhelpful influences in your life (example: violent characters on TV)?

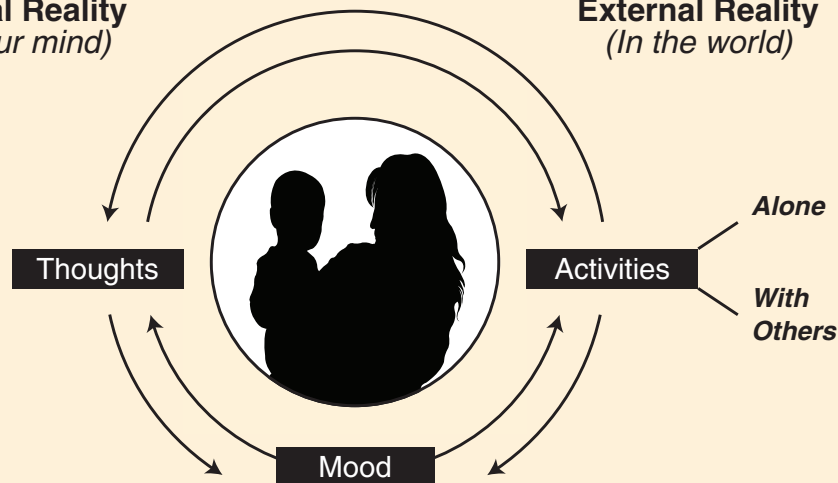


VI.A. Managing My Personal Reality

MY PERSONAL REALITY

Internal Reality
(In your mind)

External Reality
(In the world)



Promote parent-infant bonding using cognitive-behavioral strategies

Internal Reality: The world of your mind, which is yours and not observable by others. Only you have the “key” to your internal reality!

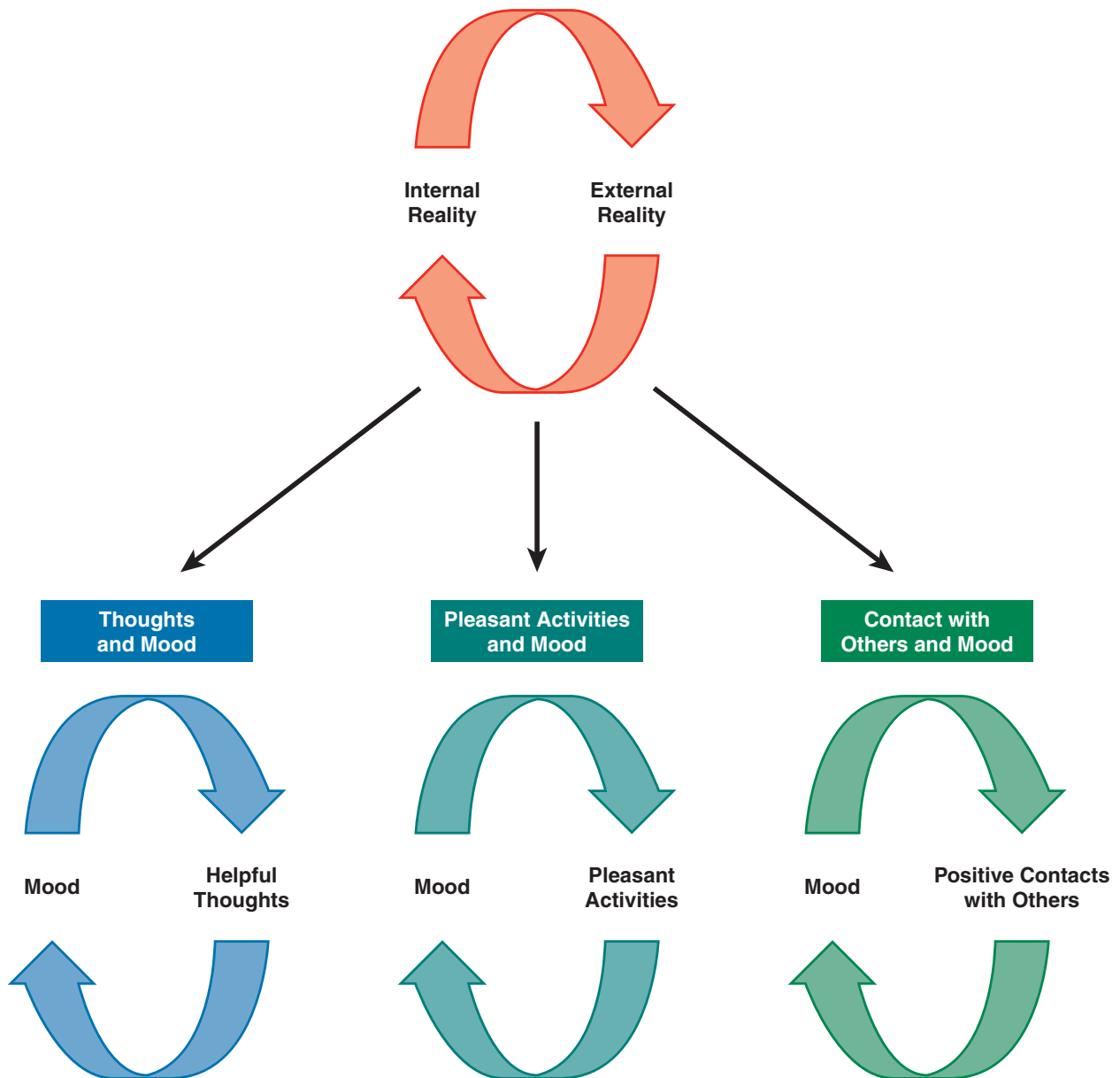
External Reality: The facts: parts of your reality that are observable and measurable.

Remember: Your internal and external reality can affect your mood. These realities affect your thoughts, the activities that you do, and your contact with other people. All these things affect:

- You
- Your baby
- The relationship between you and your baby
- The relationship between you and other people



VI.B. Creating a Healthy Reality for Me and My Baby





VII. Personal Project: Quick Mood Scale

Instructions: Track your mood every day using the Quick Mood Scale. It will help you learn to be aware of how you feel so that you can learn to have healthier moods and teach your baby to balance his/her moods. The seven columns represent each day of the week. Write down the date above each of the seven columns. Every night, before going to bed, circle the number (between 1 and 9), which indicates how you feel on that day. At the bottom, you will find a line where you can make a note of the number of thoughts, activities, and people contacts that you have. You can fill out the line that is appropriate to the module that you are working from or fill out all of the lines to see how these thoughts, activities, and people contacts affect your mood.

DATE:	_____	_____	_____	_____	_____	_____	_____
BEST MOOD	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
AVERAGE	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
WORST MOOD	1	1	1	1	1	1	1
Number of HELPFUL Thoughts:	_____	_____	_____	_____	_____	_____	_____
Number of HARMFUL Thoughts:	_____	_____	_____	_____	_____	_____	_____
Number of PLEASANT Activities:	_____	_____	_____	_____	_____	_____	_____
Number of POSITIVE Contacts:	_____	_____	_____	_____	_____	_____	_____
Number of NEGATIVE Contacts:	_____	_____	_____	_____	_____	_____	_____

OPTIONAL PROJECTS (pick one of the following):

1. Review the course materials, especially the activities that are meaningful to you.
2. Practice any of the relaxation exercises you learn in this course.



VIII. Final Activity: What Others Like About You!

Lined writing area for the final activity.

IX. Graduation Ceremony and Celebration

