PRACTICUM

THE USE OF COLLECTIVITY IN A SHORT-TERM PROGRAM FOR PARENTS OF DISCHARGED PREMATURE INFANTS

by

Susan Leona Bugaliski

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ABSTRACT

This report is based on a practicum experience where collectivity was used as an intervention tool in a time-limited open-membership program for parents of discharged premature infants. A review of the literature emphasized the benefits of peer contact in this population and indicated that these parents experienced a more difficult post-partum adjustment than did parents of full-term infants. The practicum involved the development and implementation of a collectivity (a less developed form of group) as the means of service delivery. The purpose was to provide a non-medical intervention to assist parents in the early months following the discharge of their baby from hospital. The goals of the program were to provide information and support to parents, to enhance their feelings of competency around baby care and to provide parents with brokerage service where appropriate.

Data collection tools involved a pre- and post program self-report of parents' functioning in terms of stress related to baby care, feelings of competency, satisfaction with support and feelings of satisfaction with one's present situation. Other data collection tools included a pre-program demographic questionnaire as well as a post-program evaluation interview with participants.

Empirical results indicated that most parents experienced a modest increase in overall functioning with greater benefits for those participants who did attend the program more often. Parents found the program a worthwhile experience and found the receipt of information and contact with other parents as most helpful. The evaluation data indicated that the use of collectivity was an effective means of service delivery to this population. Observations on the use of collectivity are given and several recommendations are made concerning future programming.

INTRODUCTION

Rationale for Development of Service to Parents of Discharged Premature Infants

In Canada approximately 7% of all births are preterm: this means that the baby is born between 25 and 37 weeks gestation (Banks, 1989). Because of prematurity, the majority of these infants require a course of intensive medical treatment or special care in order to survive. The baby is usually hospitalized until about the time of their due date. When the baby is finally ready for discharge home, the care of this baby is still not equivalent of that of a full-term (40 week gestation) baby (Ladden, 1990).

The literature indicates that parents of premature infants are at greater risk for attachment and parenting difficulties than parents of full-term infants (DuHamel et al., 1974, Mobel & Hamilton, 1981, Minde et al., 1980, Siefert, et al., 1983). A study by Hunter et al. (1978) found these babies to be at an eightfold greater risk for maltreatment during their first year of life. Their study suggested that parents with limited social supports and/or emotional reserve had difficulty forming a positive attachment to their premature child. The birth and care of a premature baby can place significant stress on the family, including both marital and sibling relationships (Cohen, 1982, Ladden, 1990).

At the time of discharge from hospital, the premature baby is not necessarily neurologically mature. As a result of this neurological immaturity, premature babies do not give easy-to-read signals and clues about hunger, tiredness and over stimulation. Premature babies often take longer to console and longer to develop reasonable eating and sleeping patterns. All of this can have a "disorganizing" effect on the parents.

Parents of discharged premature infants may experience what Helen Harrison (1983) calls "post-nursery depression." The parents are often already fatigued from daily visits to baby in hospital and then from frequent feedings and fussiness when baby comes home. Many parents feel anxious about caring for an infant who previously had 24-hour nursing care (Ladden, 1990). High anxiety levels experienced during baby's hospitalization period do not recede overnight. Also, the parents no longer have daily and supportive contact from nurses, doctors, social workers and other parents in the nursery. The parents may begin to feel alone and isolated. The need for peer support may not become apparent to many parents until after their baby is home and their formal association from hospital has ended (Cohen, 1982, Harrison, 1983, Henry, 1990, Ladden, 1990, Nance, 1982).

In the community, support groups for parents focus on either parents of full-term infants or parents of infants with special needs, i.e. Spina Bifida, Down Syndrome. Although these groups may meet some of the needs of parents of premature infants, these groups do not address the unique experience and concerns of caring for a premature infant. This may leave the parent feeling isolated within the group. The student's premise is that parents of a premature infant have a different adjustment period at home than do parents of a full-term infant and consequently they have needs of a different order. Currently, Winnipeg has no established support service specifically for the psychosocial needs of parents of newly discharged premature infants.

The social work practicum upon which this report is based involved the development, implementation and evaluation of a non-medical time-

limited outreach intervention for parents of premature infants who had been discharged from the special case nurseries at both St. Boniface General Hospital and Womens' Hospital in Winnipeg. The program, "Now That Baby's At Home ..." was a short-term preventative service that focused on the psychosocial needs of the parents in the early period after the baby came home from hospital. The program addressed issues identified in the literature as generic to this population that otherwise would be missed in the context of programs for parents of full-term infants.

The program worked with parents in the context of collectivity (a form of social group work) rather than individually, as this social context seemed to normalize the experience, reduce isolation, and offer more than one source of helping and support. Further, the literature reported extensively on the benefits of peer contact with this population (Boukydis, 1982, Dammers, 1980, MacNab, 1985, Meiers, 1978, Minde, 1980, Schosenberg, 1980). The collectivity also served to increase the potency of the helping relationship between the worker and individual members (Lang, 1986).

The student chose to develop a time-limited collectivity rather than an ongoing support group because of the transitional nature of the problems related to prematurity as opposed to the more permanent nature of conditions such as Spina Bifida. Also, there did not appear to be large enough numbers to spontaneously develop an ongoing support group despite the fact that premature infants represent a significant portion (5-7%) of all births. The limitations of the population, such as the short-term nature of the problem and demands on the population i.e., child care, fatigue, etc., lead to a high turnover in the parents and result in a lack

of continuity of experience and development of group (Lang, 1986). The resulting entity is a collectivity rather than a group.

The collectivity had a self-selecting open membership with very little restriction on attendance. Parents were invited to come out to the program as many times as they choose to attend. The program consisted of six evening sessions and met every two weeks. The collectivity relied on content and structure to provide continuity of experience.

For the purpose of the student's learning and the practicum, the program was repeated. The first program was held from September until December 1990 and will be referred to as Cycle I of the program. The program was repeated over February to April 1991 and will be referred to as Cycle II.

Objectives

The objectives of the program for parents of discharged premature infants were to provide participants with:

1. Information on topics of concern to parents at this stage of parenting.
2. Support to promote the resolution of baby's hospitalization and issues related to prematurity.
3. Competency. The program aimed at increasing parents feelings of being capable caretakers of their own babies.
4. Brokerage service to parents who have needs that are beyond the helping potential of the meetings.

The personal learning objectives of the student were:

1. Development of knowledge and skills in facilitating a collectivity.
2. To develop knowledge and understanding about the experience (needs) of parents of premature infants once their infant has been discharged home.

The student also wished to examine the possibility of St. Boniface General Hospital or Womens' Hospital continuing to offer the program after the completion of the practicum.

Organization of the Practicum Report

This report is organized into seven chapters. The report begins with this current chapter, Chapter One, and sets out the rational for the need for service to parents of discharged premature infants, and the practicum objectives. Chapter Two provides the literature review on the transition to parenthood and provides background information on premature infants and their families. Chapter Three contains the theoretical framework for the program. This includes an outline of small social forms, social group work and the use of groups in health care settings. This chapter also contains a discussion on collectivity as it relates to the practicum. The chapter concludes with a discussion on social support as it relates to both the transition to parenthood and as an element in collectivity.

Chapter Four, Practicum Methods, Procedures and Evaluation Instruments, reports on the planning phase of the program as well as the program structure and methods of data collection. Chapter Five, Practicum Results, reports on the findings of the outcome measures identified in Chapter Four. It also includes profiles of individual clients and

observations from process recordings. Chapter Six is an evaluation of the program as a whole, and draws on the student's observations of the collectivity and the program interventions. It also links the theory put forth in the literature review with what actually happened in the program. The final chapter (Chapter Seven) includes comments on the student's personal learning, recommendations for future practice and closing remarks.

CHAPTER ONE

LITERATURE REVIEW

The following review of the literature will focus on 1) the transition to parenthood and 2) premature infants and their families. Factors that contribute to stress experienced by parents during transition to parenthood will be identified. In addition strategies to assist parents in adaptation to this new role will also be discussed. The review will then focus on the experience and needs of premature infants and their parents. The review will consider the greater vulnerability of parents of premature infants during the period of transition to parenthood and will discuss the increased number of incidents of abuse and neglect among premature infants.

The Transition to Parenthood

"The transition to parenthood, as the term typically is used, refers to the fairly brief period of time from the beginning of a pregnancy through the first months of having a child" (Goldberg, 1988, p. xiii). The early literature on the transition to parenthood suggested that the birth of a couple's first child represented a crisis necessitating a major upheaval in the lives of the parents (Hobbs, 1965, Russel, 1974). Gottieb and Pancer (1988) rejected the concept that the event was a crisis. Instead, they viewed it as a normative transition process of adaptation and adjustment. This view of parenthood as a normative transition was first proposed by Rossi (1968) and then supported by Miller & Sollie (1986).

Rossi (1968) identified numerous factors that made the transition to parenthood more difficult than other role changes in adult life. These factors included: pregnancy was not always a planned event; infants had an

absolute need for the parent(s); parenthood was an abrupt and not a gradual responsibility; most role transitions were revocable, parenthood was not; there was a lack or at least a scarcity of formal or informal preparation for parenthood; the anticipatory stage of pregnancy failed to give one realistic training for parenting; and parents had few guidelines to tell them how well they are doing as parents.

Miller and Sollie (1986) suggested that roughly the first year of parenthood entailed a slight to modest decline in personal well-being and some increase in personal stresses for many parents. The baby could cause certain stresses arising from numerous child care tasks, a lack of sleep, feelings of overwhelming responsibility and a lack of time for self and spouse. Both Bennet & Slade (1991) and Gottlieb and Pancer (1988) suggested that new mothers experience these stresses more keenly than new fathers. Furthermore, many mothers were faced with hard decisions about the balance of motherhood and employment.

Miller and Sollie (1986) reported that new parents employed a number of coping strategies in response to this time of transition. Broadly stated, these strategies included adaptability and integration. Adaptability involved learning to live with a lack of predictability and schedules, learning patience, becoming more organized and becoming more flexible. Integration involved a recognition that parenthood is a shared responsibility, an attempt to maintain some activities that were engaged in before the birth of the baby, the use of both community and social support to strengthen individual responses to stress. Other indicators that parents had been able to integrate parenthood into their lives included finding satisfaction in caring for baby, being able to take some

time away from baby, and realizing that others were dealing with similar struggles and feelings about their baby. Parents also used looking to the future or realizing that baby care becomes easier as time goes on as another coping strategy.

The transition to parenthood appears to be a time of satisfaction coupled with stress and worry (Hoffman & Manis, 1978 cited in Antonucci & Mikus, 1988). If this is true for parents of a full-term infant, then it is likely to be even more true for parents after the birth of a high-risk infant.

Premature Infants and Their Families

Most parents planning to deliver a baby anticipate a safe birth, a joyful event and expect to leave hospital with baby in a few days after the birth of the child. Parents who deliver their infant prematurely have most of their plans and expectations shattered. The early birth of their baby is most often filled with feelings of guilt, anger, helplessness, fear and hope (Harrison, 1982, Kitcher, 1983, Nance, 1982). Although it may go unspoken, many parents fear the real or perceived threat of death or injury as a result of the baby's premature condition. Many parents felt that somehow the baby's prematurity was their fault. Few parents have ever faced a more distressing situation than the one that confronts them as parents of a very premature infant (Harrison, 1982).

As previously mentioned, about 7% of all births are preterm. This means that the babies were born between 25 and 37 weeks gestation and usually weighted between 600 and 2,500 grams at birth (Barbs, 1989). The premature baby's rate of survival depends on both gestational age and

birth weight. Babies weighing less than 907 grams (two pounds) have a slightly better than a 50 - 50% survival rate, but this increases to 90 - 98% survival rate if the baby's weight is more than 1,588 grams (3½ pounds) (Harrison, 1982). At least initially, most premature infants require intensive medical care in order to grow and develop. This may include life support, increased oxygen for respiratory difficulties, body temperature regulation, drug therapy, surgery, and intravenous feedings, etc.

While these babies have "extra" needs so do the parents. Briefly stated, the needs of the parents include:

Information. These parents need to be informed of their baby's progress and the implications of prematurity on the baby and the care of the baby.

Competency. These parents need to know that they play a vital and unique role in their baby's health and development regardless of the baby's need for medical intervention.

Support. These parents find it helpful to know that others have gone through a similar situation. Also, a premature birth places a strain on the family system.

Resolution. The parents need to grieve the loss of a full-term child in order to form an attachment to their pre-term infant. The parents also need to resolve the hospital experience. Often it is not until after the crisis has passed that parents begin to identify the strain that they felt when their baby was in the special care nursery.

These points will be elaborated upon in this section of the report.

Almost as soon as the premature baby's condition has stabilized, parents are encouraged to actively participate in some of baby's care needs, i.e., mouth care, cord care, bottle feedings, etc. However, as long as their baby remains dependent on medical staff for survival many parents feel more like a visitor to their baby than an actual parent (Cohen, 1982).

Parents may employ a variety of defence mechanisms to deal with their baby's hospitalization. Parents may avoid touching and/or visiting their child out of fear that bonding with the baby may leave them even more vulnerable to emotional upsets. Other parents may spend a great deal of time with baby and not attend to the care of their other children and responsibilities. Some parents find it easier to clutch at all types of medical information, i.e., blood-gas readings, heart rate, weight gain, etc., rather than relating directly to the baby in a non-medical comfort-giving role. Each of the baby's parents may cope differently with baby's hospitalization. A couple's different coping styles may make it difficult to receive comfort from each other and their relationship may experience much discord (Cohen, 1982).

Relatives and friends can be either a source of support or stress for parents. They may provide a listening ear, help the parents with the care of the other children, etc. They may also try to minimize a parent's anxiety and concern and this can often leave the parents feeling misunderstood and isolated. Sometimes relatives and friends are uncertain how to respond to the parents and may avoid them until the baby comes home from hospital. Another consideration is that one's extended family may

live far away and that friends may not be available to provide emotional and practical support because of their own schedules (Ladden, 1990).

The arrival of a new baby is often a time of upheaval for older children in the family. The birth of a premature baby can intensify these normal feelings. Children can sense the tension in the family and are often upset by the absences and preoccupation of the parents. The brothers and sisters need simple but honest age-appropriate answers about the new baby and mon and dad's concerns about the baby. Brothers and sisters may need some help forming an attachment with the new baby. Involving the siblings in projects for the baby may help smooth the eventual transition period when baby comes home from hospital (Harrison, 1983).

The premature infant's discharge from hospital is often looked upon by parents with mixed emotions. Hamelin (1991), Kaplan and Mason (1960) and Ladden (1990) reported that when premature infants were discharged from hospital parents may have experienced renewed anxiety, stresses and need for support. There was a relief that baby was finally home, but there may also have been some anxiety about now having to care for a delicate premature baby who only days or weeks before required complete medical support. Also, parents were often concerned that the very treatment needed to save their baby may later have an adverse effect on their child. Follow-up studies on premature infants showed that these infants were at greater risk for respiratory illnesses, poor weight gain, developmental delays or uneven developmental progress, learning disabilities and handicaps such as visual impairment or cerebral palsy (DuHamel et al. 1974, Harrison, 1983).

Premature infants frequently have uneven neurological development. These babies have been required to eat and breathe much earlier than term infants but will usually require more time to coordinate all of their body systems. For example, these babies when fatigued may be just as likely to become highly irritated as to act sleepily. These infants tend to have shorter attention spans, difficulty shutting out extra-stimuli, and tire more easily (Nance, 1982). All this creates a need for extra patience and understanding with the parenting of these infants.

Parents have legitimate reasons to be concerned about the development of their premature infant. Infants with a low birth weight (under 1,400 grams) are at greater risk of developing handicaps. It is difficult to predict the long-term outcome for a baby. Some babies with serious medical problems often turn out amazingly well (Harrison, 1983). Parents sometimes need to guard against becoming overly protective of baby or overly anxious about baby's developmental progress.

A developmental assessment once or twice yearly enables early identification of any weakness or delays in baby. The formation of a treatment plan helps these children overcome or compensate for a problem more quickly (Harrison, 1983). The prematurely born infant has his or her developmental age adjusted or rather "corrected" for prematurity. An infant's "corrected age" is the infant's calendar age minus the number of weeks baby was born early. For example, a six month old baby born at 32 weeks will have a developmental corrected age of four months. In other words, this baby would not likely be able to sit up alone for another two months or at a six months "corrected" age. Correcting for prematurity is important in the first two years of life when a few months can make a

great difference in terms of a baby achieving developmental milestones, i.e., sitting, crawling, etc. Even when a prematurely born baby's age has been corrected the baby may not reach developmental milestones according to the norm.

Parents of premature infants need to resist comparing their babies to term babies and even with other premature infants. Each premature baby is unique and babies with delayed early development can grow up quite normally (Nance, 1982).

In summary, the birth of a premature infant creates a unique experience for parents. It is very unsettling for parents to leave hospital without an infant and to spend weeks or months visiting an infant who was simply not supposed to be born yet. Even when these prematurely born infants are discharged home, parents are concerned that "something else is going to happen" to their baby. It can take time to resolve feelings of high anxiety and to settle into a "normal life." A prematurely born baby at 40 weeks (term age) is not the equivalent of a full-term baby. The post-hospital period is a time when contact with parents who have shared and coped with a similar experience can be most beneficial (Harrison, 1983). The literature reported the successful use of parent groups while the baby was still in hospital (Boukydis, 1982, Duhamel et al., 1974, Dammers, 1982, MacNab, 1985, Meier, 1978, Minde, 1980, Schosenberg, 1980). However, literature reported less extensively on the use of group support after the baby was at home. Harrison (1983), Henry (1990), and Nance (1982), report that peer support may have been of greater benefit to parents once their baby was home from hospital.

The Consequences for Parents of Premature Infants

Parents of premature infants have a vastly different hospital experience than do parents of full-term infants. They also have a different set of concerns for their baby at the time of discharge, i.e., the effects of long-term hospitalization on baby, caring for an infant that previously depended on highly trained medical staff, and concerns about normal development, etc. Therefore the post partum needs of parents of premature infants would differ from parents of full-term infants.

Bennett and Slade (1991) adeptly argued that infants born at risk place mothers at greater risk for problems in post-partum adjustment. Bennet and Slade (1991) conducted a study on mothers of these infants (53% of the sample were infants cared for in NICU) and found that these mothers experienced increased levels of emotional distress and depressive symptoms six weeks following the infant's discharge. In addition, these mothers perceived themselves as having more difficulty in expressing affection towards their baby. Bennett and Slade also found the mothers of infants born at risk reported greater dissatisfaction with the social support they were receiving from their social network than did mothers of full-term infants. However, dissatisfaction with social support did not extend to the infant's father. Fathers of pre-term babies have been found to be more involved in the care of their infants than those of full-term babies (Blake, Stewart & Turcon, 1975, Jeffocoate, Humphrey & Lloyd, 1978 cited in Bennett & Slade, 1991).

The consequences of the additional strain placed on parents of premature infants is born out in the literature. Beaton (1974) cited Stern who noted a strong relationship between prematurity and mother-

infant separation and child abuse. Hunter et al. (1978) reported in their study that premature babies were at an eightfold greater risk for maltreatment in their first year of life. Siefert et al. (1983) also found that premature babies were at higher risk for abuse and neglect. DuHamel et al. (1974) cautioned that the irritability and prolonged crying of these infants may increase parental frustration and lead to increased incident of child abuse.

Easterbrooks's (1988) article on the impact of infant risk on the transition to parenthood cited several sources who reported that there was indications that preterm infants were over represented in populations of nonorganic failure to thrive, and in populations of abused and neglected infants. The need of preventative services in this population is obvious. Siefert et al. (1983) conducted a study on prenatal stress and factors linked to parenting problems found that family closeness was associated with decreased likelihood of such problems. The study also found that family contact with a social agency was associated with decreased risk of parenting problems. These findings suggested that community resources, follow-up, and parent-support programs should be available for families of premature infants (Siefert et al., 1983).

In summary, the literature identifies the transition to parenthood as a time of greater stress in the parenting role. The literature also identifies the additional stresses placed on parents when their infant is born preterm. Furthermore, it also holds that the additional concerns and responsibilities for parents do not dissipate when the infant is discharged home. This additional strain increases the risk of subsequent abuse and neglect of these infants. It is evident that these parents as

well as their infants are populations at risk.

CHAPTER TWO

THEORY RELATED TO COLLECTIVITY AND RELEVANT CONCEPTUALIZATIONS

Theory Related to Collectivity and Related Conceptualizations

As outlined in the Literature Review, the need for peer support among parents of premature infants has ben well documented. Leiderman (1975), in a survey of parents of premature infants, found that these parents perceived other parents as persons best able to provide them with the kind of help they needed. The literature also makes reference to parent's need for support once baby is at home and formal ties with hospital staff have ended (Harrison, 1983, Nance, 1982). Harrison (1983) acknowledged that a parent's feeling of high anxiety about baby's health and development did not instantly recede once baby was at home. Cohen (1983) wrote that support can assist parents with the resolution of the crisis of a premature birth.

Given these findings in the literature, the student developed a voluntary short-term support program for parents of recently discharged premature infants. As the benefits of peer support were well documented, the student chose to work with individuals in a group-like setting (a collective) so that parents would have the opportunity to benefit from contact with other parents. The form of group work chosen as the method for working with this population was collectivity. The student borrowed from the literature on both collectivity and social group work in order to develop the framework for the intervention. The student wishes to point out that the term "group" has been loosely applied to many social forms. "This phenomenon has pervaded the helping professions, including social work, and has resulted in a lack of specificity with regard to the meaning of group" (Young, 1986).

For the purpose of clarification, a description will be provided for

the following types of small social forms: aggregate, collectivity and group. The Chapter will continue with a discussion of the social group work including the reciprocal model of social group work and stages of group development. The discussion on collectivity follows the section on social groups as an understanding of groups is central to understanding of collectivity, a less developed form of group. Under the topic of collectivity the student has identified paradigms of change in collectivity, the use of group work dynamics applied to collectivity, and a report on the use of collectivity in the literature.

Because of its relevance in working with parents of premature infants and to more generic issues in groups and collectivity, the student has included reference to the value of the use of groups in health care settings and has included a section on social support. In conclusion, various points in the preceding material will be applied to the program for parents of discharged premature infants.

Small Social Forms

Lang (1986) stated that an "array of small social forms has been lumped under the general discriptor 'groups' whether or not the activity attains the essential feature of small group and functions as a small group" (p. 7). This obscures group practice and masks the helping potential of less developed social forms. Lang identified a continuum of small organizational forms ranging from aggregate through collectivity to group:

Aggregate is the simplest of the small social forms. Hartford cited in Lang, (1986) described an aggregate as "a simple collection of people,

bounded by location, usually experiencing common influences, but having no common bond or significant interaction."

Collectivity in the helping professions has been described as an entity midway between an aggregate and a fully developed group. Lang give a definitional description of this as: [a] collectivity is likely to be lacking in shared, common group goals, and in such essential group phenomena as group autonomy, group cohesion, and procedures for pursuing collective goals through group-directed effort," (p. 203). Collectivity can have two meanings. The first describes entities capable of becoming a group but have not yet developed to that point. The second describes a more limited social form which is complete in itself. It is similar to but functions differently than a group.

Group is the more highly evolved social form. Theodorson and Theodorson cited in Lang, (1986) defined a group as:

> "A plurality of persons who have a common identity . . ., common goals and shared norms . . . . The group has direct or indirect communication among it members, standardized patterns of interaction based on a system of interrelated roles, and some degree of interdependency among members. According to this usage, a group is a more developed type of collectivity with a distinct sense of identity, and definite social structure, based on direct or indirect interaction among its members."

In a fully developed group, group dynamics function at a high enough level to enable the group to become an autonomous and cohesive entity.

Social Group Work

Social group work is the basic belief that a group is a helping system in which clients use and need each other along with the group worker to work on common problems (Schwartz, 1974). Although there are many types of groups, the two primary divisions in social group work are task groups and treatment groups. The practicum intervention drew from a type of treatment group the reciprocal or mutual aid model (Toseland & Rivas, 1984).

In the reciprocal model the group leader is a mediator who attempts to facilitate the group's functioning to achieve the optimum adaptation and socialization among its members. The members work together around common shared concerns and for a mutual aid system. The reciprocal model processes include the use of shared common experience, learning from the experience and resources of others, and the premise that it is easier to accept confrontation or direction from someone who has been through a similar experience. Also, as group members help an individual with a specific problem, they are helping themselves with their own similar concerns (Shulman, 1986). In the reciprocal model, the group worker is only one source of help in the group and works to make connections between individuals in the group and works to unleash the natural helping potential in the group. This model of group work is consistent with the literature on support groups for parents of premature infants and their need for peer support.

Stages of Group Development

Toseland and Rivas (1984) propose that groups change over time.

Group development can be categorized into four phases:

1. Planning;
2. Beginning;
3. Middle; and
4. Ending

The planning phase entails all the worker's actions toward forming the group. The importance of this phase should not be ignored as it lays a foundation for the group. Tasks involved in the planning phase involve establishing the group purpose and clarifying its role with the sponsoring body or host agency, establishing group objectives, preparing group content, recruiting members, composing the groups and preparing the group meeting space.

Gitterman (1982) wrote on the use of groups in health care settings. He cautioned his readers that organizational forces can promote or restrain the development of group service. He suggested that part of planning a group was to ensure support of both upper administration and horizontal interdisciplinary and peer staff involvement. Other staff need to have their own self-interests addressed to ensure cooperation i.e., to ensure referral of appropriate clients, etc.

In the beginning stage, groups are very dependent on the leader for structure, cohesion, accomplishment of goals, etc. A true group then develops into a more self-functioning middle phase. In the middle phase the group dynamics have developed sufficiently for the groups to become more self-regulating and lessen the influence of the worker on the group. The interaction pattern is characterized by member-to-member interaction as opposed to worker-to-member dyadic functioning. The group becomes an

autonomous and cohesive entity (Young, 1986). Autonomy happens when the group dynamics operate at a significantly high enough level that the group develops a "life of its own."

Lang (1986) wrote that social entities missing the properties of a developed group are not a "true" group but are rather a less developed entity i.e., a collective or aggregate. Many forms of social entities, however, are commonly, although erroneously, labelled "groups."

In the ending phase of a group the worker must help members close the group's work. It is not uncommon for members to have some ambivalence with termination. The worker can help members by empowering them with feelings of potency that they are capable of accomplishing goals in their lives (Toseland and Rivas, 1984). The ending phase is also a time for members to look at maintaining individual accomplishments and identifying supports in their own networks.

Group dynamics of cohesion, norms and mutual aid will be discussed in a later section under collectivity. The Chapter continues with a report on the use of groups in health care settings.

Why Use Groups in Health Care Settings?

Groups have a broad potential for social service delivery and are used in various settings. Gitterman (1982) noted that groups are perceived by agency administration as economical and effective. Rutchick (1990) wrote that groups in health care settings were receiving growing attention as a means to treat psychosocial aspects of disease, to reduce psychological stresses that accompany changes in one's health status and as a preventative and supportive approach to assist individuals coping

with "normal" life stresses. Groups that address life transitional issues may be both a preventative as well as a rehabilitative service (Glitterman, 1982). Dobrof et al. (1990) concurred with the above and noted that, for some persons, an individual treatment approach accented loneliness and isolation.

Groups provide opportunities to trade and share experiences and insights and to develop socialization skills and social networks. The skills learned in group can be transferred outside of the group and can assist one to be better able to interact with others in their community (McGuire & Gottlieb, 1979 cited in Gottlieb & Pancer, 1988). Both Dobrof et al. (1990) and Rutchick (1990) acknowledged the therapeutic benefits of emotional catharsis, information sharing, role modelling, anticipatory guidance, normalization and peer support in group. Effective use of groups in health care settings can enhance an individual's method of coping and the quality of their life as well as decrease patient misuse of medical appointments for psychosocial issues (Dobrof et al., 1990).

Collectivity

A definition of collectivity was given in the earlier section on small social forms. Collectives may be a social form deliberately chosen for its appropriateness for a particular helping endeavour. Also, collectives may be the resultant entity when an intended group was arrested in development by the operation or presence of particular variables. Group variables that create collectivity include: insufficient time per session or in the program to generate a group experience; the meeting space may not be conducive to the needs of a group; the

individuals may not have the social skills necessary to participate in a group; individual membership may be of a short duration; there may be a poor compositional fit among individuals with a resulting lack of commonalities; and an over representation of group workers or the worker may 'over-control' the group process. These variables may operate singly or in combination and shape the various helping capacities of collectives.

If a practitioner does not recognize a collectivity for what it is it may be seen as a 'failed' group. Consequently, the usefulness of the entity is lost. The helping capacity of a collectivity differs from a fully developed group. Because collectives lack group development, cohesion, autonomy and integration, the principal interaction between worker and participants holds central importance and may be considered the equivalence of certain central group processes. In collectivity, the dynamics of change are different than those related to practice in a group (Lang, 1986).

Paradigms of Change in Collectivity

Lang (1986) has identified four paradigms of change employed in collectivity. These paradigms are:

1. Learning Paradigm. The dynamics of individual change arise in a teaching - learning relationship i.e., knowledge = change in behaviour.
2. A Relational Paradigm. The relationship between the worker and each individual participant is primary but this relationship is not expected to have sufficient potency

without the social context of the collectivity to reinforce the individual endeavour.

3. Social Compliance Paradigm. Participants are socialized to a learned procedure through a social comparison process that induces and reinforces compliance.

4. A Change Endeavour Paradigm. This paradigm suggests that change does not rest on relationships or content but rather on a brief single interactional process with strangers.

The paradigm for change utilized in the collectivity for the program was the relational paradigm. The presence of other parents of premature infants was a vital part of the collectivity. It strengthened information imparted to parents as well as validated experiences shared by parents.

Group Dynamics Applied to Collectivity

Collectives can be an effective means for members to achieve individual (as opposed to group) goals, to gain information and to influence behaviour change in a short-term program (Bothwell & Eisenberg, 1986). Although collectives differ from groups, many of the same group concepts and opportunities are present but in a more restricted scope (Clarke, 1986). Pappel and Rothman (1986) wrote that many mainstream group principles operated in collectivity. The student will consider the dynamics of cohesion, norms and mutual aid within the context of collectivity.

Cohesion

Individuals join and/or remain in collectives/groups because of

cohesion. Cohesion provides a sense of "we-ness" and holds individuals together. Individuals are attracted to collectives and groups for reasons such as the need for affiliation, for the resources and activities available in the entity and because of expectations about the beneficial consequences of participating in a collective or group (Toseland and Rivas, 1984).

Cohesion is present in collectives but to a less developed degree than in groups. Cohesion is an important dynamic for the effectiveness of a collectivity. Structured procedures may provide a sense of cohesion, especially in open membership collectives with a different composition of individuals for each session (Lang, 1986). Structure in the collective also helps to provide some continuity between sessions.

Sulman (1986) reports that in collectivity the worker must take greater responsibility and more direct action to generate cohesion. The worker needs to point out commonalities and to build ties between members. This can be a difficult task because a collective mimics the beginning stages of group formation over and over. The worker may have to re-build cohesion in each session and cannot necessarily rely on cohesion to carry over from session to session. However, the worker can attempt to increase cohesion and conformity between sessions by summarizing the content of previous sessions (Sulman, 1986).

Norms

Norms are a shared belief about what is appropriate behaviour. Norms stabilize and regulate behaviour in collectives and groups. In a group, norms develop over time. As the collective usually has a shorter

life span and is less autonomous than a group, there is limited opportunity for norms to develop. Therefore the worker is responsible for the provision and regulation of norms.

Mutual Aid

Mutual aid is a group dynamic that has been extensively described by Shulman & Gitterman (1986). Mutual aid has been defined as "a helping system in which clients need each other as well as the worker. This need to use each other, to create not one, but many helping relationships is a vital ingredient of the group process" (Shulman & Gitterman, 1986). Mutual aid is a healing tool created by members empathizing with each other in a non-judgemental caring way. To learn that someone else has similar concerns is a powerful experience. Mutual aid builds the condition for members to learn new skills and methods of responding to problems.

In collectivity because opportunities for mutual aid are less likely to be repeated than in a fully-developed group, the worker must capitalize on opportunities for caring and intimate exchange. This means that the worker needs to take risks to make connections between participants in collectivity as there is less time and/or sufficient group development that would allow this to occur spontaneously (Sulman, 1986). Clarke (1986) used single session collectives in a paediatric Spina Bifida clinic to create an atmosphere that encouraged mutual aid between the participants. Clarke noted that natural helping networks can arise out of collectives.

Cohesion, norms and mutual aid are components in collectives as well as in groups. In collectives, however, these components are present to a

lesser degree than in a group. Further, the worker is relied upon heavily to generate cohesion, norms and mutual aid in collectivity.

Stages of Group Development in Collectivity

Groups develop and change over time, however, Sulman (1986) noted that a collective "mimics . . . beginning stages of group formation over and over again." Consequently, the worker's role in a collective is very much like the worker's role in the beginning stages of a group. Especially in open-ended collectivities the worker and participants have the ongoing task of continually making acquaintances and building relationships.

When collectivity is the intended social form there is little likelihood that the entity will go on to develop into a true group. This should not be considered as a negative factor because when collectivity is recognized for what it is, rather than for what it is not, collectives are a significant helping entity (Lang, 1986).

Collectivity in the Literature

Reports on collectives in social group work is sparse and under-developed (Lang, 1986). The literature makes no specific mention of the use of collectivity with parents of premature infants. However, the literature does report on the use of collectives with individuals facing other health-related issues. For example:

1. Clarke (1986) used single session collectives with parents of children with Spina Bifida.
2. Bothwell and Eisenberg (1986) used time-limited collectivity

with cardiac patients and spouses.

3. Warren (1986) used collectives in the community with ex-psychiatric patients.

4. Sulman et al. (1986) used collectivity with an elderly population in an acute care hospital.

The available literature found collectivity to be a useful alternative method of working with various populations when the development of a group was impractical i.e., due to time limitations, nature of the issues, etc. Bothwell and Eisenberg (1986) found that, aside from offering support, information and mutual aid, collectives were capable of influencing behaviour change in short-term structured programs.

Clarke (1986) supported the usefulness of collectivities to serve clients in life crisis or in life transitions. The purpose of such collectivities tended to serve a specific client need. These collectives most often were short-term and had an open member composition. Clarke encouraged social workers in health care settings to make greater use of collectives to address the psychosocial needs of patients and their families.

Social Support

Social support has important implications for primary prevention (Dean & Lin, 1972) as a buffer against the negative effects of stress (Brown, 1986, Gottlieb, 1987) and can restore one to a pre-crisis level of functioning (Lee & Swenson, 1986). Social support is a particularly important means of countering increased physical and emotional demands and other stressors faced by new parents (Bennett & Slade, 1991, Gottlieb &

Pancer, 1988, Miller & Sollie, 1986). Bennett and Slade (1991) hypothesized and confirmed that social support plays ". . . an even more crucial role after the birth of a high-risk infant" (p. 160). Social support has been identified as relevant in reducing the likelihood of maladaptive parenting (Turner & Avison, 1985) and of reducing the occurrence of postpartum depression in a population of mothers of high-risk infants (Bennett & Slade, 1991).

Social support focuses on the relevance and significance of human relationships (Turner & Avison, 1985) rendered by non-professional helpers (Lee & Swenson, 1986). Social support is related to but has a much more diffused base than mutual aid (Lee & Swenson, 1986). Gottlieb and Pancer (1988) propose that four types of social support are called for to meet the needs of parents during the postpartum adjustment period. These types of support are:

1. Emotional Support includes expressions of esteem for the individual, confiding interactions, ventilation of feelings and insecurities. Emotional support fosters feelings of self-esteem and provides validation about an individual's feelings about himself or herself and their situation.
2. Cognitive Guidance consists of advice and normative information about an individual's handling of a situation or plans for handling situations. It is typically called upon when decisions must be made about ways of handling present or anticipated demands. It is provided by social network members either through direct discussion of the situation or through the process of social comparison.

3. Tangible Aid consists of resources extended (without costs) by others. This includes gifts, loans and favours i.e., babysitting.

4. Coherence Support conditions an individual's appraisals of their ability to withstand or come to terms with turbulent or stressful situations. Coherence support provides parents with confidence that they will be able to accommodate changes wrought by the transition to parenthood in their personal life and marital relationships.

Bennet and Slade (1991) identify the sources of support as intimate relationships, friendships, and neighbourhood or community contacts.

Social support cushions the stressors experienced by new parents. There is a paradox though in that many new parents are relatively housebound and often fatigued and have difficulty obtaining adequate support from their social network just when it is most needed. The mobilization of social support may be restrained by a parent's concern that he or she may be perceived as inadequate or concern that they may have to reciprocate the help. Also, a parent's overwhelming need for assistance may adversely affect potential sources of support (Gottlieb & Pancer, 1988).

Bennett and Slade (1991) found that mothers of at-risk infants experienced inadequate social support. The authors suggested that either high levels of support may have diminished by the time the infant was discharged home or that in this population there was an increased need for social support with an average level perceived as insufficient. Another problem with social support for new parents of full-term infants, and

especially for parents of premature infants is the possibility that persons in their network lack understanding of the special strains the parents are experiencing and hence they may withhold support (Easterbrooks, 1988, Gottlieb & Pancer, 1988).

"Social support may come form sources other than established networks of family and friends" (Gottlieb and Pancer, 1988). For example, other parents who have undergone similar experiences with their own pregnancies and infants are a common source of support (Easterbrooks, 1988). Gottlieb (1987) postulated that group consensus can counteract negative stressors and promote a normalizing effect far better than feedback from a lone individual. He adds that support-group interventions expanded an individuals social world and offered many new possibilities of support. Further, Gottlieb held that at times of transitions, such as new parenthood, contact with a support group could provide more relevant contact than with members of one's own network. It is noteworthy that McGuire and Gottlieb cited in Gottlieb & Pancer (1988) found that participation in support group can encourage greater reliance on informal supports available in the parents' own social networks. Gottlieb (1988) concluded that one of the primary functions of social support was the reduction of uncertainty either through direct feedback or through social comparison.

Summary

This chapter has reviewed the literature on social group work, collectivity, the relevance of groups in health care settings and the concept of social support. This material was reviewed as a prelude to the

use of collectivity in a short-term program for parents of recently discharged premature infants.

The need and benefits of peer contact for parents of premature infants has already been established. Group work has been the long-favoured choice for working with a collection of individuals in a single setting. The student, however, chose to use collectivity rather than a group. Collectivity provides many of the same opportunities for the pursuit of individual goals as does a group. Further, collectivity has been found to be an effective means of imparting information, influencing behavioral change and providing support in short-term programs (Bothwell & Eisenberg, 1986). It also has been found to be able to provide an opportunity for the establishment of a mutual aid system (Clarke, 1986).

Collectivity places parents in contact with other parents thus creating opportunities for social support and increasing the size of their network. Gottlieb (1987) wrote on the provision of social support and emphasized that at times of transition one's own network may not be able to provide the specific form of social support needed. He advocated the use of support groups for the provision of social support around such specific needs i.e., medical issues, transition to parenthood. The student advocates that collectivity is also an effective vehicle for the provision of social support. The student further advocates that the rationale for the groups in health care setting also applies to the use of collectivity.

Finally, the use of collectivity rather than a group fits with the student's proposed program for the reasons cited in Norma Lang's (1986 Social Work in Small Forms: Identifying Collectivity. The student's

reasons for using collectivity include:

1. Time frame of six sessions is too brief to allow the entity to become a group.
2. For the most part, the problems that result from the baby's early birth and hospitalization are transitory and not a permanent health issue such as Spina Bifida. In other words, as the baby grows and develops there is less of a need for affiliation with other parents who's infant was preterm.
3. The program had an open membership as it was anticipated that there would be a high turnover and fluctuating attendance. This would have led to limited opportunity for a continuity of experience that would enable a sense of "groupness" to develop.
4. While the shared experience of having had a premature infant is a cohesive factor, an entirely homogenous population is unlikely as the parents are from various social and economic backgrounds. This could have interfered with a sense of "groupness."
5. The parents faced mitigating circumstances such as a sick baby at home, a lack of child care or transportation and needs of other family members all of which may prevented parents from investing meaningful time and effort in attending the program. Likely this would have circumvented the development of leadership roles among members.
6. The sessions are structured and are leader-focused rather than focused on interaction between participants. This precluded

the development of a sense of autonomy in the program.

The rationale for the use of a short-term collectivity as a means of service delivery for parents of discharged premature infants has been established in this chapter. The following chapter will focus on the implementation of the program.

CHAPTER THREE

PRACTICUM METHODS, PROCEDURES AND EVALUATION INSTRUMENTS

Practicum Methods, Procedures and Evaluation Instruments

The student's practicum took place under the auspices of the Department of Social Work at St. Boniface General Hospital in Winnipeg between August 1990 and June 1991. Because the student wished to work with parents of recently discharged premature infants at both St. Boniface General Hospital and Health Sciences Centre, the student contacted the department heads of neonatology and head nurses of the special care units (for premature infants) at both hospitals to ask for their cooperation and support of the program. The student also informed the Head of Social Work Services for Womens' and Childrens' Hospitals at Health Sciences Centre of the project before proceeding with including parents of Health Sciences Centre in the program (refer to Appendix A).

The student's practicum was a short-term six session program for parents of recently discharged premature infants. The practicum consisted of two cycles of the program. The first cycle ran from September until December 1990 and will hereafter be referred to as Cycle I. The second cycle ran from February to May 1991 and will be referred to as Cycle II.

Member Eligibility

Individuals eligible for the program were parents of recently discharged premature infants from St. Boniface General Hospital and Health Sciences Centre in Winnipeg. The term "recently discharged" premature infants was defined differently in each cycle of the program. This resulted in a different member composition for each cycle of the program.

In Cycle I a "recently discharged" premature infant was defined as an infant six months corrected age or younger. This definition was used

because the student wished to achieve a composition of parents all engaged in adjusting to bringing their premature infant home from hospital. This resulted in a group of parents with similar needs and issues, but it also probably contributed to a small turnout of parents. In Cycle I, only five parents came out to the program.

In Cycle II a "recently discharged" premature infant was redefined to include infants up to one year chronological age. This change was based on feedback from individuals in Cycle I. The parents pointed out that limiting participation to those parents whose infants were six months corrected age or younger was too restricting and not helpful to parents. They pointed out that most parents felt reluctant to take their baby out to stores, social gatherings etc. until after the infant had been home for two or three months. The parents also indicated that they would like to return for Cycle II but they did not think they could do so unless the parents of older infants could also be eligible for the program The student acted on the suggestions of the parents and this resulted in a larger turnout. In Cycle II, fourteen parents came out to the program. These parents had a greater variation in the age range of the infants and in the needs and issues of the parents than in Cycle I. This however, proved to be amendable to the overall functioning of the program.

Recruitment

The recruitment of eligible persons for the program primarily involved a process of self-selection. However, the student used various means to recruit parents to the program. In both Cycle I and Cycle II, the primary means of recruiting parents was by the availability of the

program. A pamphlet describing the program (see Appendix C) was made available to parents of hospitalized and recently discharged premature infants. Parents could then make their own decision as to whether or not they were interested in attending the program.

Pamphlets were on display in the Intermediate Care Nursery at St. Boniface General Hospital and at Health Sciences Centre (T-1 Nursery). The student requested that the nursery nursing staff distribute the pamphlets to all parents of infants discharged from these nurseries. In an attempt to avoid parents feeling that they were singled out for the program to avoid confusion for staff about to whom to distribute the pamphlet, the student asked that the pamphlet be given to all parents regardless of whether or not they resided in Winnipeg. Although the student made this request there was no means of enforcing this request in either hospital. In all likelihood many eligible parents did not receive the pamphlet.

Other ways of recruiting parents to the program included distribution of the pamphlet through hospital nursery social workers, public health nurses and by the student going into the nurseries to visit soon-to-be eligible parents to invite them out to the program. The student also advertised the program on the Community Access Channel on television. The use of these methods of recruitment are discussed as follows:

Hospital Social Workers in both Cycles I and II were requested to pass along the pamphlet to parents whom they thought might be interested in attending the program.

Public Health Nurses were asked to pass on the pamphlet to parents

whom they felt were appropriate for the program. In Cycle I the student distributed program pamphlets to only a limited number of public health nurses on an ad hoc basis. In Cycle II the student made a systematic distribution of the program pamphlet to the City and Provincial Offices of the Public Health Nurses for the City of Winnipeg (See Appendix B). The student also included an outline of the program objectives for the nurses. Public health nurses continue to have access to parents once the premature infants are discharged from hospital. They are an important resource in recruiting parents for the program. This resource was probably under utilized by the student in Cycle I.

Community Access Television was contacted in Cycle I to ask that an advertisement for the program be placed on their roster of community events. Although the advertisement was placed on the channel, pertinent information was left out. The student attempted, without success, to correct this situation. Because of this unsatisfactory experience, the student did not pursue this means of recruitment in Cycle II.

Direct contact with parents in the nurseries was made late in Cycle I. Almost all parents who were approached were receptive to hearing about the program and to having the student "admire" their baby. The length of meetings between the student and parents varied from 5 to 30 minutes or longer.

Some parents used this time with the student to talk about their concerns about baby, and a number of parents volunteered information about their personal circumstances. On several occasions the student suggested community resources applicable to the parents' situation. The student also let the parents know that she was not the unit social worker but

could put them in touch with that social worker if they so desired. On average, the student made one visit a week to the Intermediate Care Nursery at St. Boniface General Hospital and to the T-1 Nursery at Health Sciences Centre. The student continued this form of recruiting in Cycle II. However, it was suspended temporarily because of the province wide nursing strike during January, 1991.

The number of parents contacted during these visits is recorded in Appendix D. The student had contact with some parents on more than one occasion but only first time contacts are recorded.

Program Structure

The program "Now That Baby's at Home ...." consisted of six sessions of inter-related topics focusing on adjustment issues generic to parents who had recently brought their premature baby home from hospital. The sessions were 1½ hours in length and were held bi-weekly over a three month time span. This program schedule was chosen to strike a balance between providing support to parents and encouraging parents to reach out and develop their own network of support. It was hoped that parents with limited social supports would choose to seek out support from other parents between sessions.

For the purpose of the student's learning and the practicum, the program was repeated. The first program was held from September until December 1990 and will be referred to as Cycle I of the program. The program was repeated over February to April 1991 and will be referred to as Cycle II.

In both Cycle I and Cycle II, the meetings were held at 7 p.m. on

Tuesdays. This meeting time was chosen to enable parents employed during the day to attend or to provide child care (if so required) so that the other partner could attend the sessions. It was left up to parents to decide whether or not to bring the premature baby to the sessions. Although some parents felt more secure leaving a very newly discharged baby at home, the majority of parents brought their infants to the sessions. This eased the problem of looking for a baby-sitter capable of caring for a premature baby.

The babies became an important part of the meetings. The babies were an easy and natural way for parents to connect with each other. Also, parents received a lot of validation from each other for their baby's growth and development and support when their baby was fussy during a session. The student enjoyed the inclusion of the babies in the meetings, even if it sometimes meant that there was a need to balance the session agenda with infant crying and the need for diaper changes.

Parents of recently discharged infants are a transitional population: therefore the program had an open membership composition. The needs of these parents are immediate and the open membership accommodated new members without making them wait for the next cycle. Also, the open membership meant that members who discontinued attendance could be replaced by new parents and this enabled the program to continue despite some fluctuation in the attendance. The open membership also enabled parents to participate at the level to which the felt comfortable.

Because of the many demands and responsibilities on new parents it is difficult for them to get out of the house for almost any reason. Therefore, the student felt that it was important to make parents feel

welcome whether they choose to attend one session or the entire program. The program was completely voluntary and based on self-selection. A core of members did develop and this helped to add some continuity in the program.

There were some disadvantages to an open collective membership such as loss of cohesion because of a changing composition of members. The open membership also likely arrested the formation of a fully developed group. Nevertheless, the advantages of open membership outweighed the disadvantages.

Description of the Setting

The "Now That Baby's at Home ..." program was held in the Nursing Education Building at St. Boniface General Hospital. The location was easily identifiable and centrally located in Winnipeg. Parking was available on the street or in hospital lots. The group met in a room called the front parlour. It was an attractive spacious room comfortably furnished with sofas, upholstered armless chairs, coffee tables and several over-sized long wooden tables. Washrooms, telephones and a night receptionist were in close proximity of the meeting room.

The student quickly found out that a large space was needed as parents arrived loaded down with babies, car seats, diaper bags, coats etc. There were times when several babies were fussy and crying at the same time. The size of the room seemed to help absorb this noise. This reduced the interference of fussy babies during meetings whereas a small meeting room likely would have magnified the noise level. The main meeting area was a circle of chairs and the large room allowed parents to

leave the circle to attend to baby and yet to remain at least partially connected to the group.

In Cycle I the student had a coffee table in the centre of the chairs and this seemed satisfactory. Mid-way through Cycle II the babies were growing and could no longer be easily accommodated on parents' laps. The student decided to remove the coffee table and replace it with blankets and toys to create a play area for the babies. The student was surprised to find that the coffee table had been like a structured barrier in the group. The central play area made it easier for parents to have causal and informal contact with each other while attending to their babies. Also, this arrangement was much easier for parents to attend to active babies during a meeting. The student would recommend that other practitioners working with similar populations consider including a play area for infants as a focal point in the physical setting.

Leadership/Role of the Collectivity Leader

The student as collectivity (group) leader played a central role in the program. In the sessions, tasks related to the planning, structuring and facilitation remained the responsibility of the student. This heavy reliance on leadership was seen as necessary to the program given the characteristics of the population. Parents of premature infants are besieged by the care of their infants and there is little available time to take on the tasks of leading a group. Furthermore, the short duration of the program and the transitional issues of this population allowed little time for a leadership role to emerge among the members.

During the program the student was the sole leader. The student did

have guest speakers in for two sessions in both Cycle I and Cycle II to address a specific educational topics, i.e. infant development, infant feeding. However, the speakers did not serve as co-leaders. Co-leadership might be desirable if meetings averaged eight or more members, but as most meetings averaged six or fewer participants co-leadership would have resulted in leader-heavy sessions.

The student, as collectivity leader, filled several roles in the program. Aside from the primary task of facilitator, this role included providing information, support, continuity and brokerage service to members where appropriate. Information was provided in a session by the student organizing a short presentation on a selected topic and then facilitating the ensuing discussion on the topic. Support was provided to members by validating their concerns, experiences and allowing time for an open-topic discussion for parents to voice any other concerns of relevance to them that week. The leader facilitated these discussions and attempted to find some commonalities between an individual member's concerns and that of the larger group. Providing links between members and between the topics presented served to provide continuity in the sessions. The student filled the role of providing brokerage service both inside and outside of sessions with members. Some members seemed more comfortable disclosing emotionally laden issues (i.e. family alcoholism), outside of the collectivity and the student attended to these concerns on an individual basis. The student directed members to a variety of community resources throughout the program.

Size of the Collectivity

The size of the collectivity varied in each cycle of the program. In Cycle I attendance was low. The average size of attendance was three persons per session. In Cycle II attendance increased considerably. The average number of persons in attendance was six. There was, however, a variation in members in attendance. Sessions 1, 2 and 5 had four members present, while session four had six members and session three and six had ten and eleven participants respectively.

Because most parents attended with their baby and the babies brought their own needs to the group, i.e., feeding, diaper changes, soothing, etc. some attention away form the collectivity process was often required. On the odd occasion, infant crying was sufficiently loud enough to make it difficult to continue with the session agenda. Consequently the combined needs of the babies seemed to be equivalent to that of one or two extra collectivity members. The student found that when more than six parents and babies were in attendance that the level of personal sharing was reduced and that it was difficult for a single leader to attend to the needs of each member in a single meeting.

The student had anticipated that an average of five parents would attend a session. The optimum size of a meeting was estimated at eight parents. After having completed the program though, the student would place the optimum collectivity size at six rather than the proposed eight per session.

Collectivity Content

Program Agenda

The program agenda was designed to assist parents during the

adjustment period following the discharge of a premature infant from hospital. The student compiled topics of concern identified in the literature as generic to this population group. The student then developed a session around each of these topics and linked these topics together under the theme of adjusting to caring for one's premature baby at home. Please refer to Appendix S for a detailed outline of the topics chosen for Cycle I and Cycle II respectively and to Appendix R for an outline of the format for individual sessions.

The session topics remained the same for each cycle except for Session Three and Session Six. In Cycle I, Session Three focused on "Brothers, Sisters and the Premature Baby and Community Resources."

In Cycle II, Session Three was changed to "What Do I Feed My Baby?" This change was based on feedback from parents and the students own observations that parents were only mildly interested in learning more about the sibling adjustment. Also, it seemed more relevant to discuss community resources when it is applicable to the parents concerns rather than as a set topic during one of the sessions. The session on infant feeding was found to be very relevant to the parents' concerns and the student would continue to include it as a regular session topic.

In both Cycle I and Cycle II, Session Six was titled "Parents Choice." This session invited input from parents in choosing the focus of the session. In Cycle I the parents choose to invite the assistant head nurse (Joyce Olenick) of Intermediate Care Nursery, St. Boniface General Hospital to speak about the partnership between parents and medical staff in caring for hospitalized infants. In Cycle II, several parents wanted to learn Infant Cardiac Pulmonary Resuscitation (CPR) during the final

session. A second suggestion was to have a meeting focused on Infant First Aid. As instruction on either of these topics was far beyond the time allotted or the scope of a closing session, the leader felt that these requests could not be honoured. Instead, this session focused on "Infant Safety in the Home." In retrospect, this session could have been better utilized to help parents with termination and to identify their own sources of coping and support outside of the group.

Approach to Work in the Collectivity

The student used a structured approach to the work in the collectivity. This was necessary because a collectivity does not have enough autonomy to formulate and work toward accomplishment of its goals and because of the time-limitation in the program (Lang, 1986). Some structure was therefore necessary to accomplish the goals of the sessions.

One of the ways that the program was structured was by the use of a detailed program pamphlet. The pamphlet could help orientate parents to the program as well as to the topic and issues that would be addressed in each session. Also, at the start of each session the student set out the agenda. Again, because of time limitations, the student set the topics rather than allowing these to emerge from the participants. Although topics were planned, content and sharing emerged spontaneously from the process. The structure provided some boundaries and a climate that enabled members to share concerns despite having been in the program for only a brief time. The student noted that it was in the sessions with looser structure that personal sharing seemed to be more limited.

Toseland and Rivas (1984) noted that support groups for parents were

more successful if the worker took an active role in the sessions. They suggested that the worker facilitate the parents sharing of mutual concerns and ways of coping, but at the same time that the worker curtail discussion not related to parenting. The structure contributed to the formation of a mutual support network among the parents.

Interventions

The student used a group (collectivity) intervention to accomplish the goals of the program. The collectivity served to normalize the experiences of the parents, to reduce isolation, to offer role modelling for this stage of parenting and to offer more than one source of helping and support. Within the collectivity the student used two broad categories of intervention. These categories could be classified as the provision of information and the provision of support.

Under the intervention of providing information, the student used a number of formats such as specific-topic sessions, short presentations, guest speakers, video, informational hand-outs and sharing of information between participants. The specific-topic sessions provided information on both concrete topics such as infant development, feeding and on less tangible, but more personal, topics such as on morale (coping) and relationships. During the short presentations by the student and guest speakers, parents received information in both a didactic and a question and answer format. In Cycle II a short video, Infant Crying, was shown as a means to instruct parents on causes of and means to sooth infant crying.

Following the provision of these structured forms of information there would be a discussion about the material by the parents. These

discussions would yield further information as parents would often seek advice from each other. The student, as collectivity leader, found these discussions very useful and practical as a means to support members' adaptation to their circumstances of to correct any distorted perceptions about premature babies.

Take-home handouts for parents were an important part of the informational component in the program. In an effort to reinforce the information that was provided during a session, the student usually provided parents with handout information on the selected topic for the session. Feedback from the members indicated that the handouts were appreciated. Some members used the handouts as a source of discussion with spouses who did not attend sessions or to help inform spouses and relatives about the various issues of infant prematurity and parenting a young baby. In essence, the handouts made it possible for non-attending partners of members to benefit from the program. The handouts also helped to keep absent members current with the collectivity as they would frequently ask the student to mail the handout material to them.

In terms of the second category of interventions as members found support in each others' company within the collectivity, the student attempted to help members make connections with each other outside of the collectivity. For this purpose a telephone sheet was circulated in the fourth session. The telephone sheet included times when parents felt it would be the best for them to receive a call from another parent. In order to maximize the benefits of a telephone sheet in future, the student suggests that it would be circulated earlier in the program. In the final session of Cycle II the student took several group pictures of the parents

and their infants. The parents appreciated the pictures. The student hoped that the pictures would serve as a reminder of the support and sharing that the parents experienced in the program.

Evaluation Methods

The student focused assessment and evaluation efforts on three primary areas: 1) the program members; 2) the program itself; and 3) group leadership skills and the student's learning.

Data was collected from consenting parents at the time of their first attendance to the program and at the conclusion of each cycle of the program. The student had also planned an ongoing evaluation of members by the use of a Client Self-Rating Scale. The data collection tools were developed by the student for the purpose of the practicum. A minority of parents - five out of fifteen parents - who came out to the program did not give their consent to participate in the assessment and evaluation. The following collection tools were used to gather evaluation data:

a. <u>Pre-Group Data Collection Sheet</u>

This is a short pencil and paper survey that was given to consenting parents at the time of their first attendance to the program. The Data Collection Sheet asked parents to give some demographic data about themselves as well as to recall the level of stress that they thought they experienced during the first week after their baby was born and the first week after their baby was discharged home from hospital. The purpose of this instrument was to gain a profile of the parents coming out to the program. Please refer to Appendix G

for a copy of this instrument.

b. Client Self-Rating Scale

This scale asked parents to participate in their learning by setting a personal goal for each session. An example of a goal might have been to meet other parents or to have asked for some suggestions about ways to help baby sleep through the night. The client should have been able to meet the goal within the course of the session. At the end of the session, participants were asked to note how close they came to meeting their goal. This pre-post session measure would glean how helpful participants felt a session was to their individual concerns. The measure also encouraged members to take responsibility for their own learning. Please refer to Appendix J for a copy of this scale.

c. Pre- and Post Program Client Questionnaire

This questionnaire asked parents for their own perceptions about their competency in the care of their baby, about the stress they experienced related to baby care, about the help they had received related to baby and about their satisfaction with family life and their own life. The parents were asked to answer most questions on a scale of 1 to 4 or 1 to 5.

This questionnaire was developed for the purpose of the program and it had not been standardized nor tested for reliability or validity. However, the student felt that it would reflect any major changes in the above noted areas. The pre-program questionnaire was administered by pencil and paper at the time of a parent's first attendance to a session. The post-program questionnaire was

done one month after the completion of the program cycle. The post-program questionnaire was administered over the telephone by the student in order to ensure collection of the data. The student was concerned that if the questionnaire were mailed, most parents would fail to complete and/or return the data.

d. Simple Observation

Although it was not an objective measure, the student planned to observe whether or not participants appeared to have benefitted from attending the program. The student relied on contact with participants both inside and outside of sessions to draw these conclusions. The student recorded the number of clients who had been provided with brokerage service during the program (please refer to Appendix Q).

The student wished to obtain feedback about the program from the participants and to observe the program for its effectiveness as a means of working with a group of voluntary parents after their premature infants have been discharged from hospital.

a. Client Satisfaction and Feedback Sheets

Participants were asked to complete these sheets at the conclusion of each session. These sheets asked participants to rate on a scale of 1 to 6 the relevance of the session's topic to their concerns as well as to mark off whether or not they learned anything new and whether or not they were left with a feeling of support from attending the session. The Feedback Sheets also asked open-ended questions of the participants. Please refer to Appendix K for a copy of the Feedback Sheets.

The Feedback Sheets were useful as they provided immediate feedback from the participants. The information obtained helped in the planning of the ongoing sessions.

b. Post-Program Interview

A semi-structured interview was completed by telephone approximately one month after the end of each cycle of the program. The student felt that the time delay would serve to allow participants enough distance from the program to speak more candidly about their impressions. It was completed in conjunction with the Post-Program Client Questionnaire and was only completed with those participants who gave their consent for the follow-up interview.

In this semi-structured interview the student asked parents a series of questions about their perceptions of the program. These questions included data about the four goals of the program (providing information, support, feeling of increased competency and brokerage service) and whether or not parents felt that their attendance at the sessions had been a worthwhile experience. In addition, the student asked open-ended questions such as asking parents for suggestions and comments about the program. Parents were also asked whether or not they continued to identify their infant's prematurity as a primary consideration in the care of their baby. (See Question 1, 2, and 7 in Appendix O). Please refer to Appendix N for an outline of the Post-Program Interview.

The strengths of this tool were the flexibility in its administration and a greater specificity with regard to an operational understanding of the participants' situation. Because the student

wished to increase her understanding about the needs of the targeted population group this was an advantageous means of collecting data.

A weakness of the post-program interview was that the feedback from the participants about the accomplishment of the program goals was not objective as it was based on their own perceptions. The participants may have received benefits that they did not perceive. Also, their reports may have been coloured by social desirability. In other words, they may have felt uncomfortable about giving the student negative feedback about the program. Lastly, although the post-program interview gave further data about participants it could not be ascertained if the program contributed to the change in the participants' functioning or if the change was due to other factors i.e., behaviour of baby, level of support from ones' network, etc.

c. Process Recordings

The student's process recordings contained: the session topic, the date, attendance, purpose of the session, what happened in the session and analysis of the session. The student completed a process recording after each session and after viewing the session videotape (when available). The student's process recording provided an ongoing record of what happened in the sessions.

d. Review of the Session Videotapes by the Practicum Chairperson

Three sessions in Cycle I and five sessions in Cycle II of the program were videotaped. The sessions were taped with the group members' awareness and consent. Difficulty with the video equipment prevented the student from taping all of the sessions. The

student's practicum chairperson reviewed the tapes and provided critical feedback on the group process.

Corey and Corey (1977) ascertain that group leadership skills could be learned and constantly improved. A primary objective of the practicum was for the student to develop knowledge and skills in facilitating a collectivity (group work).

a. Modified Group Leadership Skills Rating Scale

Corey and Corey (1977) developed a scale that asks group leaders to rate themselves on a scale of one to seven with regard to one's ability to carry out each of the 15 skills identified as important in providing effective group leadership. The student modified the scale to include 10 of the 15 skills identified by Corey and Corey. In addition, the scale was modified to adapted to the student's novice level of group work and to fit with the characteristics of collectivity.

The student completed the Modified Group Leadership Skills Rating Scale after each group session., By completing the scale, the student had a means of identifying which skills were being performed satisfactory and which skills needed improvement. This also provided the student with a record of which skills improved over time.

b. Review of the Session Videotapes by the Practicum Chairperson

The practicum chairperson reviewed the videotapes and provided ongoing feedback as to the student's leadership in the collectivity. This included identification of which skills were performed well and which skills required improvement. The practicum chairperson

provided direction and suggestions about the student's role in the collectivity.

Summary

This chapter has covered the planning stage and outlined the structure of the program as well as listed and discussed the evaluation methods.

CHAPTER FOUR

PRACTICUM RESULTS

Practicum Results

In this chapter the student will report on the evaluation of the data collection and intervention strategies. This will be covered in the following three sub-sections: 1) results related to individuals; 2) results related to the program; and 3) results related to the student's personal learning.

Results Related to Individuals

In Cycle I and Cycle II a total of 15 parents and four friends of parents came out to the program. Cycle I had a small attendance of five parents (4 mothers and 1 father). Cycle II had a larger attendance of 14 parents (9 mother and 5 dads) and four friends of parents. In Cycle II four of the mothers and one of the fathers had also attended in Cycle I. Of the 15 parents attending, 10 parents (9 mothers and 1 dad) agreed to provide demographic information about themselves and to participate in a Pre- and Post Program Client Questionnaire. In this section the student will report on the results of the measures used to collect data and measure change among the ten research subjects.

Examples of Actual Parents

For the purpose of providing a sense of the type of parent who came out to the program, profiles of four parents (two of the parents are a married couple and are included in one profile) are given. These parents represent variations among the parents in the program. The profiles chosen are: 1) Alice and Barry, who are parents of twin girls and are representative of one of the three couples who attended; 2) Carla, a first

time mother and regular group attender who came out the first week that her baby was home; and 3) Lisa, a first-time mother who attended without her husband and came out to both Cycle I and Cycle II. Profiles of six other research subjects are included in Appendix P. Please note that the names used in the practicum report are not the actual names of the research subjects.

1) Barry and Alice are a married couple and parents of five month old twin girls who had been born two months premature. Alice was a first-time parent and Barry had a child from a previous union. Barry and Alice are university educated and in their early 30's and late 20's respectively. Barry is employed outside of the home and Alice is currently home full-time with the babies.

Alice had a difficult delivery and was quite ill when the twins were first born. In the collective, Barry shared that the weeks following the birth of the twins were the most stressful of his life.

Life for Barry and Alice has remained stressful. One of the twins has been colicky since they coming home from the hospital. Although these very capable parents seldom complained about their situation it was obvious that it was very taxing. The couple had a part-time homemaker come in three times a week to help Alice with the twins. Barry's parents were also available to help with child care; however, the couple preferred not to use their help on a regular basis as it came with too much "well-meaning advice."

There was evidence that Alice was probably experiencing a post partum depression. In Session Five Alice asked the student about post partum depression but was very reluctant to discuss her own situation.

She accepted the student's offer to call her the next day with phone numbers of community agencies specializing in post partum depression services. Over the phone Alice admitted to feeling very low. The student offered to meet with her on a one-to-one basis to discuss this matter further but she declined saying that she preferred to stay anonymous on the issue. Alice's Pre- and Post Client questionnaire mean score fell 6 points. This would support the student's observations and Alice's own admission that she was going through a very difficult time.

Barry also appeared to be taxed by caring for premature twins; however, he appeared to be managing better than Alice. Barry's pre- and post program mean scores remained relatively unchanged (+1). Barry joked that he used going to work as a means to take a break away from the twins. Barry was articulate and open with the other group members. Other members could readily identify with him when he confessed that he sometimes went down to the basement to scream to let out pent-up frustrations. Barry was empathetic to other members, especially with the other fathers who came out to the program. When other parents or couples expressed that they were experiencing conflict around differing styles of caring for baby, Barry would sympathize. Barry would say that he and Alice experienced this as well even though they had a very good marriage.

Barry appeared concerned about Alice's low spirits. He seemed to try to get Alice to verbalize her feelings but at the same time he was respectful to her and would not push Alice to share more than she was willing to so about this matter. The couple interacted easily with each other and had a definite show of support to each other in the meetings. It is hoped that the strength of their relationship would help to buffer

some of the stresses from caring for the twins.

2) Carla attended the program after her daughter, Angela, had been home from hospital for only three days. This was a first child and an unplanned pregnancy for Carla and her husband Ernie. The couple are in their early forties. Carla attended four sessions and her husband was present with her for two of those sessions. Carla and Ernie live in a small community outside of Winnipeg. Carla had several pre-session contacts with the student. It was clear that Carla was anxious and required a great deal of reassurance. Carla benefitted from the content of the program but especially benefited from contact with the mothers of older premature infants.

A couple of the mothers readily gave Carla their home phone numbers and an invitation to call them at anytime. By the end of the program Carla presented as much more at ease with her baby. During the program evaluation Carla expressed that she thought that the program had been a very positive experience because she met other mothers who provided her with a lot of information about caring for Angela at home.

During the time of her attendance in the program, Carla was dealing with more than adjusting to caring for her premature infant. Carla had "carpal tunnel syndrome" and this restricted her use of her hands. Carla had hired a private duty nurse to help her when the baby first came home from hospital. She then used the services of a part-time homemaker until about the end of the program. At the time of the program evaluation Carla was caring for Angela without the assistance of these services. Carla had reported that she had no assistance from her extended family but that she had a network of friends who gave her a lot of emotional and tangible

support.

Carla was also dealing with a difficult marital situation. When Ernie attended sessions with Carla it was obvious the couple was experiencing tension around differences in their parenting and care of the baby. Ernie tended to have a difficult time following the content; however, he liked to participate in the sessions. Unfortunately his participation, at times, had a disruptive effect.

Outside of the collective Carla confided that her husband had a serious alcohol problem. Carla seemed to be carefully considering how Ernie's alcoholism would affect the upbringing of their daughter. The student strongly encouraged Carla to seek professional counselling around this issue and to re-new her involvement in AlAnon.

Carla's Pre- and Post Program questionnaire scores showed an overall increase of +3. For Carla the information and social support received through the program very likely led to feelings of increased competency and served to buffer the stress of dealing with her baby's prematurity, an unhappy marital situation and her disappointment about the lack of help from her relatives.

3) Lisa attended both Cycle I and Cycle II of the program. Lisa is married, in her early 30's and has chosen to stay at home with her son. Lisa has a history of both a miscarriage and a stillbirth. Her son, Bobby, was born at 30 weeks gestation and went home after two months in hospital.

Lisa first attended the program when her son Bobby was six months old. She attended the program with a friend, although her husband did come to the last meeting of Cycle II. Lisa indicated that she came out to the

program for information about the normal behaviour for a premature baby. Lisa seemed to struggle to deal with off-handed comments made by some relatives and friends about her baby's size and development. Although her baby's behaviour was delayed for his chronological age it was appropriate for his corrected age. Lisa used the collective in Cycle I to discharge some hurt feelings about these remarks and about the lack of help and support from relatives.

Lisa also used the collective to share her feelings of sadness about her earlier pregnancy losses. Lisa found support and understanding for these feelings as other parents also had experiences with pregnancy losses. At times it seemed as if Lisa's son Bobby was like a trigger for memories and feelings about the stillbirth of her first child. Lisa's references to her pregnancy losses diminished as she continued on in the program.

It was the student's impression that the information aspect of the program did not seem as important for Lisa as the support component. Lisa appeared to have a real need to talk and to connect with other parents in the program. Lisa really seemed to enjoy the sessions that included an exchange of personal feelings and experiences among parents. Lisa participated easily with the other parents in both cycles of the program.

In Cycle II the student noticed that Lisa was looking happier and seemed much more attentive to her personal appearance. She also began to take some greater personal risks such as sharing her unhappiness about receiving almost no help from her husband with baby care or chores. It is very likely that the collective had become a significant part of Lisa's support system and had assisted her expression and release of unresolved

feelings around her baby's early birth. Lisa had a relatively high score on the pre-program questionnaire and gained three points on her post-program questionnaire. Over the course of the program Lisa appeared to have made a successful adjustment to parenthood.

The composition of parents who came out to the program contained several surprises. First of all, there was only one single parent who came out to program. The student would have hypothesised that single parents had additional issues that placed them in greater need of support and therefore they would have come out to the program in greater numbers. In retrospect, it may have been that the program pamphlets appeared to be directed toward couples and this may have deterred single parents. In future, the student would clearly indicate in the pamphlet that both single parents and couples are invited to attend the program.

The student was somewhat surprised by the rather high incident of miscarriages (40%) among the mothers attending the group. The student can only speculate that these neonatal losses followed by caring for a premature baby left these mothers with a feeling of heightened vulnerability. Also, the presence of the new baby may have inadvertently been a reminder to the mothers of the loss of their unborn children. In Cycle I discussion of the miscarriages was a regular theme among those parents in attendance. The telling of their experiences may have helped to unburden the parents and to leave them in a better position to attend to their new baby.

The student had a rather conventional group of parents in attendance. The detailed information given in the pamphlet probably directed it away from younger, less formally educated parents of premature babies.

Also, as many of the parent groups in the community are directed toward young parents with limited life skills, more mature and skilled parents who were interested in finding a group may have been attracted to the "Now That Baby's At Home ..." format. As mentioned earlier, Appendix P contains the profiles of six other parents who had agreed to participate in the program evaluation.

Individual Evaluation Results

In this section of the report the student will comment on the useability of the data collection methods before going on to discuss the findings of these methods. As stated in the previous chapter the methods of assessment the student planned to use were:

a. a Pre-group Data Collection Sheet;

b. A parent Self-Rating Scale;

c. Pre- and Post Client Questionnaires; and

d. Simple Observation.

Pre-Group Data Collection Sheet. The Pre-Group Data Collection Sheet was found to be a useful instrument to gain information about characteristics of the parents who came out to the program. The parents did not seem to have any difficulty completing this form except for the parents of twins. Parents of twins found some confusion about responding to some of the questions as the forms were designed for parents with single births. The student suggests that a separate set of forms be developed for parents of multiple births. Only one of the five fathers who came out to the program completed this form. Most of the fathers declined to fill out the form, indicating that they did not feel that it was necessary as their wives had

already completed it. Perhaps one means to encourage the fathers to participate in future research would be to designate separate forms for mothers and fathers. Please refer to Appendix G for the raw data obtained by the use of this instrument.

Client Self-Rating Scale. The use of the parent self-rating scale in theory might have been a good idea. However in the first session it was readily apparent to the student that this scale was too formal and that it did not fit with the 'flow' of the sessions. The student therefore did not ask parents to complete this scale.

Parents really seemed to appreciate the informal relaxed style of the meetings. It was the student's impression that the parents would have felt awkward and put on the spot to if they had to write down a goal for the session and then later rate themselves on the accomplishment of achieving this goal. A parent self-rating scale would probably be more suitable to a task or therapy group rather than to this form of a parent group. Also, it would have been too difficult mechanically to administer this form to parents each week as there was really no writing space and most parents had a baby in their arms for a good portion of each session. At best, at the introduction of the sessions the student asked parents what they hoped to get out of a session.

Pre- and Post Program Client Questionnaire was simple and easy to administer. Although it was not a rigorous means of testing for change in the parent group, it appeared appropriate for this demonstration program. One caution about interpreting the results of this tool is that one cannot necessarily attribute parent change to the program. This tool cannot screen out influences on the parent from sources outside of the group.

Another caution around this tool is that the progress or regression of one parent may be lost within the average of all the parent scores. Please refer to Appendix I for the raw data from these questionnaires.

Analysis of the Individual parent Results

Progress of the Individual parents as a Group. Progress of the individual parents as a group was based on the Pre- Post Program Client Questionnaire. The pre-program mean score for the group was 30 and the post-program mean score for the group was 31.4. (Please refer to Table One for the Individual Mean Scores). This Table shows that for the group as a whole there was little change or progress over the time span of the program. Visual examination of the mean scores shows that each of the three parents of twins were significantly below the mean scores on both the pre- and post testing. When the scores of the parents of twins are eliminated, the pre-program mean is 32 and the post-program mean is 35. This shows that for the others there was a modest improvement in personal circumstances over the time span of the program. From the mean scores one can safely speculate that for the parents of twins this remained a difficult time in their lives and that their challenges were beyond those of parents of a single birth.

Table One

PRE- AND POST PROGRAM CLIENT QUESTIONNAIRE			
INDIVIDUAL OVERALL SCORES			
	Pre-Test	Post-Test	Change of
Alice♦	26	20	-6
Carla	28	31	+3
Barry♦	23	24	+1
Lizzy	32	32	0
Mary♦	24	26	+2
Rita	33	32	-1
Tammy	29	31	+2
Judy*	39	42	+3
Natalie*	31	37	+6
Lisa*	35	39	+4
Mean Score for all Par-ticipants	30.0	31.4	+1.4
Mean Score excluding parents of twins	32.4	34.8 = 35	+2.4
Legend ♦ = parent is the parent of twins * = parent attended two Cycles of the Program			

If the Pre- and Post Program mean score for each of the questions is reviewed, there are three questions with a difference of more than 0.5 in the Pre- and Post Program mean score among the multiple choice questions. Please refer to Appendix H for the Questionnaire and to Appendix I for the raw data from the questionnaires. Question #5 had a decline of -0.8. Question #5 deals with the participant's perception of understanding that they receive from persons close to them. Question #7 shows an increase of

+0.6 indicating that the participants had an increase in self-perceived knowledge of baby care. Question #9 shows a decrease of -0.6 in participants perception of their family life.

Change in the Pre- and Post Program mean scores of the other questions was less than 0.5 and was not considered significant. There were two yes/no or arbitrary questions #2 and #11. Question #11 showed an increase of more than 5 points. This increase was considered significant. It indicated that overall participants had more contact with others e.g, other parents after the program than they did prior to the program.

Progress of Individual Clients

The Pre- and Post Program Client Questionnaire showed a clinical variation in the parent mean scores (Table One) and as well as in the scoring of the individual questions. If a variation of ±3 is arbitrarily chosen as showing a significant change between the pre-program and post-program mean scores, then six parents showed a significant positive change in their life circumstances. The student considers a change of ±3 as significant as it indicates that the parent would have had to answer differently on approximately six out of eleven questions to achieve this level of change in the outcome score. A notable increase in scores was found in four clients: Carla +3, Judy +3, Natalie +6, and Lisa +4.

The changes in Carla's responses to individual questions with the Pre- and Post Questionnaire is most interesting (Appendix I). One will note that she reported a significant decrease in supportive understanding from people close to her and in her satisfaction with her personal and family life. But Carla reported significant improvement in her daily

coping with baby care. Carla also showed an increase in contact with other parents of premature infants outside of the group. For Carla issues directly related to baby care improved significantly and outweighed problematic issues she was facing in other areas of her life (as she had confided to the student). (Please refer to Carla's profile included in the earlier section of Results Related to Individuals).

For Judy, Natalie and Lisa the areas of change were more subtle but reflected an overall positive change in their personal situations. Judy had the highest pre- and post mean scores. Natalie's increase by 6 points in her Pre- and Post Program mean scores was the greatest individual parent change in the program. A review of Natalie's scores show the most significant area of improvement came from a reduction of stress related to baby care and an increase in her perception of her own coping with baby care. Lisa's score increased by +4 points and reflects an overall progress except for a decline in the area of practical help and understanding from persons close to her.

Alice had a significant decrease in her mean scores from 26 on the pre-program to 20 on the post-program score. Anne's scores showed an increase in her self-perceived knowledge about caring for baby but also an increase in the stress of caring for babies and a decrease in day-to-day coping with baby care. For Alice there was a further drop in her satisfaction with her personal life and her family life. At the time of the follow-up program evaluation, Alice confided that one of the twins had remained colicky and that this had become increasingly more difficult to cope with over time.

Difficulties related to baby care appeared to have had a negative

influence on other areas in Alice's life. Alice appeared to recognize this effect. She had recently followed up on an earlier suggestion of the student to phone the Post-Partum Stress Counselling Service in an attempt to gain more help with her situation.

All of the parents of twins had means scores significantly below those of the other parents. Alice's husband, Barry's score was 23 at the pre-program and 24 and the post-program questionnaire. It could be that Barry's time away at his job helped to buffer him from the day-to-day difficulties that his 'stay-at-home-wife' faced. Mary, the other parent of twins, had scores that were six and five points below the group mean scores at the pre-program and post-program level. Their mean scores reflect what Barry had so succinctly said in his post-program interview, "Having twins is a double responsibility and having prematurity and twins is even more responsibility."

Five parents showed a minimal change in their pre- and post mean scores. They were: Barry +1, Lizzy 0, Mary +2, Rita -1, and Tammy +2. All of these parents had attended only one cycle of the program and three or fewer sessions. Judy, Natalie and Lisa were three out of the four parents who showed significant improvement in their scores and had attended two cycles of the program. The remaining client, Carla, attended four sessions in Cycle II. This would suggest that the more time a parent spent in the program the more benefits the parent derived.

Overall, the results show some improvement over time and this might suggest that for the most part that a baby's prematurity is a transitional conditional. Consequently as the baby's prematurity is "outgrown" there is a gradual but steady improvement in the parents' circumstances. Except,

however, for the parents of twins.

Results Related to the Program

In this section of the paper the student will present the results related to the program.

Client Satisfaction and Feedback Sheet

In Cycle I there were 13 feedback sheets completed and there were 14 feedback sheets turned in for Cycle II. Please refer to Appendix K for a copy of the Client Satisfaction and Feedback Sheet. Most of the sheets were only partially answered. The majority of parents completed item #2 which asked them to rate the relevance of the session topic to their current concerns. This was on a 1 to 6 scale with 1 being most relevant and 6 being the least relevant. Please refer to the Table Two below for the results. Of the 27 sheets returned, 19 sheets had checked #1; thus it can be safely assumed that in most incidences parents were satisfied with session topics and that the program was meeting the goal to provide information to the parents.

Another item asked parents what they liked best about a session. Their responses in order of greatest frequency were: contact and sharing with other parents of premature infants, the information presented and the informality of the sessions. Item #5 asked parents if meeting with the group leader and the other parents left them with a feeling of support. Of the 25 sheets that had this question answered, all responses were marked yes. On remaining items, responses indicated that members found the meeting time and location to be convenient and the

objective of providing support to parents was met.

Table Two

CLIENT RATING OF SESSION TOPICS						
Relevance of Session Topic	Most Relevant		Somewhat Relevant		Not Relevant	
	1	2	3	4	5	6
Responses of Participants	19	1	4	2	0	0

Post-Program Interview

The interview asked for parents' perceptions about the program and about their infant. Please see Appendix O for the Raw Data and Table Three below for the summary of responses. Questions 1 and 2 asked parents if at the time of discharge and then at present whether or not they felt their babies required more care and responsibility and care than that of a full-term infant. At the time of discharge, 9 of 10 parents felt that their babies required more care. This is in direct contrast to the parents' response at the completion of the program when only 1 of 10 parents felt that their baby required more care than a full-term infant. Also, at the end of the program half of the parents felt that they could satisfactorily discuss their parenting concerns with parents of full-term infants.

Question #3 pertained to the goals of the program and directly asked parents about information, support, competency and brokerage gained through the program. Member's responses indicated that the program goals were clearly accomplished. The participants unanimously reported that they

had felt support from attending the meetings.

Table Three

POST-PROGRAM INTERVIEW QUESTIONS 1 - 8	
Question Number	Question
1	Care at Discharge - 10 of 10 respondents felt that baby that required more care than a term baby
2	Care at Present - 9 of 10 respondents felt baby was now about the same
3	Benefits derived from the Program - a. Information, 8 of 10 felt that they received new information from the program b. Support, 10 of 10 felt they received support c. At Ease, 8 of 10 felt that the program contributed to their feeling more at ease with baby d. Brokerage, 5 of 10 felt they received information about other services for parents
4	Sessions Attended - the average number of sessions a respondent attended was 3
5	Program as a worthwhile experience - 10 of 10 respondents felt that their attendance at session(s) had been a worthwhile experience
6	Would recommend program - 10 of 10 respondents answered yes.
7	Preference of discussing baby care with another parent of a premature infant or another parent of an infant - 50% of parents preferred to talk with another parent of a premature infant
8	Aside from family member, parents main source of support with baby - 8 of 10 respondents answered friends

Further, 8 out of 10 felt that they had a) gained more information about caring for baby from the program and b) that attendance in the program contributed to their feeling more at ease with their baby. In addition,

5 out of 10 parents identified that they learned of other resources in the community during attendance in the program.

Group members were asked to comment on what they thought parents needed when their premature baby came home from hospital. Among the parents' replies, the need for information, confidence, reassurance and support were the most common answers (please refer to Question #9 in Appendix O). A second question posed to parents asked for their comments or suggestions about the program (please refer to Question #10 in Appendix O). A couple of parents commented that they would have liked to have had more information covered at the meetings. But what almost all parents commented on was how much they enjoyed having a chance to talk to other parents of premature infants.

In summary, the respondents' post-program interviews bear out several assumptions made earlier in the report. First of all, for the participants, it does appear that the infant's prematurity is a transitional issue that decreases in importance over time. Secondly, feedback from the respondents indicates that peer contact remains an important source of support for these parents. The interview results also validate the parents' need for social support when baby comes home from hospital: parents listed there was a need for reassurance (coherence support), for information (cognitive guidance) and (emotional) support. Because all of the parents indicated that they found attendance at the sessions to be a worthwhile experience and 80% of the parents returned to attend further sessions, it stands to reason that they found the program to be a worthwhile experience.

Process Recordings

The student's process recordings were based on observations made in the collective and from watching session tapes. The process recordings showed that in Cycle I the collective operated as a cohesive unit from Session Two until the end of the Cycle. This very quick development of cohesion was probably a result of the small size of the collectivity (2-5 persons per session). Also, two of the participants were good friends and their comfort in relating to each other seemed to transfer over to the other parents present.

In Cycle II the population was larger and less stable. The collective did not appear to become functionally cohesive until Session Three when a core of regular members began to develop. Once the collective became more cohesive members began to shift conversation away from direct discussion of the babies and toward other parenting concerns. Members began to share feelings and to talk about their own struggles related to fatigue, feeling over-responsible for baby and trying to learn to accept that their partner's style of caring for baby even though it was not the same as theirs.

The student's process recording also identified the sessions topics and the parents response to the topic. This was helpful in identifying which sessions were and which sessions were not relevant to parents' concerns. The themes that members raised during the sessions were also recorded. Common themes for Cycle I were breastfeeding issues, explaining to non-family members about how prematurity affects baby, and lingering sadness from earlier childbearing losses. In Cycle II common themes included how to sooth fussy babies, the need to take a break from "respo-

nsibility' of caring for baby and fear that baby could develop new health problems. Themes that were common to both sessions included discussion about post-partum depression, fatigue from the endless baby care chores and that it helps to know that you're not the only one caring for a premature baby. Please refer to Appendix S for a more detailed reporting of the themes as well as a summary of the content of the program sessions.

The student found that the practice of making process recordings helped to contribute to sharpening her observations of the participants, the collectivity process and her own style of working within the collectivity. The process recordings indicated that in the collectivity a degree of cohesion needed to be established before members would share more personal concerns. In Cycle II, where the size of participants was greater and the composition fluctuated, the student had to work harder and longer to establish cohesion.

Feedback from the Practicum Chairperson

Dr. Don Fuchs, the Practicum Chairperson, provided feedback throughout the program. In Cycle I Dr. Fuchs pointed out that the student's attempt to adhere to the session agenda was at times inhibiting opportunities for members to bring out and work on their own issues in the group. The student was able to use this feedback and make improvements in this area. Another area of the group process that the student needed to work on was the group introductions and closings. For example, at the end of sessions, the student needed to summarize the content of the session and formally close the session.

In Cycle II, Dr. Fuchs noted that the early sessions members were

less cohesive than in the previous cycle. It was suggested that the student begin sessions with a joining exercise. The joining exercise would set a norm for member-to-member interaction and most likely increase group cohesion. Dr. Fuchs found that the student was readily able to facilitate linkages between parents. However, he continued to challenge the student to find a balance between following the group agenda and picking up on spontaneous issues raised by members.

In Cycle II, the student found it easier to tune in to the latent messages of the members and the collectivity. Dr. Fuchs encouraged the student to explore having the members work in greater depth on their personal issues. The student learned to recognize which issues could be dealt with in the framework of the group and which issues would be better serviced by brokerage outside of the sessions.

Dr. Fuchs also identified that the student needed to work on the termination tasks of the final group session. The student was encouraged to recognize that at a final session the focus of the work was on helping members to identify outside sources of support and building on their own networks.

In terms of whether or not the sessions functioned at the level of a group or a collective, Dr. Fuchs noted that the latter held true. Although the sessions had the presence of group dynamics, they had not evolved to the autonomous level of functioning characteristics of a true group.

Results Related to Group Leadership Skills and the Student's Learning

The results of the student's group leadership rating scale and

feedback from the practicum chairperson are included in this section.

Modified Group Leadership Rating Scale

As reported in the methods section the student modified the Corey & Corey (1977) Group Leadership Rating Scale to better fit with the student's beginning level of group work and the short-term nature of the program.

In Cycle I the student's strongest skills were, active listening (Item #1) and linking (Item #4). These two skills continued to be among the students better performed skills in Cycle II. The student's weakest skills in Cycle I were clarifying (Item #2), and termination (Item #10). In Cycle II the student was able to make some significant improvement in clarifying, but terminating skills remained weak.

In Cycle I the student's leadership skills mean score was 3.6. In Cycle II the overall mean score was 4.1 indicating that the student had been able to improve leadership skills with practice. The student had made an improvement of at least +0.5 on 7 of 10 leadership skills. The skills that showed the greatest area of improvement were clarifying (+1.0) and empathizing (+1.5).

At the end of the program the student's better performed skills were: active listening, linking, supporting, facilitating and empathizing. The student's weaker skills including those most in need of improvement were: clarifying, summarizing, blocking, evaluating, and terminating.

Review of Session Video Tapes by the Practicum Chairperson

The student has already highlighted feedback from Dr. Fuchs on leadership skills related to group structure and cohesion. Feedback on additional leadership skills is included in this section of the paper.

Dr. Fuch's noted that the student needed to scan the collective and when working with one individual to remember to check out how the conversation was impacting on the other members. Another leadership skill that warranted improvement was keeping the group on track. At times when members spontaneously raised issues of importance to them the student needed to take a more direct role around getting the conversation back to the original topic or making a conscious decision to pursue a new direction in the collective. Improvements in these skills were noted in Cycle II.

Summary

The student concurs with Kagan and Seitz (1988) who indicated that it was easy to want to determine if a program had a measurable impact on persons participating in it, but that this was a very difficult goal to accomplish. The Pre- and Post Client Questionnaire reflected a change (improvement) for most parents in their self-perception of their care of the baby and issues related to parenting. However, this change did not hold true for the parents of twins whose circumstances showed little improvement. Unfortunately, changes or lack of changes in the parents' scores cannot with total certainty, be attributed to participation in the program. Nevertheless, the questionnaire indicated that circumstances did improve for most of the parents. The Pre-Group Data Collection Sheet and

the parent profiles reflected that in addition to infant prematurity, parents were dealing with additional stressful issues such as past childbearing losses, marital conflict, family alcoholism, and post-partum depression. These additional stressful issues were better addressed by brokerage services to parents outside of the sessions. The parent profiles and process recordings indicated that parents were able to utilize the collectivity to enhance their coping with caring for their premature infant at home and assist their transition to parenthood. Finally, the post-program interview concurred with the video tapes and the student's process recordings that the program objectives had been accomplished. The student was able to measure improvement in leadership skills in the collectivity through the use of a modified Corey & Corey Leadership Rating Scale.

CHAPTER FIVE

EVALUATION OF THE PROGRAM AS A WHOLE

Evaluation of the Program as a Whole

This chapter will deal with an evaluation or rather a review of the program as a whole. The preceding chapter focused on the outcome of the data collected, this chapter will focus more on process evaluation. This information is important and useful as it enables others to replicate the program and allows it to be adapted successfully by other practitioners (Kagan & Seitz, 1988). In the first half of this chapter the student will review the characteristics of collectivity as it pertained to running the program. This will include a review of the group dynamics operating within the collectivity and a review on the primary interventions used in the program. In the second half of this chapter the student will discuss implications for practices. Under implication for practice the student will link new observation of the program.

Collectivity

As outlined in the theoretical framework, the student proposed that the program sessions would unlikely to develop into what social group work would classify a 'true' group. Instead, as anticipated, the sessions remained at the level of collectivity with some group elements operating on a more restricted scope. The sessions fit more with collectivity than a group for the following reasons:

a. The time frame of six sessions was too brief to allow the entity to develop a lasting sense of "groupness." For example, in Cycle II higher levels of cohesion were achieved in Session Three and Four but there was no time for this to develop further as by Session Five the collective was needing

to focus on termination. Also, the time for individual sessions was too short as the sessions rarely concluded on time.

b. There was a lack of stability in attendance. This resulted in a different composition of members at each meeting (Young, 1986) and made it difficult to carry over important issues from one meeting to the next. For example, in Cycle II, Session Three members invested in ways to help another member Ernie cope with infant crying. The members elected to view a video on the subject at the next session. Unfortunately Ernie was not able to attend the session and the opportunity for further problem solving was lost. Mitigating circumstances such as baby illnesses and work schedules interfered with member's attendance.

c. There was heavy reliance on the leader to provide structure and goals for the sessions. The session goals were already pre-planned and were included in the program pamphlet. Little would have been accomplished if the worker had not taken charge.

d. The members had limited autonomy. The leader in many incidents attempted to limit free flowing conversations except in those incidents where it related to the infants or parenting issues. Also, the members lacked autonomy to develop and pursue common goals through group directed effort.

e. The sessions continued to operate at the developmental (beginning) phase. The leader had the ongoing task of

pointing out similarities and making linkages between members in an effort to foster cohesion. Also, the worker needed to capitalize on opportunities for sharing and support between members (Sulman, 1986). Although some members took risks in sharing, it was difficult to move members into a genuine work phase to deal with issues.

Also, the sessions did not result in a fully developed group because this was not the intended form for the entity. As a collective, the sessions helped members achieve individual goals, to gain information, and even to influence behaviour change (See Appendix O, Post Program Interview - Raw Data).

The program sessions fit with Lang's (1986) relational paradigm for change. Although the student as the collectivity leader was a key figure in the sessions, this relationship between the collectivity leader and members would not have had any potency without the presence of other parents of premature infants. The parents provided each other with a depth of understanding, normalization and validation that could not be afforded by the collectivity leader alone. For example, in Cycle II, Session Three a member asked how others deal with not getting enough sleep because of the baby. Another member responded that he too finds the situation stressful and added that "We're lucky that we love each other and that the kids are cute." The others laughed and joined in adding that they too were coping with "total exhaustion." The student implored the collectivity to identify some means to cope with the situation. Members suggestions included: realizing that this is a tough time that just has to be gotten through, taking turns getting up with baby and remembering to

hug your spouse when times get rough. The power of these suggestions carried more weight because they were provided not by the collectivity leader but by other members experiencing a similar situation.

Group Dynamics in Collectivity

Although the sessions were collectives there were elements of group dynamics present.

Cohesion

The student attended to group cohesion by establishing connections between members i.e. both of your babies were born at 29 weeks, and by building structure into the program. Structure in the meetings seemed to help members begin to build comfort so that they could then move on to more direct contact with each other. One example of structure enhancing group cohesion were the joining exercises that were used in Cycle II. Another example was the use of vignettes in Cycle II Session Five that helped to ease members into discussing relationship issues. Vignettes were not used for this same session in Cycle I and discussion remained at a superficial level.

Another factor that contributed to cohesion among members was the need for affiliation. Parents of premature infants had a need to identify with others who had been through a similar experience. The parents who came out to the program differentiated their infants from full-term infants. They expressed that they felt supported by sharing their concerns with other parents of premature infants. This finding was in total agreement with the literature that borne out the need for peer

contact (Boukydis, 1982, Dammers, 1980, MacNab, 1985, Meier, 1978, Minde, 1980, Schosenberg, 1980) and with the finding that for many parents the need for contact with peers became particularly apparent once baby was at home and the parents' ties with hospital staff had been discontinued (Cohen, 1982, Harrison, 1983, Henry, 1990, Nance, 1982).

For the most part the sessions had a level of cohesion sufficient enough for members to want to return to the program, and a small core of members developed.

Norms

The worker shared collectivity norms in the first couple of sessions of each Cycle. These norms included: all experiences will be validated; when speaking to another member or offering suggestions speak from an "I" position rather than a "you should" position; take from the sessions only what fits for you; and we know more together than we do by ourselves. Other norms that developed as the collectivity progressed included:

a. When there is a conflict between information offered in the session and direction given to you by your baby's doctor, follow the direction from the doctor.

b. Breast feeding during sessions is very permissable.

c. Infant crying and fussiness are a normal part of the sessions; and

d. That members in distress will be attended to outside of sessions (i.e. brokerage).

These norms that developed were in response to the characteristics of the population. In retrospect, the student found it surprising that

parenting groups in the literature did not provide any direction on how to accommodate or even address issues such as breast feeding, infant crying or handle conflicting information about infant care.

Mutual Aid

Shulman (1986) stated that in the conceptualization of mutual aid is that the group leader is but one source of help and members are a source of help to each other. As one member helps another with a specific problem they are also helping themselves with similar concerns. Mutual aid was present to some degree in most of the sessions. Parents regularly consulted the collectivity about how to handle new situations with baby. For example one member wanted to go away on a short holiday with the baby and her husband. She seemed nervous about the car trip and about being away from home. The members discussed the situation and gave her reassurances that the trip seemed to be a reasonable thing to do. As the members were helping this parent resolve the issue of the trip they were also helping themselves by reminding themselves that being overprotective of the preemie babies was not helpful.

Mutual aid appeared to be more common in the later half of each cycle after members had gained some comfort and familiarity with each other. The members were able to explore more 'taboo' subjects such as talking about the frustration of caring for a difficult baby or admitting to habitual conflict with spouses around differences in opinion about child care. As other members listened to the discussion they were helped to get in touch with their own issues. They then had the opportunity to discuss these issues and thereby unburden themselves of unresolved

feelings.

The members also offered tangible support to each other such as rides to meetings, and lending of preemie sized baby clothes. They also provided advice to each other about methods of formula preparation, preferred brands of baby food, toys that were most suitable to baby and ways to handle well-meaning but unwanted advice from ill-informed friends and relatives.

Although mutual aid was a regular occurrence in the group it did not happen by itself. It came about through an atmosphere of support and through gentle direction on the part of the student. Members then quickly realized that they are "all in the same boat." This then lowered defenses and allowed members to begin to reach out to help each other and resolve issues and feelings of their own.

It was cited in the theoretical framework that social support is a more diffused form of mutual aid (Lee & Swenson, 1986). The mutual aid that took place within the collectivity fit with Gottlieb & Pancer's (1988) findings on social support as it included emotional support, cognitive guidance, tangible aid, and coherence support, all various forms of social support. This observation concurred with Gottlieb (1987) who suggested that at times of transitions, such as new parenthood, contact with a peer support group is often more helpful than contact with members of one's own network. At the time of this writing, the parents themselves had organized and gotten together for a summer barbecue and were making plans for another get-together in the fall. The continuation of contact among parents with each other is an indication that mutual aid or rather social support had been achieved in the collectivity. It also indicates

the importance of the program for these parents.

Interventions Used in the Program

As outlined in the rationale and theoretical framework, the student set the program goals: as providing parents of discharged premature infants with information; providing support, increasing their feelings of competency; and providing brokerage service. This was accomplished through the use of collectivity employing the relational paradigm put forth by Lang (1986). The student concurs with Lang that the presence of the other members increased the potency of the interventions. Within the collectivity the student focused on two broad categories of intervention: the provision of information and the provision of support. The student found that at times these two interventions worked very will together and were almost interchangeable. The student also found that the provision of information proved to be a non-threatening entry point for parents to join the program. The parents were motivated to learn more about their babies. But, it is the student's impression that what ultimately motivated the parents to return and remain in the program was the provision of support.

Under the intervention of providing information to parents the student had employed a variety of means. This included use of mini-presentations, guest speakers, video(s), group exercises, discussions and take-home handouts. The variety of means helped to keep the program interesting and accommodated a variety of learning preferences such as experiential and didactic learning. The provision of information enabled parents to gain a better understanding of the behaviour of premature infants. For example, some parents were largely unaware of the develop-

mental delays experienced by most premature infants. The provision of information also corrected misconceptions and faulty learning and in other cases it reassured parents that in many incidences they knew more than they thought they did about their babies. The student found that the provision of information increased adaptation in both the transition to parenthood and in the day-to-day care of their premature infant. The student concurs with Clarke (1986) that the provision of well-timed information is an inoculation against stress.

The other generalized intervention used in the program was the provision of support to parents. Support was provided to parents in a number of ways. This included listening to their concerns and allowing them to unburden themselves, validating their feelings, normalizing their experiences, and empowering parents. Many parents seemed intimidated by the medical care that their infants had required. It was important to assist parents with identifying that they are the experts when it comes to their own infants.

The parents took an active part in providing support to each other. Because they were "all-in-the-same-boat" the parents knew instinctively the kinds of support that each other needed. It also seemed easier for them to accept support from others who had been through a similar situation as they did not need to defend their need for support. Feeling supported and understood was an important means of enabling parents to feel more comfortable, competent and increase their adaptation to caring for baby at home.

Implications for Practice

The literature identified the transition to parenthood as a time of increased stress. Based on her observations of the parents in the program, the student would agree with this finding. In addition to adapting to caring for their premature infant at home, these parents were dealing with normative stresses characteristic of the transition to parenthood. This included feelings of fatigue, isolation and overwhelming responsibilities (Miller & Sollie, 1986) that all new parents face. And like parents of full-term infants, they sought to adapt and integrate the changes that parenthood had brought into their lives. As indicated in the literature, the parents coped with the demands placed on them by seeking help and support from their spouses, by taking pride in their baby, by reaching outside of the family for additional help and support (i.e., coming to the program), and by reminding themselves that child care would become easier in the future.

The literature (Easterbrooks, 1988, Kagan & Seitz, 1988) indicated that parents of premature infants have a more intensified or complicated transition to parenthood. The student frequently observed the parents having to face additional concerns because of the baby's prematurity. Often the parents appeared to be caught between looking back and trying to resolve their baby's early birth (i.e., "I thought my baby was born early because I had done something wrong" and with trying to move on and parent their baby. The literature (Hamelin, 1991, Harrison, 1983, Kaplan & Mason, 1960, Ladden, 1990) was correct when it identified that for many parents, taking their baby home was a second crisis. Many parents continued to experience heightened levels of anxiety, self-doubts about

their competency with baby care and fear that something else may happen to their baby, i.e., Sudden Infant Death Syndrome (SIDS).

As noted in the literature (Harrision, 1983, Henry, 1990, Nance, 1982), these parents benefitted from peer contact after their infant was discharged home. The student had observed that in some instances, parents had been aware of the program in Cycle I but did not attend until Cycle II at which time they were still experiencing some ongoing concerns with parenting their infant. Parents expressed that it helped to know that others were dealing with similar feelings, issues and concerns.

The post-hospital discharge period was a difficult time for these parents. The student noted that three of the nine mothers were dealing with post-partum depression issues and this bears out Bennett & Slade's (1991) study that found these mothers at increased risk for problems with post-partum adjustment. The literature (Bennet & Slade, 1991, Gottlieb & Pancer, 1988) also noted that many parents of premature infants are dissatisfied with their levels of social support. Many of the parents in the program expressed that they felt some relatives and friends did not understand their situation and did not lend their support. The literature identified premature infants as over represented in populations of abused and neglected infants, however, the student did not observe signs of infant maltreatment among the parents and babies in the program.

The literature reported extensively on the positive benefits of support groups for parents whose premature infants had not yet left hospital (Boukydis, 1982, Duhamel et al., 1974, Dammers, 1982, MacNab, 1985, Meier, 1978, Minde, 1980, Shosenberg, 1980). The student reasoned that if in-hospital groups were beneficial to parents then parents would

also benefit from support groups after baby was discharged from hospital. Subsequently, the student was surprised by the absence of reporting on the use of group in this area. Harrision (1983), Henry (1990), Nance (1982) and Sieftert et al. (1983), however, all reported the need for support groups and programming once parents have brought their infants home.

In preparation for developing the post-discharge program for parents, the student reviewed the available literature on in-hospital support groups. The student found the reports to be largely descriptive as opposed to research oriented. However, despite the descriptive nature of these reports the articles did not address significant issues or themes that arose in this program. The student found that many of the parents used the program to some extent to express concerns about issues other than their premature infant. These issues included: past childbearing losses, personal health issues, marital conflict, post-partum depression and alcoholism in the family. Only one author, Schosenberg (1980), acknowledged that in parent groups some participants will have special needs and problems that are better addressed outside of the group.

Gitterman (1982) reported on the use of groups in health care. The student fully agrees with his observation that if a group is to succeed it is essential to have the staff hours for the project, to have support and backing of upper administration, and to have the support of peers as well as that of horizontal interdisciplinary staff. The student found that a wide range of disciplines, from nursing staff and physicians to secretaries and housekeeping staff, played a role in the operation of the program. It was important to have their good-will in order to achieve the success of the program.

The student found that collectivity was a very practical means of service delivery in that the issues of parents were largely problem-specific and transitional (short-lived) in nature. While the babies began to "out-grow" issues related to prematurity the parents would begin to "out-grow" the program and then could look to other sources for support and information. In this sense, the population in need for this program was "recyclable." This matched the nature of collectivity in that it too was "recyclable" and mimicked the "beginning stages of group over and over again" (Sulman, 1986). The student agrees with Clarke (1986) that collectives are well-suited to serve parents in life-transitions and as a means of working with collections of individuals in health care settings. As postulated by Bothwell & Eisenberg (1986), the program collectivity enabled parents to receive support, information and mutual aid without the time or personal investment required for group development. The student found that the collectivity generated a functional level of cohesion that enabled parents to benefit from peer contact. At the same time some needs were better addressed outside of the collectivity and the moderate level of cohesion likely made it easier for members to maintain ties to their own network and to engage in brokerage service with the student outside of the collectivity.

Bennett & Slade's (1991) writings on the importance of social support in this population was most relevant. The student agrees with the authors that an "average" level of social support does not meet the needs of parents with high-risk infants. Also, Gottlieb & Pancer's (1988) observation that parents are too busy caring for baby to seek out social support was woefully accurate among the program members. Further, these

parents contact with others in the collectivity was in many instances more attuned to their current needs than contact with members of their own established networks.

The student found that the literature on social support, especially Bennett & Slade (1991) and Gottlieb & Pancer (1988) as most enlightening and provided her with a better understanding on the role of support in the program. For example, Gottlieb & Pancer (1988) identified that support groups gave parents the opportunity to practice reaching out for help and that this skill could then be transferred outside of the group (collectivity) and back to their own networks. By the end of the program the student had observed several instances where parents began to make better use of their own resources, for example: the mother of twins had decided to contact another mother of twins whom she had met while she was in hospital; several parents decided to join neighbourhood parenting groups; and other members decided to ask their spouses to become more involved with baby care so that they could begin to have more time out of the house. The literature on social support helped the student to better conceptualize ways to empower parents so that they could be better able to care for their own needs.

Summary

This chapter has focused on and attempted to relate the less measurable but equally important aspects of the program. This has included a process review of collectivity and the group dynamics in collectivity. Under the section on implications for practice, the student reported on observations of the program and linked these observations to the

literature. The student's experience supports the use of collectivity with parents of discharged premature infants.

CHAPTER SIX

PERSONAL LEARNING, RECOMMENDATIONS AND CONCLUSION

Personal Learning, Recommendations and Conclusion

Personal Learning

The student accomplished her primary personal objective of developing, implementing and evaluating a program for parents of premature infants. Through this process the student discovered that the planning phase of a program is vitally important and can set the tone for the success or failure of the project. The student developed a better knowledge and understanding about the experience and needs of parents of premature infants once their infant has been discharged home. The student found that the literature on parents of premature infants was largely accurate but that it did not report on the resiliency of the parents or recognize the deep commitment and desire of the parents to compensate for their infants difficult early birth. The student also learned first-hand of the types of support these parents needed and the role of social support in both their resolution of their infant's prematurity and adapting to caring for their infant. The student also developed knowledge and skills needed in facilitating a collectivity. The student became better versed in the characteristics and uses of collectivity and was able to practice and improve on such skills as linking and facilitating which were essential to work in a collectivity.

The student's learning stretched beyond the personal objectives set out in the introduction of the report. The student found that the process of this practicum improved her ability to develop and organize her thinking around intervention with parents in her daily work. Also, the work with collectivity necessitated a major shift in the student's

thinking. The student's background is primarily casework in a hospital obstetrical unit. Her job placed a heavy emphasis on identification of child welfare concerns and this had accustomed her to looking for social high risks. Working with the parents in the collectivity required the student to identify and build on parent strengths rather than to try and compensate for weaknesses.

The student had to expand her thinking away from working with individuals to working with many individuals simultaneously in a collectivity. The student found that she had to find ways to set limits on behaviours if it interfered with the overall functioning in collectivity. The student found confrontation a difficult skill to master.

The practicum experience also taught the student the value of evaluation of self, of the chosen intervention and of clients. The student found that self-evaluation through the use of a modified Corey & Corey Leadership Rating Scale helped her to begin to take a more systematic look at her own practice, to identify which skills were in greatest need for improvement. The scale also provided positive feedback in that it enabled the student to note improvements in practice. By evaluating the chosen intervention, working with parents through collectivity, the student was able to identify whether or not the intervention was suited to the population and program objectives. By evaluating the parents themselves the student increased her knowledge about this population as well as which interventions do or do not work with these clients. Evaluation enabled the student to gain feedback and make changes and ongoing improvements in the program. Finally, evaluation was seen to be important because it indicated whether or not a prac-

titioner is achieving her desired results as well as offering tangible indication of the usefulness of the intervention.

Recommendations for Future Work

First of all, the student wishes to recommend that the program continue to be available to parents on a once or twice yearly basis. There is a need for psycho-social support services for parents of premature infants that is not being met by other programs or agencies in the community. Further, as indicated by feedback from parents, the program was a worthwhile experience and enhanced their day-to-day coping with their infants. The student offers the following considerations to practitioners who would plan to provide such a program to parents of premature infants or similar populations. The student suggests that:

a. Programs be well advertised both in the hospital as well as in the community. Further, it is very important to educate interdisciplinary peers about the program in order to ensure their cooperation with the project.

b. The program be held within the hospital as the hospital lends credibility to the program, and parents are already familiar with this location.

c. The program be facilitated by hospital-based social workers familiar with the course of hospital care of premature infants.

d. The program continue to be offered to parents whose infants are one year chronological age or younger. Parents with very young infants are often reluctant to leave the house with

baby and therefore would not make use of the program.

e. The length of each session be increased from 1½ hours to 2 hours to allow time for covering the session topics and time for socializing among the parents.

f. The program duration be increased by one or two sessions. With the present length of six sessions, parents are ready to begin to do some personal work at about the time the collectivity needs to address termination issues. The student suggests that additional sessions might include instruction on first-aid for infants.

g. Increase the focus on the collectivity as a means of providing social support to parents.

Persons working in this or similar programs must be able to reach out and quickly engage participants. It would be helpful but not necessary for such persons to have direct knowledge of infant care. However, when working with parents and infants in either collectivity or groups it is necessary for the leader to be able to express warmth and caring and above all to remain flexible as the infants have their own schedules and agendas. The student strongly suggests that the leader have either a working or theoretical knowledge of collectivity to minimize the potential of the leader setting goals and expectations that the collectivity cannot fulfil.

The student strongly suggests that persons wishing to conduct such a program have an understanding of hospital obstetrical issues and of the treatment of premature infants. The student feels that this is essential to understanding the experiences of the parents. Many parents of

premature infants have unresolved issues surrounding their baby's early birth and subsequent hospitalization. The parents need to have a program leader who understands and has observed how many parents have had to make first contact with their infants through such barriers as incubator walls or with tubes, monitors and ventilators attached to their baby.

Most parents had a need to "look back" and talk about their baby's hospitalization before they were able to become more present focused and look forward to their infant's future. This was an important piece of work in the program. The student found that these issues were more appropriately discussed when raised by parents rather than being regulated to one of the session topics. The student has some concern that if the program was offered by a community agency that this subtle but important part of the program might be missed. f a social agency or department such as a public health office were to coordinate the program the student has concerns that the program be available to <u>all</u> parents and not just to parents living in the catchment area of the agency.

The student strongly suggests that the program continue to be facilitated by a social worker rather than nursing. Parents of premature infants have had to rely on high-tech medical care for their infants survival. Consequently, parents can become prone to talking about their baby in medical terms. Once their infant is discharged home parents need to see themselves as competent in the care of their infant. The student has some concern that if medical staff, i.e. nurses, were to lead the program that parents may tend to rely on their medical authority to such an extent that the parents may fail to identify themselves as the "expert" when it comes to their own baby.

Social work has traditionally provided a bridge between the hospital and the community. The student identifies social work as the appropriate discipline to empower the population of parents of discharged premature infants. Social work has had the expertise in assisting parents with the parent-child relationship as well as with developing and strengthening the parents' ties to their sources of social support. Attention needs to be paid not only to the infant's medical and physical transition to home but also to the infant's social transition to home.

Conclusion

The field of neonatology, over the last twenty years, has radically advanced the care of premature infants (Banks, 1989). This has necessitated the need for the advancement of social work service to the parents of premature infants. The needs of parents of hospitalized infants has been well identified, however to date, the literature has ignored these parents once their infants have been discharged from hospital.

There is a need for further study into the services that these parents require once their infants are at home. Based on findings in this practicum, the student suggests that the needs of parents of multiple premature births be assessed as a separate category. The parents of multiple births appear to have unique needs in addition to those of parents of single premature births. However, there is a need to offer all parents of premature infants follow-up services that can assist them in their adaptation from caring for their infant in hospital to caring for their infant at home. These services should be exclusive to parents of premature infants and should address the needs of the parents as well as

issues related to the care of the infants. The use of a collective or group is an ideal means of service delivery as it can validate and normalize the concerns of the parents as well as offer the support and information on this stage of parenting a premature infant.

This practicum report demonstrates the benefits of the use of collectivity in a population of parents of discharged infants. It also shows that the needs of parents of premature infants are of a different order than parents of full-term infants. However, the special needs of these parents tend to be transitional in nature and can be accommodated in a collectivity with a focus on support, information and contact with peers.

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APPENDICES

Appendix A

LETTERS

October 2, 1990

Dr. Nigel MacDonald
Section Head, Neonatology
Rm E3003
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, MB
R2H 2A6

Dear Dr. MacDonald:

Thank you for your support of the pilot project, **Now That Baby's At Home . . .**, that has been undertaken as part of my Masters of Social Work Practicum.

Please find enclosed a copy of the program pamphlet.

The pamphlets have been forwarded on to the special care nurseries for distribution to parents by the nursery staff. Also enclosed is a copy of **Information for Health Care Staff** that provides a brief outline of the program objectives and information about distributing the pamphlet.

If any questions or concerns about the program arise, please call me. Thank you.

Susan Bugaliski
Masters of Social Work - Candidate

Enc.

October 2, 1990

Mrs. Edith Parker
Director of Maternal Child Nursing
St. Boniface General Hospital
409 Tache Avenue
Winnipeg, MB
R2H 2A6

Dear Mrs. Parker:

Thank you for our recent meeting about the pilot program, **Now That Baby's At Home . . .** . Your interest and support of this program is most appreciated.

Please find enclosed a copy of the program pamphlet. The pamphlets have been forwarded on to the special care nurseries for distribution to the parents by the nursery staff. Also enclosed is a copy of **Information for Health Care Staff** that provides a brief outline of the objectives of the program and information about distributing the pamphlet. Thank you for the assistance of nursing staff in the distribution of the pamphlet.

If any questions or concerns about the program arise please call me.

Thank you.

Susan Bugaliski
Masters of Social Work - candidate

Enc.

October 2, 1990

Mr. Dick Marinelli
Assistant Director
Department of Social Work
Children's & Women's Hospital
Room 347
Community Services Building
Health Sciences Centre
678 William Avenue
Winnipeg, MB
R3E OW1

Dear Dick:

This letter is written to update you on the progress of my Masters of Social Work practicum. The program for parents of recently discharged premature infants has been called **Now That Baby's At Home.** The pamphlets advertising the program have been distributed to the special care nurseries at both Health Sciences and St. Boniface General Hospital. A brief outline called **Information for Health Care Staff** has been written to provide staff with the objectives of the program and information about distributing the pamphlet. I have included a copy of the pamphlet and background information for your perusal.

I would like to thank you for the assistance and support of Barb Trail and Meaghan Beamish in enabling parents from Health Sciences Centre to participate in this program. Both Barb and Meaghan have been very helpful in this endeavour.

If any questions or concerns about the program arise, please call me.

Thank you.

Susan Bugaliski
Masters of Social Work - Candidate

Enc.

October 2, 1990

Dr. Molly Seshia
Section Head, Neonatology
Room WS012
Women's Hospital
Health Sciences Centre
735 Notre Dame Avenue
Winnipeg, MB
R3E 0Z3

Dear Dr. Seshia:

Thank you for your support of the pilot project, **Now That Baby's At Home** that has been undertaken as part of my Masters of Social Work practicum.

The program pamphlets have been printed and distributed to the special care nurseries at Health Sciences Centre as well as St. Boniface General Hospital. For your perusal I have included a program pamphlet and a copy of **Information for Health Care Staff**. The latter provides a brief outline of the program objectives and the role of nursing staff in the distribution of the pamphlet.

I am very happy to be able to include parents of premature infants from Sciences Centre in the program. If any questions or concerns about the program arise, please call me.

Thank you.

Susan Bugaliski
Masters of Social Work - candidate

Enc.

October 2, 1990

Ms. Sybil Russell
Head Nurse
Neonatal Intensive Care Unit
Children's Hospital
Health Sciences Centre
840 Sherbrook Street
Winnipeg, MB
R3A 1S1

Dear Sybil:

Thank you for our recent meeting about the pilot program, **Now That Baby's At Home . . .** . Your interest and support of this program is most appreciated.

Please find enclosed a copy of the program pamphlet and several copies of an outline called **Information for Health Care Staff**. The latter provides a brief outline of the program objectives and information about distributing the pamphlet. Thank you for the assistance of your nursing staff in distribution of the pamphlet.

If any questions or concerns about the program arise, please call me.

Thank you.

Susan Bugaliski
Masters of Social Work - Candidate

Enc.

October 2, 1990

Ms. Barbara Overlea
Head Nurse
T1 Nursery
Women's Hospital
Health Sciences Centre
735 Notre Dame Avenue
Winnipeg, MB
R3E 0Z3

Dear Barb:

Thank you for your interest in the pilot program, **Now That Baby's At Home . . . a short-term program for parents of discharged premature infants**, that has been undertaken as a part of my Masters of Social Work practicum. I am very happy to be able to include parents from Health Sciences Centre in this program.

Please find enclosed a copy of the program pamphlet and several copies of an outline called **Information for Health Care Staff**. The latter provides a brief outline of the program objectives and information about distributing the pamphlet. Thank you for the assistance of your nursing staff in distribution of the pamphlet. It is most appreciated.

If any questions or concerns about the program arise please call me.

Thank you.

Susan Bugaliski
Masters of Social Work - candidate

Enc.

Appendix B

INFORMATION FOR HEALTH CARE STAFF (1991)

(On the Now That Baby's At Home ... A Short-Term Program for Parents of Recently Discharged Infants)

The above-named program is a pilot project undertaken as part of my masters of Social Work practicum. The project is sponsored by the Department of Social Work at St. Boniface General Hospital and the Faculty of Social Work at University of Manitoba.

OBJECTIVES AND RATIONALE

"Now That Baby's At Home ..." is a time-limited outreach program for parents of recently discharged premature infants. It is a preventative service aimed at providing information, support, feelings of increased competency and brokerage service for parents.

The program is designed to address issues identified in the literature as generic to this population that would be missed in parenting programs for parents of full-term infants. The post-hospital period can be a time when parents can benefit from contact with other parents who have been through a similar experience and are now adjusting to life with baby at home.

TARGETED GROUP

The program is open to parents of newly discharged premature infants from St. Boniface General Hospital and Health Sciences Centre. Parents are eligible to attend if their infant is one year of age or younger. Parents' participation will be by self-selection and parents may join at anytime during the program. By placing some restriction on those parents eligible to attend the program, I hope to have a group of parents with

similar needs.

THE PROGRAM

"Now That Baby's At Home ..." is a three month program consisting of six evening sessions about 1½ hours in length. Please refer to the program pamphlet for the content and agenda of the program. The structure of the program has been choosen to strike a balance between providing support to parents, facilitating an exchange of information and experiences between parents and encouraging parents to work at developing and maintaining their own support networks.

Because of the transitional nature of problems related to prematurity (for most babies) I have chosen to develop a time-limited program rather than an ongoing support group. Also, although parents of premature infants are a significant portion of the population (5 - 7% of all births), it does not appear there is sufficient number of parents in Winnipeg to develop an ongoing support group. Please note that this program ran from October to December 1990 and then is again being offered February to April 1991.

ROLE OF HOSPITAL NURSES, PUBLIC HEALTH NURSES, SOCIAL WORKERS AND OTHER HEALTH CARE STAFF IN THE PROGRAM

The primary means of advertising the program is by distribution of the pamphlet to parents at or before the time that baby is discharged from hospital. If you are involved with the discharge of an infant, please supply the parents(s) with the pamphlet regardless of the geographic location of their home. This is a very important step in letting parents

know that this resource is available to them (if they choose to use it).

If you are involved with the family of a discharged premature infant and you think that they might be interested in the program, please pass the pamphlet along to the parent(s). Some families may receive more than one pamphlet but this is not a problem. If you would like more information about the program, please call the writer at 237-2449, Department of Social Work, St. Boniface General Hospital, between 9:00 A.M. and 4:00 P.M., Monday to Friday. Your interest in the program is appreciated.

EVALUATION

At the completion of the program in May, 1991, a brief summary of the program findings will be forwarded to the special care nurseries at Health Sciences Centre and St. Boniface General Hospital. If you or your unit would like a copy of the evaluation of the program, please let me know and one will be sent out to you.

Thank you for your cooperation and assistance with this program.

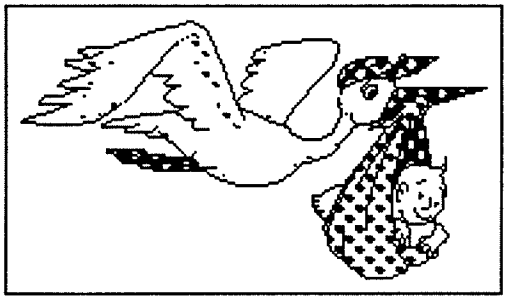
Sincerely

Susan Bugaliski

Appendix C

PROGRAM PAMPHLET

Now That Baby's At Home .... A Short-term Program for Parents of Discharged Premature Infants



As parents of a newly discharged premature baby, you are invited to participate in a program that focuses on adjustment issues that all parents face once their baby is home from hospital.

Bringing home a premature baby can be a time of questioning and uncertainty. Coming together with other parents who have shared and survived a similar experience allows for the exchange of support, ideas and information.

The program consists of six sessions. Each session will consist of a selected topic, program activity, and break followed by an opportunity to talk informally and to share how your week with your baby has gone.

The program leader will be available to answer questions about community resources and to facilitate the exchange of ideas between parents.

WHO CAN JOIN?

This program is open to parents of newly discharged premature infants from St. Boniface and Health Sciences Centre. Parents whose infants

are six months '**corrected**' age or younger are eligible to attend the program. Parents are welcome to bring their infant, if that is their choice.

ATTENDANCE

Parents are invited to attend all six sessions, or only those meetings of interest to them.

PROGRAM SESSIONS 1990

Session One, October 9

"NOW AND THEN." Parents are asked to bring in a picture of their baby during hospitalization and a picture of baby since discharge at home. This session will look back on bringing the baby home from hospital and the changes in since that time.

Session Two, October 23

"INFANT STIMULATION AND DEVELOPMENT." An Occupational Therapist will be present to discuss development of the premature infant and demonstrate positioning and handling techniques to interact and "play" with your baby.

Session Three, November 6

"BROTHERS, SISTERS AND THE PREMATURE BABY. COMMUNITY RESOURCES." What was your child's reaction to the early arrival of the new baby and the disruption in your home life? This session will also discuss community resources and programs available for families.

PROGRAM SESSIONS 1990

Session Four, November 20

"MORALE BOOSTERS." The joy of having baby come home can give way to fatigue, feeling isolated and ongoing worries. Learning to take care of oneself is an indirect but vital means of taking care of one's baby.

Session Five, December 4

"RELATIONSHIPS." Do you have questions about bonding with baby, changes in your relationship with your partner, friends or relatives? How are you feeling about yourself as a parent?

Session Six, December 18

"PARENTS' CHOICE." Do you have a topic that you would like covered in this session? The subject for this session will be selected from parents suggestions.

Phone Sue Bugaliski at 237-2449 with your suggestions.

"IN ACTUALITY, THE BABY WAS FINE BUT I WAS A WRECK."

"WHEN WE BROUGHT OUR 4½ POUND SON HOME, WE THOUGHT WE WERE BRINGING HOME A NORMAL NEWBORN. NOT SO!"

"HE SETTLED RIGHT IN AND WAS NO MORE DIFFICULT THAN OUR FULL TERM DAUGHTER HAD BEEN."

Comments on the post-hospital nursery period.
The Premature Baby Book, Helen Harrison
* * * * * * * * * * * * * *

WHEN AND WHERE?

The sessions will be held every other Tuesday

from 7:00 to 8:30 p.m. in the School of Nursing at 431 Tache Ave, Winnipeg. (The School of Nursing is the North Building attached to St. Boniface General Hospital).

COST

There is no charge for these sessions. Please pre-register your attendance at 237-2449 by 4:00 p.m. on or before the day preceding each session to facilitate the planning of the session. If you did not pre-register, however, you are still welcome to come out to the program.

FACILITATOR

The program will be facilitated by a St. Boniface General Hospital Social Worker as part of her Masters of Social Work practicum which is sponsored through St. Boniface General Hospital and the University of Manitoba.

If you would like further information about the program, please call Sue Bugaliski at 237-2449 between 9:00 a.m. and 4:00 p.m., Monday to Friday.

Appendix D

RECRUITMENT OF PARENTS AT ST. BONIFACE GENERAL HOSPITAL AND HEALTH SCIENCES CENTRE

MONTH AND HOSPITAL	Parental Response to Invitation to Come Out to the Program				
	Good	Poor	Neutral	Lives Out of Winnipeg	Total Contacts
October					
♦ SBGH*	4	2	4	–	10
♦ HSC**	4	–	–	–	4
					14
November					
♦ SBGH	1	1	–	1	3
♦ HSC	3	1	1	2	7
					10
December					6
♦ SBGH	4	1	1	2	5
♦ HSC	1	2	–	–	11
January					5
♦ SBGH	4	–	1	–	4
♦ HSC	–	1	1	2	9
February					
♦ SBGH	2	1	–	–	7
♦ HSC	2	–	–	–	2
					9
March					
♦ SBGH	3	–	1	2	6
♦ HSC	2	1	1	1	5
					11
TOTALS	30	10	10	10	60

* = St. Boniface General Hospital ** = Health Sciences Centre

Appendix E

CONSENT TO PARTICIPATE IN PROGRAM EVALUATION

In order to evaluate the program I would like to contact you in about 4 weeks after the final session. This evaluation would be completed by telephone and should take about 15 minutes.

If you are willing to participate, please indicate your agreement by signing your name and telephone number.

Name _____ Telephone Number_____

This information will be kept CONFIDENTIAL. Thank you for your cooperation and assistance.

Number:

Appendix F

PRE-GROUP DATA SHEET

First we would like some information about you. The information that you provide about yourself and your experience with your baby is strictly voluntary. This information will hopefully help in the planning of services for future parents of premature infants. Your answers will be held in confidence and individuals will not be identified in any evaluation of this program.

Please check or circle the appropriate answers. Thank You.

1. I am the baby's: mother __ father __ relative __ friend __

2. This is my first baby: Yes ___ No ___

3. This is my first **premature** baby: Yes ___ No ___

4. This was a: single birth ___ twins ___ triplets ___

5. My baby was born at _____ weeks gestation.

6. My baby was discharged after _____ weeks in hospital.

7. Today my baby is _____ weeks old (chronological age).

8. My baby has been home for _____ weeks.

9. Previously I had a miscarriage/stillbirth Yes ___ No ___

10. Previously I had a perinatal death Yes ___ No ___

11. I am: a single parent ___ married ___ separated/divorced ___ living common law ___.

12. I am: under 22 ___, 23 - 29 years ___ 30 - 36 years ___ 37 years or older ____.

13. On a scale of 1 to 5, how stressful was the first week after your baby was born:

5	4	3	2	1
Not very stressful		Somewhat stressful		Very

14. On a scale of 1 to 5, how stressful was the first week your baby was home from hospital:

5	4	3	2	1
Not very stressful		Somewhat stressful		Very stressful

15. Was your baby in the hospital during the nurses' strike (Jan 1-31, 1991)?
Yes ___ No ___

16. Do you feel that the strike interfered with the baby care instruction that you received?

1	2	3	4	5
No, not really			Yes, quite a bit	Does Not Apply

PRE-GROUP DATA SHEET

17. How did you learn about the Now That Baby's At Home .... Program. (Please check all those that apply)

a. pamphlet	_____	e. physician	_____
b. nurse	_____	f. newspaper	_____
c. group leader	_____	g. television	_____
d. public health nurse	_____	h. another parent	_____
i. Social Worker	_____	j. other	_____

18. From your experience, what would you say parents of premature infants need once their baby comes home from the hospital? Please answer on back of paper if more space is needed.

No.	Date:

Appendix G

PRE-GROUP DATA COLLECTION - RAW DATA						
QUESTIONS 1 - 6						
Client	#1 Status	#2 1st Baby	#3 1st Premature	#4 Single Birth/ Twins	#5 Age at Gestation (Weeks)	#6 Weeks in Hospital
Alice♦	Mother	Y	Y	Twins	33	5 & 7
Carla	Mother	Y	Y	Single	29	9
Barry♦	Father	N	Y	Twins	33	5 & 7
Lizzy	Mother	Y	Y	Single	29	9
Mary♦	Mother	Y	Y	Twins	33	2 & 3
Rita	Mother	Y	Y	Single	34	3
Tammy	Mother	N	Y	Single	32	2
Judy*	Mother	Y	Y	Single	34	2
Natalie*	Mother	N	N	Single	33	3
Lisa*	Mother	Y	Y	Single	30	8
Average	9 Mothers 1 Father	7 First	9 First Premature		32 Weeks	5 Weeks
Range					29 - 34 Weeks	2 - 9 Weeks

Legend: Post = parent responses after attendance at one Cycle of the Program
() = parent responses after attendance at two Cycles of the Program
♦ = parent is parent of twins
* = parent attended two Cycles of the Program

PRE-GROUP DATA COLLECTION - RAW DATA						
QUESTIONS 7 - 12						
Client	#7 Chronological Age of Baby	#8 Weeks Home	#9 Miscarriage/ Stillbirth	#10 Perinatal Death	#11 Marital Status	#12 Parent's Age
Alice♦	20	15 & 13	N	N	M	23-29
Carla	9	0	N	N	M	37+
Barry♦	22	17 & 15	N	N	M	30-36
Lizzy	12	3	N	N	M	30-36
Mary♦	2½	0 & 0	N	N	M	30-36
Rita	8	5	N	N	S	30-36
Tammy	12	10	Y	N	M	23-29
Judy*	5(24)	2(21)	Y	N	M	23-29
Natalie *	22(36)	19(33)	Y	N	M	30-36
Lisa*	25(41)	17(33)	Y	N	M	30-36
Average	15 Weeks	10 Weeks	40% Yes	100% No	90% Married	30-36
Range	2-41 Weeks	0-41 Weeks				23-37+

Legend: Post = parent responses after attendance at one Cycle of the Program
() = parent responses after attendance at two Cycles of the Program
♦ = parent is parent of twins
* = parent attended two Cycles of the Program

PRE-GROUP DATA COLLECTION - RAW DATA					
QUESTIONS 13 - 17					
Client	#13 Stress at the Birth	#14 Stress 1st Week Home	#15 In Hospital Strike	#16 Interference from Strike	#17 Learn of Program
Alice♦	1	2	N		Pamphlet
Carla	1	3	Y	4	Pamphlet & Nurse
Barry♦	1	4	N		Public Health Nurse
Lizzy	3	4	N	1	Pamphlet & Group Leader
Mary♦	2	3	Y		Pamphlet & Nurse
Rita	3	3	Y	3	Group Leader & Social Worker
Tammy	1	4	N		Public Health Nurse
Judy*	4	4	N		Group Leader & Another Parent
Natalie*	3	3	N		Public Health Nurse
Lisa*	1	1	N		Another Parent
Average	2	2.7			
Range	1-4	1-4			

Legend: Post = parent responses after attendance at one Cycle of the Program
() = parent responses after attendance at two Cycles of the Program
♦ = parent is parent of twins
* = parent attended two Cycles of the Program

Question #18 What do parents of premature infants need once their baby comes home from hospital?

Alice: No comment.

Carla: "Talking to other parents of premature infants for support and a guide to help."

Barry: "Support - group and professional."

Lizzy: No comment.

Mary: No comment.

Rita: "Time to get things together if you weren't prepared beforehand."

Tammy: "parents need to be told what to expect of premature babies."

Judy: "Reassurance that you're doing OK."

Natalie: "Contact with other mothers of preemies."

Lisa: "Information on the differences from 'normal' newborns."

Appendix H

PRE- AND POST CLIENT QUESTIONNAIRE

First we would like some information about you. The information that you provide about yourself and your experience with your baby is strictly voluntary. This information will hopefully help in the planning of services for future parents of premature infants. Your answers will be held in confidence and individuals will not be identified in any evaluation of this program.

Please check or circle the appropriate answers. Thank You.

1. On a scale of 1 to 5, how stressful was this past week with your baby:

5	4	3	2	1
Not very stressful		Somewhat stressful		Very stressful

2. Are you concerned that your baby may have a significant developmental delay?
Yes ___ (0) No ___ (2)

3. How do you feel that you are getting on with the day-to-day care of your baby?

4	3	2	1
It has been difficult	Some days are tougher than I had expected	Most days are good	It is going very well

4. Over the last several weeks from the persons close to you, how do you feel about the practical help you received with your baby? (If you feel that this question does not apply to your situation, please check _____)

4	3	2	1
I received more help that I need	As much help as I need	Less help than I need	No help

5. Over the last several weeks from the persons close to you, how do you feel about the understanding you get with your concerns and feelings? (If you feel that this question does not apply to your situation, please check _____)

4	3	2	1
I received a lot of understanding	Most of the time I felt understood	I received some but could use more understanding	I didn't receive much understanding

6. All parents have some concerns about the care they provide for their children. In your care of your premature baby, do you feel

4	3	2	1
Uncertain about the care of your baby	Somewhat unsure about the care your baby	Fairly confident about the care your baby	At ease about the care of your baby

7. Do you feel that you have the information you need to parent and to understand your baby's needs at this time?

1	2	3	4
No, I feel quite unprepared	Not really, I could use more information	Yes, but I would like more information	I feel well informed and prepared

PRE- AND POST CLIENT QUESTIONNAIRE

8. In general, how do you feel about the assistance you received from professional persons (i.e. Public Health Nurses, Physicians, Social Workers, etc.) and social agencies (i.e. Child and Family Services, Homemaker Services, etc.) since your baby's discharge.

1	2	3	4
There hasn't been a lot of help	I've had some help but need more	It's been okay; help is there if I ask for it	I feel I've received a lot help

9. Over the last month, how do you feel about your family life?

1	2	3	4
This is a very difficult time	This is a some-what hard time	Things have been alright	It has been very good

10. Over the last month, how do you feel about your life as a whole?

1	2	3	4
This is a very difficult time	This is a some-what hard time	Most of the time it goes fairly well	It has been very good

11. Since baby's discharge from hospital, have you had any informal contact (i.e. outside of this group) with other parents of a premature baby?

Yes ___ No ___

b. If you answered yes, how many other parents have you had informal contact with? (Please count a couple as one parent.)

i. one parent ___ ii. two parents ___
iii. three parents ___ iv. four or more parents ___

No. Date:

Thank You for your time and answers.

Appendix I

PRE- AND POST PROGRAM CLIENT QUESTIONNAIRE – RAW DATA

QUESTIONS 1 - 5

Client	#1 Past Week		#2 Developmental Delay		#3 Daily Coping (Baby)		#4 Practical Help		#5 Under-Standing	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Alice♦	2	1	N=2	N=2	3	1	3	3	3	2
Carla	3	5	N=2	N=2	2	4	2	2	3	1
Barry♦	3	3	N=2	N=2	2	3	2	2	3	2
Lizzy	5	5	N=2	N=2	3	3	3	3	4	4
Mary♦	3	3	N=2	N=2	3	2	2	3	3	3
Rita	5	3	N=2	N=2	3	3	3	1	2	2
Tammy	3	2	Y=0	Y=0	2	3	4	3	4	4
Judy*	4	3(5)	N=2	N(N)=2	4	3(4)	3	3(3)	3	4(3)
Natalie*	3	3(5)	N=2	N(N)=2	2	3(4)	2	3(3)	2	3(3)
Lisa*	4	5(5)	N=2	N(N)=2	4	4(4)	2	2(1)	3	3(2)

Legend: Post = parent responses after attendance at one Cycle of the Program

() = parent responses after attendance at two Cycles of the Program

♦ = parent is parent of twins

* = parent attended two Cycles of the Program

PRE- AND POST CLIENT QUESTIONNAIRE - RAW DATA										
QUESTIONS 6 - 10										
Clients	#6 Confidence Baby Care		#7 Knowledgeable Baby Care		#8 Support From Professionals		#9 Family Life		#10 Personal Life	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Alice♦	3	3	2	3	4	3	2	1	2	1
Carla	4	3	3	3	3	4	3	1	3	1
Barry♦	3	3	3	3	3	4	2	1	1	1
Lizzy	4	4	3	4	1	1	4	3	3	3
Mary♦	2	3	3	4	3	4	3	1	2	1
Rita	3	3	3	4	3	3	3	3	3	2
Tammy	3	4	3	3	3	4	3	4	4	4
Judy*	3	4(3)	3	3(4)	3	4(3)	4	4(4)	4	4(4)
Natalie*	4	4(4)	3	3(3)	3	4(3)	3	3(3)	3	3(4)
Lisa*	3	4(4)	3	4(4)	4	4(4)	3	3(3)	3	3(4)

Legend: Post = parent responses after attendance at one Cycle of the Program
() = parent responses after attendance at two Cycles of the Program
♦ = parent is parent of twins
* = parent attended two Cycles of the Program

PRE- AND POST CLIENT QUESTIONNAIRE - RAW DATA				
QUESTION 11				
Clients	Contact With Other Parents		Number of Parents	
	Pre	Post	Pre	Post
Alice♦	N=0	Y=2	—	1
Carla	N=0	Y=2	—	3
Barry♦	N=0	N=0	—	—
Lizzy	N=0	N=0	—	—
Mary♦	N=0	N=0	—	—
Rita	Y=2	Y=2	1	4+
Tammy	N=0	N=0	—	—
Judy*	Y=2	Y=2	4+	4+(4)
Natalie*	Y=2	Y=2	2	2(3)
Lisa*	Y=3	Y=2	2	2(3)

Legend: Post = parent responses after attendance at one Cycle of the Program
() = parent responses after attendance at two Cycles of the Program
♦ = parent is parent of twins
* = parent attended two Cycles of the Program

Appendix J

CLIENTS' SELF-RATING SCALE OF THEIR GOAL(S) FOR INDIVIDUAL SESSIONS

Name:	Session:

Goal:

How close do you feel you came to meeting this goal in the session?

1	2	3	4	5
Made No progress toward meeting my goal.	Have some new ideas for meeting my goal	Partially met my goal	Came close to meeting my goal	Met my goal for the session

2nd Goal (If Applicable):

How close do you feel you came to meeting this goal in the session?

1	2	3	4	5
Made No progress toward meeting my goal.	Have some new ideas for meeting my goal	Partially met my goal	Came close to meeting my goal	Met my goal for the session

Appendix K

CLIENT SATISFACTION AND FEEDBACK SHEET FOR INDIVIDUAL SESSIONS

Please help to improve future service to parents by completing this questionnaire. Please answer as candidly as possible.

1. Did you learn anything new during the session? Yes ___ No ___

2. Was today's topic relevant to your concerns?

1	2	3	4	5	6
Yes		Somewhat			No

3. What session would you have liked to get out of the session but did not?

4. What did you like best about the session?

5. Did meeting with the group leader and with other parents leave you with a feeling of support?

Yes _____ No ____

Your comments please:

6. What could the group leader do to be more helpful to members?

7. Do you have a topic that you would like to have covered in a future session.

8. Is this a convenient meeting time and/or location?

9. This is the: 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___
6th ____ time that you have attended the program?

10. Do you have any other comments or suggestions? (Please use the back of the paper if you need more space for your reply.)

Appendix L

MODIFIED GROUP LEADERSHIP SKILLS RATING SCALE

Rate each item on a scale of 1 to 7.

1 = I am very poor at this.
7 = I am very good at this.

____ 1. **Active Listening**: I am able to hear and understand both direct and subtle messages.

____ 2. **Clarifying**: I can focus on underlying issues and assist others to get a clearer picture of some of their conflicting feelings.

____ 3. **Summarizing**: When I function as a group leader, I'm able to identify key elements of a session and to present them as a summary of the proceedings.

____ 4. **Linking**: I find ways of relating what one person is doing or saying to the concerns of other members.

____ 5. **Supporting**: I'm usually able to tell when supporting another will be productive and when it will be counterproductive.

____ 6. **Blocking**: I'm able to intervene successfully, without seeming to be attacking, to stop counterproductive behaviours (such as gossiping, story telling, and intellectualizing) in group.

____ 7. **Evaluating**: I appraise outcomes when I'm in a group, and I make some comments concerning the ongoing process of any group I'm in.

____ 8. **Facilitating**: In a group, I'm able to help others openly express themselves and work through barriers to communication.

____ 9. **Empathizing**: I can intuitively sense the subjective world of others in a group, and I have the capacity to understand much of what others are experiencing.

____ 10. **Terminating**: At the end of group sessions, I'm able to create a climate that will foster a willingness in others to continue working after the session.

(Based on Group Leadership Skills Rating Scale, Corey & Corey, 1977).

Appendix M

MODIFIED GROUP LEADERSHIP SKILLS RATING SCALE - RAW DATA								
CYCLE I								
	SESSIONS							
	1	2	3	4	5	6	Average	Change
Active Listening		4.5	3.5	5	3	4.5	4.1	n/a
Clarifying		2	3	4	2.5	3	2.9	n/a
Summarizing		3	3	4	3	4	3.4	n/a
Linking		5	4	5	4	4	4.4	n/a
Supporting		4	4	4.5	3	4.5	4.0	n/a
Blocking		4	3	4	3	4	3.6	n/a
Evaluating		3	3	4	3	3	3.2	n/a
Facilitating		4	4	5	2	5	4	n/a
Empathizing		3	3	4	3	4	3.4	n/a
Terminating		2.5	2	4	3	4	3.1	n/a
CYCLE II								
Active Listening	5	5	4.5	5	5	3.5	4.6	0.5
Clarifying	4	3	4.5	5	4	3	3.9	1.0
Summarizing	3.5	2.5	3.5	3	3	3	3.4	0.0
Linking	5	3	6	5.5	5	5.5	5.0	0.6
Supporting	4.5	4	4.5	4.5	5.5	4	4.5	0.5
Blocking	4	2.5	4	4	4	4	3.7	0.1
Evaluating	4	2	6	3	4	4	3.7	0.5
Facilitating	4	3	6	5	5	4.5	4.5	0.5
Empathizing	4.5	4	5	6	6	4	4.9	1.5
Terminating	3	2	5	4	3	3	3.3	0.2

MODIFIED GROUP LEADERSHIP SKILLS RATING SCALE - RAW DATA			
SUMMARY			
	CYCLE I	CYCLE II	CHANGE
Overall Average of all Scores	3.6	4.1	0.5

Appendix N

FOLLOW-UP PROGRAM INTERVIEW - TELEPHONE SURVEY

1. When your baby was discharged home did you feel that your baby's care and that your responsibilities were the same as a parent with a full-term infant?

   Yes - It was roughly the same.

   No - It was more responsibility and care

2. At the present do you feel that your baby's care and that your responsibilities are the same as a parent with a full-term infant?

   Yes - It is roughly the same.

   No - It was more responsibility and care.

3. Did attending the meetings leave you with:

   1) Additional information about this stage of parenting? Yes No

   2) Feeling supported after having talked to others in the program? Yes No

   3) Feeling more at ease about your parenting of your premature infant? Yes No

4. How many sessions did you attend? _____

5. Did you find the sessions that you attended a worthwhile experience? Yes No

6. Would you recommend the program to other parents of premature infants? Yes No

7. If you wanted to talk with another parent about baby care etc., do you feel that you would want to talk with:

   a. another parent of a premature infant?

   b. Another parent with a baby? or

   c. It depends on my concerns.

FOLLOW-UP PROGRAM INTERVIEW- TELEPHONE SURVEY

8. Apart from your baby's other parent or your relatives, who is your main source of support and/or help with your baby?

9. From your experience what would you say parents of premature infants need once their baby comes home from hospital?
Comment Please:

10. Do you have comments or suggestions about the program?

Appendix O

POST PROGRAM INTERVIEW - RAW DATA						
Client	#1 Care at Dis-charge	#2 Care at Present	#3 Infor-mation	a) Sup-port	b) At Ease	c) Broker age
Alice ♦	No, More	Yes, Same	No	Yes	Yes	Yes
Carla	No, More	No, More	Yes	Yes	Yes	Yes
Barry ♦	No, More	Yes, Same	Yes	Yes	Yes	Yes
Lizzy	No, More	Yes, Same	Yes	Yes	No	No
Mary ♦	No, More	Yes, Same	Yes	Yes	No	No
Rita	No, More	Yes, Same	No	Yes	Yes	No
Tammy	No, More	Yes, Same	Yes	Yes	Yes	No
Judy*	Yes, Same (No, More)	No, More (Yes, Same)	Yes (Yes)	Yes (Yes)	Yes (Yes)	No (No)
Natalie *	No, More (No More)	No, More (Yes, Same)	Yes (Yes)	Yes (Yes)	Yes (Yes)	No (Yes)
Lisa*	No, More (No, More)	Yes, Same (Yes, Same)	Yes (Yes)	Yes (Yes)	Yes (Yes)	No (Yes)
Legend: * = Attended both Cycles () = 2nd Cycle Response ♦ = Had Twins						

POST PROGRAM INTERVIEW - RAW DATA (Continued)					
Client	#4 Sessions Attended	#5 Worth-while	#6 Recommend	#7 Talk With	#8 Source of Support
Alice ♦	4	Yes	Yes	Depends	Friends
Carla	4	Yes	Yes	Premature	Friends
Barry ♦	3	Yes	Yes	Depends	Books
Lizzy	3	Yes	Yes	Premature	Friends
Mary ♦	1	Yes	Yes	Depends	Pedia-trician
Rita	1	Yes	Yes	Premature	Friends
Tammy	2	Yes	Yes	Depends	Friend
Judy*	3 (3)	Yes (Yes)	Yes (Yes)	Depends (Depends)	Friends (Friends)
Natalie *	5 (6)	Yes (Yes)	Yes (Yes)	Premature (Premature)	Friend (Friend)
Lisa*	5 (4)	Yes (Yes)	Yes (Yes)	Premature	Friend (Friend)
* = Attended both Cycles () = 2nd Cycle Response ♦ = Had Twins					

Question #9: **From your experience what would you say parents need once their baby comes home from hospital. Comment please.**

Alice: No Comment

Carla: They need more support while baby is in hospital and support when baby comes home.

Barry: Support and encouragement.

Lizzy: They need more information about premature babies.

Mary: They need good family support. It took me two months to realize that my babies weren't going to be fragile and break.

Rita: You need clothes that are small enough to fit a premature

baby. They need counselling. I didn't get enough time/counselling to let me know that his development would be delayed.

Tammy: They need lots of support and reassurance that they're OK. I blamed myself that she was born premature. Now I know that this is just something that happened.

Judy: (From Cycle I) You need confidence. A group is ;really good because it helps explain why baby does what he does.

(From Cycle II) Parents need a parent group whether it is for prematures or not. A parent group helps you become more confident. And it helps to know that others are going through the same things.

Natalie: (From Cycle I) They need contact with other preemie mothers because preemies are totally different [from full-time infants]. They need to have confidence to be able to ignore stupid comments. You need to be able to please yourself. You're the only one who knows your baby. You also need a good paediatrician or a good public health nurse.

(From Cycle II) You need someone to call to help or someone to talk to if you had a bad day. You also need to educate other family members about the amount of time that it takes to care for a preemie baby. And that you won't be able to do things socially for awhile.

Lisa: (From Cycle I) Reassurance about what is normal behaviour and development for a preemie. You know in your head that what your child is doing is OK but you have to hear it from both

friends and doctors. The development tests they do on babies are excellent.

(From Cycle II) They need support and they need information about how as preemie is different from a full-term baby. Parents also need a lot of positive reinforcement to combat what some other people will say to you about your baby being slow.

Question #10 **Do you have comments or suggestions about the program.**

Alice: I enjoyed meeting other parents and gaining some insight about how they were feeling. It was good to have babies of different ages present. We didn't always get the information covered and that wasn't so good, but people wanted to talk and I guess that you can't do both. The session on nutrition was the best. Are you going to do the groups in the summer?

Carla: The friendship from other mothers in the groups has been great. Another mother leant me preemie-size baby clothes and she helped me out a lot. I got to know two of the other mothers really well. I wouldn't have known them if it wasn't for the group. I brought my sister to a group meeting so my family could understand what it is like to have preemie and why she takes up all my time. I haven't gotten a lot of support from my husband or my family. The meetings were the only time I got out socially. I'd like to have everyone over to my place for a barbecue this summer.

Barry: It was nice to be able to get out with the family. There really aren't many places you can go with a baby. It was

wonderful to see the other babies and to know that they're healthy. It makes me feel that things will be OK for our daughters too. Having twins is a double responsibility and having prematurity and twins is even more responsibility. Sometimes the group needed to stay on topic a bit more.

Lizzy: I would have liked to have had a session on infant first aid. It would be nice to get together in six months or so and see how everyone is doing.

Mary: I found the one-to-one contact with you in hospital to have been the most helpful. I don't know what I would have done if you didn't come along. The books you suggested were great. Once both babies got home I was too busy to have time to attend anything. If I had gone to more meetings I probably would have made more connections. The hospital makes you think that everything has to be so sterile with the babies. I really needed to hear my paediatrician tell me that it was OK for people to handle the babies.

Rita: I'd like to see the program include something for single parents. It's not easy to be a single parent and to be the mother of a preemie. I think the time he needed to spend in hospital made things harder. It's hard to find a baby sitter competent at looking after a preemie. I wanted to have gone to more meetings but the roads were bad.

Tammy: I went to two sessions. The one on infant development and the last one. In the first meeting I thought the group was just a bunch of women sitting around talking about their babies.

That was alright I guess. I liked the last session better. It had more structure. I liked the exercise we had at the beginning. I don't usually talk in groups, but you got to everybody in the group and everyone was talking. I really liked seeing the fathers there. I wish that I had brought my husband.

Judy: (From Cycle I) Its good to see others with a preemie baby. It makes you feel more comfortable. The other mothers were great. They gave me confidence to handle questions from my family about my preemie baby. Its hard to explain to your family that there is more to a premature baby than just being small.

(From Cycle II) It felt good to get together with other parents of preemie babies. I compared my baby to other preemie babies and I knew that my baby was doing well. It made me feel well good.

Natalie: (From Cycle I) No one appreciates what a premature baby does like another preemie mom. Its good to hear praise [about your baby] from a friend but you need to hear it from a professional too. This is what helps you to relax [as a parent]. I'm surprised about how little time I have for myself. I realize that she won't be at this stage forever so I try to make the most of it.

(From Cycle II) I really liked going to the group. I hope that I was able to help out some of the newer mothers. Your welcome to pass on my name if you do the group again and some

mothers need someone to call for support. It was too bad that everyone wasn't there for the last meeting. I didn't get a chance to say good-bye to __ and __. Maybe we could get together later and maybe have a pot-luck supper or something.

Lisa: (From Cycle I) Keep the evening format but open the group up to parents of babies up to a year old. When the baby is really young you don't go out of the house. You don't really start taking the baby out a lot until he is about three months old. We need better weather for the meetings.

(From Cycle II) I like the group better when its a smaller size about 5-6 people. That way everyone gets to talk. When the group is bigger [10 persons] its nice to meet everybody but everybody doesn't get a chance to talk. My husband liked the meeting he went to. He said that if there were more meetings that he would probably go.

Appendix P

CLIENT PROFILES

4. **Rita** is a single parent in her early thirties. This is her first baby. Rita attended only one session of the program. She lives a three hour drive north of Winnipeg. Rita attended the first session in Cycle II with a friend. Her son, Ivan, was born at 34 weeks gestation.

In the session Rita came across as very self-assured. She seemed very determined not to have Ivan's prematurity influence his development. While Rita expressed how very much she wanted to have a baby she indicated that she was determined not to have the baby restrict her lifestyle. She would take Ivan along for cycling and training for a marathon in the spring. In all, Rita seemed to have some unrealistic expectation about how a baby, especially a premature baby impacts on a parents' lifestyle.

The other mother's in the session seemed unsettled by Rita's approach to caring for her baby. It was difficult to make connection between Rita and the others. The student had some concerns about Rita's including the baby on her exercise regime etc. and wondered how Rita would adjust if/when the baby did not cooperate with her plans. The collective could have been very helpful to Rita developing more realistic expectations around parenting her infant. Unfortunately, Rita did not return to the program.

At the time of the post-program evaluation, Rita expressed that she would have liked to attend more sessions but was unable to do so as the (winter) roads were bad. Although she had found the last week was somewhat stressful as Ivan had the chicken pox, Rita felt that she was managing baby care very well. Rita told the student that she felt she had

not been given enough information in hospital about how prematurity effects a baby's development. It seems that Rita had found that Ivan's development was delayed and that she did have to curtail some of her activities because of the baby. Rita also confided that she no longer had the practical help from friends as she did when Ivan first came home from hospital. It seems that Rita would have enjoyed and benefitted from the collectivity if she had been able to come out to more sessions. Her pre- and post program questionnaire score remained relatively unchanged.

5. **Tammy** has two other children, this is her first premature baby. Tammy is in her late twenties, married and is staying home to care for the children. She has a history of miscarriages, this however, did not present as an issue for Tammy in the collective. Tammy attended two sessions in Cycle II with a friend.

At the first session Tammy looked progressively more tired as the meeting continued. Tammy said that her baby, Jennifer, was born at 32 weeks gestation and was discharged after only two weeks in hospital. Tammy said that Jennifer had slept almost the whole time she was in hospital and that this had left her unprepared for Jennifer's irritability and sleeplessness at home. Tammy said that caring for this baby was much more difficult than caring for her two other children who were full-term infants. Tammy came to the session to find out if the other mothers were finding their infants irritable. Just as Tammy was beginning to connect with the other mother's present, her baby Jennifer became very fussy and Tammy and her friend felt that they had to leave.

Tammy and her friend returned for the final session. Tammy now looked happy and rested. She cheerfully reported that Jennifer had begun

sleeping through the nights and that she was now much less irritable during the days. Tammy was very outgoing in this session and seemed to enjoy sharing experiences with the other parents.

There was a definite difference in Tammy over time. This was most likely due to the improvement in her baby's disposition. In part, it may have also be related to Tammy coming to terms with her baby's prematurity. At the time of the program evaluation Tammy said that parents with premature babies need lots of support and reassurance that they're doing okay. Tammy said that she had blamed herself for the baby's prematurity but has since realized that this is something that just happened.

While it cannot be certain, it is possible that Tammy's relatively short involvement in the program may have helped normalize the experience of having a premature infant. Tammy's scores on the pre-and post parent questionnaire showed a modest improvement of +2.

6. **Lizzy** was a relatively quiet participant in the program. Lizzy and her husband's baby was born at 29 weeks gestation and came home after 9 weeks in hospital. Lizzy had been recruited by the student. Lizzy had several in-hospital and pre-group (telephone) contacts with the student before she came out to the program.

Lizzy first attended Session Three and then Sessions Five and Six in Cycle II. Although she certainly seemed to enjoy listening to the experiences of the parents, Lizzy seldom engaged in conversations with the other parents at break time or after the meetings. Lizzy seemed to be most comfortable talking to the student on a one-to-one before the start of the sessions. The student made several attempts to help

Lizzy talk with other parents but she seemed to remain on just the outside of the collective. This did not seem to be a problem for Lizzy. At the program evaluation Lizzy suggested that the collective have a reunion at a later date.

Lizzy appeared to feel confident and at ease in the care of her infant. She had a relatively high pre-program questionnaire score of 32 that remained unchanged over the program. One possible reason for the stability in Lizzy's score was that at the onset of Cycle II she had perceived herself as managing well with the baby and this did not diminish over time. Lizzy's overall score would have been higher except for her perception of a lack of support for professional persons since her baby was discharged. Lizzy had not received a visit from a public health nurse either before or after he infant was discharged home.

Lizzy reported that her husband Dave was a great source of help and support to her with the baby. Her husband was at home on workers' compensation. She saw this as a fortunate coincidence as she had been having periodic gall bladder attacks. Lizzy felt more secure knowing that Dave was at home and available to both her and the baby.

7. **Mary** attended the program just before one of her twins was discharged from hospital. Mary is married, in her early thirties and employed in her professional career. Mary had an uncomplicated pregnancy and was shocked when she delivered her twin sons almost two months early. The student had two extended pre-program contacts with Mary while Mary herself was still in hospital from her delivery. It was the student's perception that Mary used these contacts to help come to terms with her son's pre-term delivery. Mary had been referred to the program by one of

her babies nurses in the Neonatal Intensive Care Unit

Mary came out to Session Two in Cycle I. Mary perceived herself as having gained support and information from this one session. Mary met a couple whose son had also been born at almost the same age as her twins. The couple had brought their 5-week old son to the meeting. The baby was doing very well and Mary seemed gratified that if their son did well then so would her twins. This couple and the other parents reassured Mary that her anxiety and concerns for her babies was valid and something that they too had experienced.

During the post-program evaluation Mary indicated that she would have liked to have attended additional sessions but that she was finding it almost impossible to leave the house. The twins required much more time and energy than she had expected. Her Pre- and Post Program scores showed an increase of +2 but like the other two parents of twins her scores were among the lowest in the program. Like the other parents of twins, Mary also reported a decrease in her satisfaction with her personal and family life.

Mary is an example of a parent who might attend the program for a specific purpose (i.e., validation, normalization) and then move on once that purpose has been met. By the presence of the other parents and their infants Mary had proof that premature infants do thrive and this may have been enough to meet what this parent needed from the program.

8. **Judy's** baby was very easy to care for at the time of discharge but became more demanding over time. Judy and her husband Rick and their baby Alex attended three sessions in Cycle I and two sessions in Cycle II.

They are an attractive couple in their late twenties. They appeared to be a lot of support between the couple and it was evident that the couple had a good support network.

Judy had a history of several miscarriages. She and her husband seemed very relieved when their first child, Alex, was born healthy at 34 weeks gestation. On the pre-group data collection sheet Judy indicated that she did not find the baby's birth or first week at home to have been very stressful.

Judy and Rick indicated that they attended the group to meet other parents who were also caring for a premature infant. They interacted easily with other parents and participated openly in the sessions. Judy and Rick consulted with other parents when their son had his first illness and when they were considering starting Alex on solid foods. Judy had later voiced that the collective had helped her to feel more comfortable and confident as a new parent. Judy appeared to use the group to supplement her own support network.

This couple coped well with caring for their son and with other stresses such as the death of Rick's mother during the time of the program. In the collective, Judy had the highest pre-program questionnaire score of 39 and the highest post-program of 42. The scores suggest that Judy had made a successful adaptation to parenthood.

9. **Natalie**'s first child was a prematue baby and was born eight years ago. Natalie's second baby was also born premature. Natalie is married, in her early thirties and attended the program in both Cycle I and Cycle II for a total of eleven sessions. Natalie's husband Robert looked after the couple's eight year old daughter so that Natalie could attend the

program with the baby and with her friend Lisa. Natalie's husband Robert came out for the final session of Cycle II.

Natalie's daughter Elizabeth was born at 33 weeks gestation and came home after three weeks in hospital. Natalie's baby was five months old at the time of the first session. Natalie had been recruited to the program by her Public Health Nurse.

Natalie presented as a very competent mother. In both Cycle I and Cycle II she participated readily in the sessions. Natalie's motivation for attending sessions was to meet other parents of premature babies. Although Natalie appeared to have a sizeable social network it seemed that she was unable to find the support that she need around parenting her new premature infant within this network. For Natalie caring for a premature infant was very different from a full-term infant.

Aside from sharing everyday experiences Natalie would share some personal information such as feeling hurt about a lack of understanding from some relatives and friends about the baby's prematurity, lingering sadness about miscarriages she had sustained and the difficulties around making a decision about whether or not to return to work. Natalie alluded to having had a mild postpartum depression with this baby. However she did not discuss this issue openly and would only make vague references to it if another mother raised the subject.

Natalie readily reached out to the other parents in the program. She was a sympathetic listener and would share her own experiences with other parents if she thought that it would be a help to them.

Natalie appeared to have found the social support she was looking for within the program. Her scores on the client questionnaire support

this hypotheses. Natalie's scores were 31 for the pre-program score, 35 for the end of Cycle I and 37 at the end of Cycle II. Natalie had attended the most number of sessions and she had also a score that showed the greatest individual improvement in the program.

Appendix Q

BROKERAGE SERVICES TO PROGRAM MEMBERS		
CLIENT	TIME OF SERVICES RENDERED	AGENCIES RECOMMENDED TO CLIENT
Alice	During Program	→ Post-Partum Stress Program → Counselling through Family Services of Winnipeg
Carla	During Program and Follow-up Evaluation	→ AlAnon → Alcohol Foundation of Manitoba → Inter-Faith Pastoral Care Counselling Services
Barry	Follow-up Evaluation	→ MELD, A Parenting Program
Lizzy	N/A	N/A
Mary	Follow-up Evaluation	→ Homemaker through Family Services of Winnipeg
Rita	N/A	N/A
Tammy	Follow-up Evaluation	→ Y Neighbours, A Social Group for Mothers → Homemaker through Family Services of Winnipeg
Judy	N/A	N/A
Natalie	N/A	N/A
Lisa	N/A	N/A

Appendix R

OUTLINE OF FORMAT FOR INDIVIDUAL SESSIONS	
ITEM	**COMMENTS**
Introduction (20 Minutes)	♦ State the purpose of the program ♦ Introduce the session topic ♦ Joining Exercise ♦ Introduce members to each other ♦ Outline the agenda for the session
Selected Topic (15 Minutes)	♦ Leader or guest speaker makes a brief presentation on chosen topic. This may include a group exercise related to the topic.
Discussion Related to Topic (15 Minutes)	♦ Members are asked to share experiences related to the chosen topic.
Break (15 Minutes)	♦ Juice and cookies are served ♦ This is a time for parents to socialize and make connections with each other on their own.
Open Discussion (20 Minutes)	♦ Parents were encouraged to raise any questions or concerns that they had. Questions were usually answered by other parents in the group.
Closing and Evaluation (15 Minutes)	♦ Leader summarizes theme and content of the session including individual issues raised by the parents. ♦ Leader encourages parents to see each other as sources of support. ♦ Leader introduces topic of next session. ♦ Leader asks participants to complete and return parent feedback sheets.

Appendix S

OVERVIEW OF PROGRAM SESSIONS	
CYCLE 1	**CYCLE 2**
Session One	**Session One**
Title: "Now and Then." Parents are asked to bring in a picture of their baby during hospitalization and a picture of baby since discharge home. This session will look back on bringing the baby home from the hospital and the changes in your life since that time.	Title: "Now and Then." Parents are asked to bring in a picture of their baby during hospitalization and a picture of baby since discharge home. This session will look back on bringing the baby home from the hospital and the changes in your life since that time.
Purpose: ▸ For parents to share their experience of the premature birth of their baby ▸ To build links between members to help parents to recognize that others have had a similar experience ▸ To discuss concerns parents have around caring for baby at home ▸ To validate the individual experiences of the parents	Purpose: ▸ For parents to share their experience of the premature birth of their baby ▸ To build links between members to help parents to recognize that others have had a similar experience ▸ To discuss concerns parents have around caring for baby at home ▸ To validate the individual experiences of the parents

OVERVIEW OF PROGRAM SESSIONS	
Format of the Presentation ▸ A group discussion was planned.	Format of the Presentation ▸ Discussion group ▸ Parents brought in photos from their baby's hospitalization. This provided a low risk means to talk about their experiences. The photos were also used to help parents recognize the progress the babies had made since birth
Themes Raised by Members	Themes raised by members ▸ Fear that baby may develop new medical problems ▸ Feeling low about having been physically separated from baby during hospitalization ▸ Difficulty being around other mothers of full-term babies, especially during maternity confinement ▸ Feeling relieved to finally have baby at home but needing reassurance that their care of baby is appropriate ▸ What is colic? What can one do about it?
Attendance ▸ No parents were in attendance, this was possibly due to not having allowed enough time for the distribution of the program pamphlets.	Attendance ▸ 3 mons and 2 babies ▸ 2 support persons Regrets ▸ 2 moms ▸ 2 couples

OVERVIEW OF PROGRAM SESSIONS	
Take Home Resource Material Poems from "Newborn Intensive Share" by Susan Erling	Take Home Resource Material "And Baby makes . . . ." by Cheryl Hawkes, Canadian Living, 15(11) Nov '90
Session Two	Session Two
Title: "Infant Stimulation and Development." An Occupational Therapist will be present to discuss development of the premature infant and demonstrate positioning and handling techniques to interact and 'play' with your baby.	Title: "Infant Stimulation and Development." An Occupational Therapist will be present to discuss development of the premature infant and demonstrate positioning and handling techniques to interact and 'play' with your baby.
Purpose: ▸ For parents to voice their questions and concerns about the physical development of premature infants. ▸ To provide general information about infant stimulation and development in order to assist parents in forming realistic expectations around their infant's development. ▸ To illustrate means of stimulating premature babies through play and handling techniques ▸ For parents to receive reassurance from other parents that their infant is progressing 'normally' for a premature infant.	Purpose: ▸ For parents to voice their questions and concerns about the physical development of premature infants. ▸ To provide general information about infant stimulation and development in order to assist parents in forming realistic expectations around their infant's development. ▸ To illustrate means of stimulating premature babies through play and handling techniques ▸ For parents to receive reassurance from other parents that their infant is progressing 'normally' for a premature infant.

OVERVIEW OF PROGRAM SESSIONS	
Format of the Presentation ▸ The guest speaker, an occupational therapist, came to the group and gave a formal presentation of development and to demonstrate age appropriate play and handling techniques with babies. ▸ Some group discussion. ▸ Use of additional materials; overheads, infant toys.	Format of the Presentation ▸ A guest speaker, an occupational therapist, came to the group to give a formal presentation of development and to demonstrate age appropriate play and handling techniques with babies. ▸ Some group discussion. ▸ Use of additional materials; overheads, infant toys.
Themes raised by members ▸ The care of a premature infant differs from that of a full-term infant even after discharge from hospital ▸ Weight gain of the infants ▸ Dealing with the reactions and comments by relatives and friends around baby's size and delayed development (due to prematurity) ▸ Feelings of sadness and loss from earlier stillbirths and miscarriages ▸ A question about how long does one need to correct baby's physical development for prematurity.	Themes raised by members ▸ The babies are more difficult to care for than the parents had anticipated. ▸ Infant crying and infant soothing techniques. ▸ The stress of trying to care for baby in hospital, especially when baby was attached to monitors, etc. ▸ Different babies have different preferences for interaction ▸ Realization that others in the group have a difficult-to-care-for baby.

OVERVIEW OF PROGRAM SESSIONS	
Attendance ▸ 4 moms ▸ 1 dad ▸ 3 babies Regrets ▸ 1 mom ▸ 1 couple	Attendance ▸ 4 moms ▸ 4 babies Regrets ▸ 4 moms ▸ 1 couple
Take Home Resource Material "Insights into Child Development; Infant Stimulation - - - toys, Classes and Parent Reaction." by William Sears, M.D. in Baby Talk, July 1986 Handout on Fine Motor and Gross Motor Development in Infants. Black and White Mobile cut out.	Take Home Resource Material "Insights into Child Development; Infant Stimulation - - - toys, Classes and Parent Reaction." by William Sears, M.D. in Baby Talk, July 1986 Handout on Fine Motor and Gross Motor Development in Infants. Black and White Mobile cut out.
Session 3	Session 3
Title: "Brothers, Sisters and the Premature Baby. Community Resources." What was your child's reaction to the early arrival of the new baby and the disruptions in your home life? This session will also discuss community resources and programs available for families.	Title: "What do I feed my Baby?" Does a baby's prematurity influence weight gain or when solids are introduced into the diet? What about parents' nutritional needs? A dietician will be present to discuss these and other general questions.

OVERVIEW OF PROGRAM SESSIONS	
Purpose ▸ This session focuses on siblings as while the birth of a new baby creates a disruption in their lives, the hospitalization of a premature baby can compound this effect. ▸ Some parents may feel very protective of the premature baby. This session explores parent's feelings about siblings interacting with the new baby ▸ This session also looks at community resources available to families with young children	Purpose ▸ To address concerns parents may have around feeding and weight gain of their baby. Because of other baby's prematurity the usual guides to infant nutrition may need to be adjusted for these babies. ▸ To correct any distorted information parents may have around feeding of infants. ▸ To provide parents an opportunity to 'Check Out' how other parents handled issues around feeding, etc.
Format of the Presentation ▸ Short presentation followed by discussion group with parents. ▸ Materials used in the presentation include a collection of pamphlets on a broad range of services to families from homemaker services to Children's museum, etc.	Format of the Presentation ▸ The guest speaker, a public health nurse, gave a very short presentation on infant feeding with the majority of time given to a question and answer period. A hospital dietician was present to supplement information given by the public health nurse.

OVERVIEW OF PROGRAM SESSIONS	
Themes raised by members ▸ Feeling tired from the constant care baby requires. ▸ Difficulties getting fathers to help out more with baby. ▸ Problems in relationships with relatives. ▸ Feelings of sadness and loss over that linger from miscarriages and stillbirths. ▸ Feelings pleased with baby's physical development	Themes raised by members ▸ Can preoccupation with a premature baby's weight gain lead to overfeeding the baby? ▸ Parents have a need for information about caring for baby post discharge from hospital ▸ When is it appropriate to call a public health nurse or doctor with one's concerns about baby care? ▸ How to sooth cranky or colicky babies. ▸ Parents identified that they have a need to feel supported, to get out of the house, to get more sleep.
Attendance: ▸ 2 moms ▸ 2 babies Regrets None	Attendance: ▸ 7 moms ▸ 3 dads ▸ 5 babies (one set of twins) Regrets None

OVERVIEW OF PROGRAM SESSIONS	
Take Home Resource Material ▸ "Jealousy & Sibling Rivalry." Manitoba Government pamphlet ▸ Siblings: How to Help Your Child Accept the New Baby - Source unknown ▸ Pamphlets on community resources	Take Home Resource Material ▸ One to Grow On: Infant Feeding Guide for Parents. Manitoba Health Department. ▸ Blend on Foods for Babies and How to Buy Commercial Baby Foods. Handouts from the Public Health Department. ▸ Excerpt on "Beginning Solids" from the Premature Baby Book by Helen Harrison.
Session 4	Session 4
Title: "Morale Boosters." The joy of having baby come home can give way to fatigue, feeling isolated and ongoing worries. Learning to take care of oneself is an indirect but vital means of taking care of one's baby.	Title: "Morale Boosters." The joy of having baby come home can give way to fatigue, feeling isolated and ongoing worries. Learning to take care of oneself is an indirect but vital means of taking care of one's baby.

OVERVIEW OF PROGRAM SESSIONS	
Purpose: ▸ This session provides parents with the opportunity for validation and support around the difficult role of caring for a premature, high-needs baby. ▸ To allow for parents to vent feelings about needing to continue to be available and care for baby even when they are fatigued and/or facing other demands. ▸ To help parents identify what contributes to feeling tired and stress, and to identify what stressors can be avoided or reduced. ▸ To assist parents in finding their own ways of caring for themselves while caring for baby	Purpose: ▸ This session provides parents with the opportunity for validation and support around the difficult role of caring for a premature, high-needs baby. ▸ To allow for parents to vent feelings about needing to continue to be available and care for baby even when they are fatigued and/or facing other demands. ▸ To help parents identify what contributes to feeling tired and stress, and to identify what stressors can be avoided or reduced. ▸ To assist parents in finding their own ways of caring for themselves while caring for baby
Format of the Presentation ▸ Short presentation followed by group exercises and discussion. ▸ Members completed a short survey about self-care and listened to a relaxation tape.	Format of the Presentation ▸ Short presentation followed by group participation in an exercise a) to identify what makes them feel stressed, b) to identify means of dealing with ongoing stresses, c) to identify ways to feel relaxed ▸ Asked members to identify one thing that they could do to take better care of themselves as a parent. ▸ Use of extra materials: flip chart.

OVERVIEW OF PROGRAM SESSIONS	
Themes Raised by Members ▸ Coping with post-parium blues or depression ▸ Coping with baby's first illness after discharge from hospital ▸ Feeling unorganized and often very tired because baby care takes up most of your time. ▸ It helps to know that you're not the only one having a rough time caring for baby	Themes Raised by Members ▸ This is a stressful time on a couple's relationship ▸ Its difficult to stop feeling always responsible and to take a break from baby care ▸ Coping with infant crying is stressful. ▸ Fear that while baby is healthy now, a new threat to baby's health could arise, i.e. SIDS ▸ That talking about concerns with other parents helps to alleviate stress.
Attendance: ▸ 3 moms ▸ 1 dad ▸ 3 babies Regrets None	Attendance: ▸ 4 moms ▸ 2 dads ▸ 5 babies Regrets 1 mom
Take Home Resource Material ▸ 50 Ways to Beat Stress by Andrew E. Slaby, Source Unknown ▸ Handouts from the Canada Mental Health Association	Take Home Resource Material ▸ 50 Ways to Beat Stress by Andrew E. Slaby, Source Unknown ▸ Handouts from the Canada Mental Health Association
Session 5	Session 5
Title: "Relationships." Do you have questions about bonding with baby, changes in your relationship with your partner, friends, or relatives? How are you feeling about yourself as a parent?	Title: "Relationships." Do you have questions about bonding with baby, changes in your relationship with your partner, friends, or relatives? How are you feeling about yourself as a parent?

OVERVIEW OF PROGRAM SESSIONS	
Purpose: ▸ For parents to recognize that caring for baby impacts on their relationships with others. To enable parents to explore their feelings regarding same. ▸ To encourage parents to recognize the need to reconnect with each other as a 'couple' after baby's birth and discharge from the hospital ▸ For parents to learn from each other about ways to cope with their present situation	Purpose: ▸ For parents to recognize that caring for baby impacts on their relationships with others. To enable parents to explore their feelings regarding same. ▸ To encourage parents to recognize the need to reconnect with each other as a 'couple' after baby's birth and discharge home from hospital. ▸ For parents to learn from each other about ways to cope with their present situation
Format of the Presentation ▸ Short presentation with group discussion	Format of the Presentation ▸ Group discussion with a group exercise that had members respond to a series of vignettes on the topic of changes in relationships following birth of a baby. ▸ Also, member choose to view a video on infant aging during this meeting.

OVERVIEW OF PROGRAM SESSIONS	
Themes Raised by Members ▸ Breast feeding issues. ▸ Feeling isolated, loss of a social life. ▸ Need to help fathers to recognize the importance of their role in caring for baby ▸ Feeling unsupported by some friends and acquaintances when you're grieving a miscarriage	Themes Raised by Members ▸ Exploration around post-parium depression and community resources about same. ▸ Being physically separated from babies following a difficult labour (resolution of labour issues) ▸ Little time or energy for intimacy with one's partner ▸ This is a physically and emotionally demanding time for parents.
Attendance: ▸ 2 moms ▸ 2 babies Regrets ▸ 1 mom ▸ 1 dad	Attendance: ▸ 3 moms ▸ 1 dad ▸ 4 babies Regrets ▸ 3 moms ▸ 1 dad

OVERVIEW OF PROGRAM SESSIONS	
Take Home Resource Materials	Take Home Resource Materials ▸ "How Criticism Chips Away at a Marriage" by Catherine Findlay in Working Mother, Nov 1990 ▸ "Still Got That Loving Feeling" by Eleanor Barrington in Today's Health, April, 1991 ▸ How a Husband Can Support his Wife" by Peter J. Moses in Intensive Caring Unlimited, January/February, 1986
Session 6	Session 6
Title: "Parents' Choice." Do you have a topic that you would like covered in this session? The subject for this session will be selected form parents suggestions. Subject Chosen: "The Partnership Between Parents and Medical Staff While Baby is in Hospital."	Title: "Parents' Choice." Do you have a topic that you would like covered in this session? The subject for this session will be selected form parents suggestions. Subject Chosen: "Infant Safety in the Home."
Purpose: ▸ To help parents to resolve any unanswered questions about baby's hospitalization. ▸ To let parents know that hospital staff continue to care about the babies after discharge form hospital ▸ To review themes that were raised during group sessions. ▸ To terminate as a group.	Purpose: ▸ The topic infant safety was chosen to help parents identify the need to begin to child-proof their home even before their baby begins to walk. ▸ Also the topic encourages parents to look at their child as active and growing and is a focus away from the hospitalization of the early birth. ▸ To review themes that were raised during the group sessions. ▸ To terminate as a group.

OVERVIEW OF PROGRAM SESSIONS	
Format of the Presentation ▸ Guest speaker, the Assistant Head Nurse in Intermediate Care Nursing, St. Boniface General Hospital cane in to speak to the parents. ▸ Group discussion ▸ Time for socialization	Format of the Presentation ▸ Short presentation ▸ Group discussion ▸ Group pictures were taken ▸ Use of additional materials: various items designed for infant safety were brought in for demonstration purposes, camera
Themes Raised by Members ▸ Parents need to know their rights as parents. ▸ Need for support of breast feeding. ▸ Happy about this baby but sadness from earlier miscarriages lingers ▸ Its reassuring to talk with other parents of premature babies	Themes Raised by Members ▸ Infant teething ▸ Difficulties finding baby sitters capable of caring for a premature baby ▸ Caring for baby get easier as baby matures ▸ It is helpful to compare one's baby to other premature babies rather than a full-term babies. ▸ Its been reassuring to talk to other parents of premature babies.
Attendance ▸ 3 moms ▸ 1 dad ▸ 3 babies	Attendance ▸ 6 moms ▸ 3 dads ▸ 2 friends ▸ 6 babies

OVERVIEW OF PROGRAM SESSIONS	
Take Home Resource Material ▸ Pamphlets on Community Resources.	Take Home Resource Material ▸ Excerpt on Infant Safety from Your Baby & Child From Birth to Age Five by Penelope Leach ▸ Pamphlets on Community Resources