

NEW MOTHER GROUPS AS A SOCIAL NETWORK INTERVENTION: CONSUMER AND MATERNAL AND CHILD HEALTH NURSE PERSPECTIVES

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ABSTRACT

Maternal and child health nurses in two outer urban local government areas in Melbourne, Australia were interviewed about how they facilitated first-time parent groups. Groups were offered to all first time mothers and almost two thirds of mothers joined a group. The groups ran for approximately eight sessions and provided infant-focussed parent education and social contact. Women who joined the groups were followed up 18 months to two years later to determine the degree to which these groups continued to meet on their own accord and the extent to which they had become self-sustaining social networks. The study found a very high level of continuation, suggesting that providing such programs may be an important vehicle for enhancing social support during the transition to parenthood and thus be a useful primary prevention strategy.

INTRODUCTION

The now widely quoted African proverb that 'it takes a village to raise a child' begs the question 'and what might it take to rebuild a village?' New parent groups may be one way of recreating the village (Lawson and Callaghan 1991). A growing body of research indicates a correlation between a lack of social support and poor quality of childrearing, maternal depression, and child abuse and neglect (Brown and Harris 1978; Crittenden 1985; Quittner et al 1990; Beeman 1997) although such research does not suggest a simple causal relationship between low social support and such psycho-social problems.

With increased participation of women in paid employment, the birth of a first child is often associated with a shrinking of the social network (for example, the loss of social contact with work associates in the absence of close neighbourhood relationships) at a time of increased need for social support. Recent research shows that many women feel the lack of social support at the time of the birth of their first child (Brown et al 1994). Trends toward much earlier discharge from hospital following birth may exacerbate this (Stewart and Tilden 1995). Rogan et al (1997) found that many women report feeling drained, alone and at a sense of loss following birth. Research by Majewski (1987) suggests that while partners provide new mothers with the greatest levels of support, support provided through parent groups may create a network of friends which is sustained over time.

In recent decades the objectives of maternal and child health services have broadened from advising on and monitoring infant feeding and development to

encompassing the emotional and social well-being of the young family (Scott 1987). In the 1990s in Victoria, Australia, maternal and child health services, which are provided by local government in that State, were funded by the State Government to provide eight weekly group sessions for all first time mothers. Typically such groups explore post-birth adjustment, infant feeding, baby massage, safety in the home and child development. Groups are held at the local maternal and child health centre and comprise approximately eight to 10 women. All first time mothers with babies under approximately three months are invited to attend. A few nurses also invite fathers to attend the groups and this has led to their recent renaming as 'first time parent groups'. Anecdotal evidence suggested that some of the groups continued to meet informally after the nurse-facilitated sessions were finished. This study assessed the degree to which such groups evolved into self-sustaining supportive social networks.

METHOD

The study involved two parts - semi-structured interviews with the 17 nurses facilitating groups in two municipalities (Part A) and a telephone administered semi-structured survey with a sample of 243 women who had joined new parent groups in these two municipalities 18 months to two years earlier (Part B). The interviews with nurses were all conducted by Scott and lasted for an hour to an hour and a half. The interviews were conducted in the maternal and child health centre in which each nurse worked.

The interviews with the mothers were shared between the investigators and conducted by telephone, typically lasting 15-20 minutes. A total of 314 women were identified from maternal and child health records as having joined one of 24 first time parent groups which had started within a given 12 month period. This represented approximately two thirds of women having their first child in these two municipalities during this period. There were no fathers in the membership lists. Of the 314 participants in groups, 53 were unable to be contacted due to relocation and 18 declined to participate due to arrival of a second baby, lack of time or ill health, leaving 243 (or 77% of those who joined groups) agreeing to be interviewed.

The study was approved by the University of Melbourne Human Research Ethics Committee and the two local government authorities (the City of Wyndham and the Shire of Yarra Ranges). Maternal and child health nurses sent letters to all women who had joined the groups, seeking permission from them to be approached by the researchers to ascertain their willingness to participate in the study. Both nurses and the mothers who gave their informed consent to the study did so on the understanding

that their anonymity would be protected and that they could withdraw at any time.

RESULTS

Part A: Interviews with nurses

The 17 nurses were very experienced, with the average number of years they had been practising as a maternal and child health nurse being 17 (range seven to 28 years), and with an average of 13.5 years (range five to 28 years) in the region in which they currently worked. They also had a high level of experience in facilitating new mother groups, the average being 10 years (range three to 18 years), and the estimated average number of groups being 34 per (range six to 70).

The following topics were explored in the interviews: the ways in which nurses invited parents to join groups; their perceptions of the reasons for non-attendance; the content of group sessions; the ways in which participation was facilitated; issues relating to diversity in group membership based on factors such as gender, age, marital status, ethnicity and social class; and views on the life of the group after the nurse-facilitated sessions had finished.

Ways of engaging parents

All nurses personally invited new mothers to join a group, and in one municipality most were also sent written invitations. The nurses' styles ranged from being neutral and low key 'There's no pressure - I say to them "it might not be your scene" to active encouragement. I say they can get the kids weighed at the same time and save on petrol. I have to sell it.' Most nurses gave some encouragement on more than one occasion, and used strategies such as: writing the date of the next group in the baby's book; giving a list of topics to be covered in each session; and scheduling appointments before the group. Only one used the conventional groupwork engagement technique of directly exploring and normalising ambivalence about the prospect of joining a group: 'I often say "it can be hard to come" and I take the time to go through it with them and reassure them'.

The reasons nurses gave mothers for attending the group ranged from being child-focussed (for example, the benefits to the baby of information on feeding or CPR) to mother-focussed (for example, social contact), and nurses varied the reasons according to what they thought would appeal to the women. For example, one described how she emphasised the practical aspects of the content of the sessions, saying that 'some of them don't want the gossip thing'. Another conveyed the idea of group participation as a normative expectation but did so in a subtle and unpressured manner: 'You promote it as something for all

new parents and give some information and then gradually turn it around to meeting others and transition to parenthood issues. I think it would put them off if I wasn't low key.'

ATTENDANCE

Nurses were asked to estimate the percentage of first time mothers who accepted the invitation to join a group and where possible, this was checked against the record of the invitation list and those who actually attended. The mean estimated 'take up rate' was 68% but there was a marked difference across nurses (range 33% to 95%).

The nurses' perceptions of why some women chose not to join groups were, in the following order of frequency: returning to paid employment; adequacy of pre-existing supports; post-natal depression; personality ('not a group type'); and sensitivity about meeting in homes. The latter referred to one nurse's opinion that some women were aware of an expectation that this was the longer-term outcome of the group and chose not to join because of their discomfort about this. Nurses also identified some sub-groups of women whom they had found to be less likely to join their groups: adolescent and single mothers; women from non-English speaking backgrounds; women from very low income groups; and those experiencing family crises.

Nurses were also asked to estimate the 'drop out' rate in their groups - that is the proportion of those who joined but who were not part of the group at the stage it finished at the centre. The estimated average number who dropped out from each group (again checked against recent records where possible) was one to two (range nil to three) per group of seven to eight. Nurses nominated several reasons for women discontinuing attendance during the initial phase and these were: personality clash/group dynamics; mothers returning to work; family relocation; and lack of interest.

In relation to group dynamics, some nurses gave specific illustrations of some women feeling different from other members of the group because: they were the only one not breast feeding; they were much younger or unmarried; or because they were uncomfortable about the later prospect of meeting in one another's homes. There were only a couple of references to actual inter-personal conflict occasionally occurring within groups during the period it was facilitated by the nurse.

Size, frequency and location of groups

Nurses reported that the ideal size for a group was seven to eight members. All but one nurse ran weekly groups. The average number of sessions offered was eight with most Shire of Yarra Ranges nurses adopting a model

of seven weekly sessions and one follow up session when the babies were one year old. All of the groups were held in maternal and child health centres. These were generally satisfactory venues, although nurses commented on problems such as limited space, excessive heat in summer, and traffic problems (noise and parking). In the semi-rural areas in the Shire of Yarra Ranges, some centres are only open for a couple of sessions a week and so it was necessary for some women to travel to another area to attend a centre in which a new group was being formed.

Ages of babies

Most babies were aged between three and 17 weeks when their mothers joined the group (total range one to 26 weeks), with most nurses expressing a strong preference for a younger and narrower age range (such as four to 12 weeks). The reason given by nurses was that this enabled women to share similar issues in the early transition to motherhood and for the content of sessions to be relevant to their babies' ages.

Group content and process

Most nurses had set topics for each session although the topics chosen varied somewhat between nurses. The Shire of Yarra Ranges had developed a manual which many nurses in that area used as a guide, and this included suggestions for facilitating participation as well as content. The topics covered did not differ between the two local government areas. A typical first session might start with introductions and debriefing on experiences of pregnancy and labour. Some nurses focussed more on the 'here and now' and asked women how the reality of being at home with a new baby compared with what they had expected it to be like. Later sessions focussed on topics such as baby massage, settling techniques, nutrition and introduction of solids, child development, women's health, and safety in the home (including CPR). A few nurses also invited guest speakers to the groups to cover topics such as speech development or children's books.

A video entitled '1+1 = 3' was used by about half the nurses in the first session to introduce issues related to transition to parenthood, including the challenges this poses for the couple relationship. Some nurses explored emotions associated with birth and adjustment experiences in some depth, seeing self-disclosure as a vehicle which generated an early and strong sense of trust and cohesion in the group. Others were quite cautious about this ('I don't let things get too personal too quickly'), fearing that this might be threatening, and chose to focus more on the more practical aspects of day-to-day infant care.

Nurses gave numerous examples of how they adapted the content of the group sessions to suit the stated preferences and the often implicit rather than explicit

wishes of group members. Most nurses saw the provision of information and facilitating social interaction as equally important dimensions of the group and none saw information provision as being the primary function of the group. Many nurses were trying to make the groups less didactic.

Some saw social contact and peer support as more important than information provision, or at least recognised that this was how the mothers saw it, and ran the group in a highly unstructured way to facilitate a sense of group cohesion and informality. 'My overall aim is to get them connected with one another ... I don't give information directly, I draw out their experiences' said one nurse. This was echoed by another who commented that 'Sometimes they don't want information and I have to balance that - they want the social experience'.

Facilitating participation

Nurses facilitated participation in the group in a number of ways. Some introduced themselves as mothers, thus minimising the social distance between them and the other women, and modelling limited and appropriate self-disclosure ('I give a little anecdote and if people don't talk I'll tell them mine and draw them in'). Many nurses emphasised the importance of doing the introductions well and ensuring that the members actually got to learn one another's names, using name tags or reiterating their names and the babies' names for the first few weeks until everyone was familiar with them. Some nurses deliberately underscored what the mothers had in common in order to strengthen the cohesion of the group, and avoided drawing attention to differences.

Nurses described using different ways to encourage participation. For example, some deliberately but gently drew quiet members into the discussion, or broke the group into small sub-groups or into rotating pairs for discussion on particular topics. Before and after the group some nurses acted in a way in which a good hostess might do at a social function, one describing how she 'worked the room', making people feel comfortable, connecting individuals to each other by being alert to what they might possibly have in common (for example, 'did you know that you live just two streets from each other?').

The participation of fathers and grandmothers

Fathers infrequently participated in the groups and there were marked differences in nurses' attitudes to this. While most were undecided about it, others were either strongly opposed or strongly in favour of fathers' participation. One nurse who was adamantly opposed stated that the groups were 'women's business' - 'I don't want the fathers! It's not the same - women want to discuss private things and while they (the men) are not told not to

come they soon get the message'. Others were not hostile toward fathers *per se* but their experiences of having had them in parent education groups had not been overly positive and they thought that men being there adversely affected the group dynamics.

Others were of a very different opinion and on the initial home visit would often meet the fathers and tell them they were welcome to come to the groups if they were free during the day. One remarked that 'I haven't had a problem with it - when men come I'll include them and ask 'what do you see from a male perspective?'. In the Yarra Ranges fathers often came to the CPR session which was normally scheduled for an evening to make it possible for both mothers and fathers to come. These sessions were often described as 'hilarious' and for some groups it was the beginning of them mixing socially as families outside the group sessions. One Wyndham nurse had gone to great lengths to run a small group for fathers in the primary caregiving role and 10 men had participated in this group over a two to three year period.

Generally nurses were less ambivalent about the occasional participation of maternal grandmothers in the group, although there were still positive and negative aspects of this. Grandmothers visiting from overseas were welcomed and in some instances played an active role ('an Indian grandmother came to all the sessions and she was my expert baby massager') and in other instances grandmothers declined to take part in the group and sat outside the group minding the baby for the mother. Local grandmothers also sometimes participated, particularly coming to the CPR sessions in Yarra Ranges, or accompanying a mother with twins, and these were seen as very positive experiences. However, there were occasions when grandmothers were perceived as giving inappropriate advice, and as having a negative impact on the group climate.

Dealing with diversity - ethnicity, social class, age and marital status

Nurses were aware of the difficulty associated with encouraging the participation of mothers from diverse ethnic backgrounds. The demographic profile for the City of Wyndham is predominantly Anglo-Celtic, and is particularly so for the Shire of Yarra Ranges. Some nurses also observed variations in the response of different ethnic groups. For example, east Asian women from India (fluent English speakers) were more likely to become involved than women from Vietnam whose English was poor. In some instances, for example, the very well-established Italian community in Wyndham, the low level of participation was not seen as problematic as these women were perceived to have very strong social support from within their own extended family and friends who lived locally.

A few nurses described working very well with migrant women, including those who had a struggle with the English language. One nurse was excited about one of her groups in which ethnic diversity was actually what gave the group its cohesion. 'There are virtually no Anglo-Australians and it's a real multicultural group and they're mixing really well together' she said, adding that the husbands had also joined in regular social occasions which the group had organised. Another nurse described how 'in one group there was only one 'Anglo' and they were just wonderful, and they're still meeting - they are a very diverse group'. This nurse recalled that the most popular session she had run for that group was on the theme of 'parenting in a new land' in which the members had shared similar experiences.

All nurses reported that women from lower socio-economic status were less likely to join and/or to remain involved in the groups. The two regions differed somewhat in their demographic profile in respect to social class. All but one of the Wyndham neighbourhoods were very homogenous in relation to income, education and housing quality while in some of the areas in the Yarra Ranges there was great diversity within the immediate locality. Not surprisingly it was the nurses in the Shire of Yarra Ranges who described some women's sensitivity about meeting in one another's homes as their housing varied greatly in level of affluence. The Yarra Ranges nurses were also more likely to explore with their groups alternative to meeting in homes such as using community centres as the venue.

Moreover, in terms of running the group itself, the Wyndham nurses did not report the same level of difficulty resulting from class diversity. Some even found it a positive feature. 'My best group in 1997 was a great mix of incomes ... A 16 year old girl, two 18 year old single mothers who were shop assistants, one 17 year old and the others were professional women in their thirties!'. All but one of the Yarra Ranges nurses saw class diversity as a major challenge. One said 'they have different ways of expressing themselves', and another commented 'I mix them diplomatically and I have to deal with it - financial counselling referrals, one who swears like a trooper ... others talking about how much money they have'. The one Yarra Ranges nurse whose centre was located in a very homogeneously low income area on the rural fringe of the Shire said that she did not encounter any problems in this respect and that the few mothers with higher education had learned to fit in with the majority.

All the nurses saw it as difficult to involve adolescent and single mothers in the groups, although most commented on the clear exceptions to this, such as the confident breast feeding adolescent, or how some adolescent mothers had taken the initiative in the group and both older and younger mothers had ended up mixing well.

Some nurses reflected on the dynamics of their relationship with adolescents. One remarked 'With the real teenage mum I haven't had much success - the one looking for Mum thinks I'm wonderful but the one rebelling against Mum thinks I'm terrible'. Others explained the problems in different ways, seeing the maternal role as quite marginal to the adolescents' sense of identity ('they're just not on the same wavelength'). A few successfully ran groups just for younger mothers, although this was dependent upon having sufficient numbers. These groups were described as being very different from other groups ('I serve coke instead of tea!') and less reflective and more action oriented ('we just sat on the floor and made toys and they loved it'). One nurse said she avoided using videos as the adolescent mothers just 'switched off as if they were back in the classroom'. Both areas had a centralised specialist service for young mothers but only a small minority of young women became involved with this. Those who experienced problems such as substance dependence were particularly hard to engage and also resisted referral to the specialist service. Specialist outreach workers and a non-government agency which ran an innovative peer based program for adolescent mothers were seen as valuable alternatives.

The continuation of the groups

Almost all the nurses thought that it was a good idea for groups to continue to meet after the formal sessions were finished, and most said their groups did so. Some gave anecdotes about groups which had led to deep and long lasting friendships. 'I have groups I started 15-20 years ago that are still meeting ... those groups end up working like an extended family - they become so important in each other's lives, they are like family members'.

RESULTS

Part B: Consumer survey

The majority of the women were 25-34 years of age (72%), were in two parent households (92%) and had English as their first language (97%). Nearly all (98%) had worked full time prior to the birth of their first child, the largest occupational category being retail and clerical. By the time the children were 12 months of age, 30% of women had returned to work, mostly in a part-time capacity. At the time of follow-up for the study (at which time most of the children were aged close to two years), 60% of women had returned to work, the majority in a part-time capacity. Comparative data was not available on those who chose not to join groups, but given the broader demography of the areas and the nurses' perceptions, it would appear that young, single and low income mothers were likely to have been under-represented in the groups.

Initial phase of the group

Most of the women (75%) reported positive feelings about the prospect of joining a group, with the remainder equally divided between those who were neutral, those who were negative and those who felt hesitant about doing so. The most important things women hoped to gain from the group were, in the following order: child health and development information; the sharing of experiences and mutual support with other first time mothers; to make friends in the local area; and to 'get out of the house'.

The majority of women (76%) reported that the members of their group got along well. Those who had been in groups where this had not happened thought that the reasons included: group size (too large for the group to 'click' or 'gel' as they described it); too great a diversity of age and backgrounds; and differences in values and lifestyles, especially related to child rearing. Most women (60%) were highly satisfied with the way their group was facilitated. Those who expressed dissatisfaction reported that the sessions were too didactic ('too much like a school class') or that the physical aspects of the centre itself were a problem (for example, too small, noisy, too hot in summer). A small number were dissatisfied due to differences in maternal age, marital status and ethnicity which they thought made the group harder to 'gel'.

Longer term group outcomes

All but one of the 24 groups continued to meet informally after the sessions at the centre had ended with five ending by 12 months. At 12 months 18 groups (constituting two thirds of the women in the study) were still meeting, and 16 groups were still meeting at the time of follow up (18 months to two years). Women returning to paid employment was related to groups not continuing but some groups with members who returned to paid employment went to considerable lengths to change the group meeting times to accommodate this and these groups continued to flourish.

Even among those groups which were not meeting 18 months later, there was considerable one-to-one contact between some members and significant friendships had been made through the groups. One-to-one relationships were classified as mutual aid friendships, social activity based friendships or acquaintance relationships. A large majority (80%) formed at least one mutual aid friendship through the group, and had frequent contact with the friend(s) outside the group, often assisting each other with babysitting, as well as being a confidante.

Those who did not form a mutual aid friendship reported having formed social activity based friendships or acquaintance relationships. Social activity based friendships did not involve the sharing of personal information but were characterised by participating in activities such as children's birthday parties, clothes

parties and occasional evenings spent together without the children. In some instances family to family contact developed which involved the fathers (for example, barbecues and picnics with the children).

The women who formed acquaintance relationships in which they would occasionally 'bump into one another at the shops and have a chat' were usually the women who had only attended the group for a short period of time or had resumed work and lost contact with the group. However, even this level of relationship was described by some as important in that it gave them a sense of familiarity with others in their community.

Women gave multiple reasons for participating in the continuation of their group, with the main reasons being: that they enjoyed sharing their experiences of motherhood with one another (96%); that the groups provided support (95%) and that it was beneficial for their child to have contact with others (82%).

Most of the groups met in one another's homes on a rotating basis. As the children became increasingly mobile this presented problems and some of the groups evolved into playgroups which met at community venues. A few women spoke of their discomfort at meeting in one another's homes, particularly where there was a discrepancy in the level of affluence among members.

CONCLUSION

This study found that the majority of new parent groups evolve into self-sustaining social networks and provide important social support for families experiencing the transition to parenthood. Most women highly valued the groups both for the benefits they had for their children and for themselves. A few women experienced some aspects of the groups as negative.

While the study did not investigate the women who did not join groups, this is obviously an area which needs further research, preferably in a prospective study, as it is likely that current groups do not reach some of the most socially isolated and vulnerable families in the community. However, new parent groups are not the only way to strengthen social support for parents in the transition to parenthood and it should not be assumed that they are necessarily helpful to all first time parents. In some circumstances one-to-one professional, peer or volunteer-based home visiting programs may be more appropriate and preferred by the family. Some parents may have little need or interest in such groups. Just because most who chose to join a group found it a positive experience does not mean that others should be pressured to do so.

Most nurses also expressed satisfaction with the outcomes of the groups they facilitated although a few

found their role anxiety-provoking and hard to manage on top of their other duties. Considerable differences existed between nurses on the involvement of fathers. Whether such groups are 'new mother groups' or 'new parent groups' requires further discussion, and research is required on the best ways to facilitate single sex and mixed parent groups.

Notwithstanding these issues, it is clear that for many families professionally facilitated social networks have the potential to perform a similar role to that traditionally played by naturally occurring neighbourhood based social networks. Economic and social changes have had a major impact on family structure and functioning with women's participation in paid employment and increased mobility decreasing the opportunities which once existed for naturally occurring neighbourhood-based social support. For many families, first time parent groups can play an important role in nurturing neighbourhood networks which may build social capital in communities. In the words of one maternal and child health nurse, 'You are creating a little community, you are building a little village'.

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