The Development of a Facilitators Training Manual for a Coping-Oriented Support Group
to Assist with Perinatal Bereavement

By

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The procedures in this staff/training manual/workshop are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff. Materials from this training manual cannot be replicated or distributed.
Dedication

I would like to dedicate this applied thesis to my amazing on-site supervisor, Danna Hull, for her guidance and support throughout my placement. I am very blessed to have had her as my on-site supervisor for my final placement.
Abstract

Perinatal loss is a traumatic event that parents are unprepared to cope with physically, emotionally, and psychologically. Bereaved parents are at an increased risk for developing complicated grief, depression, and posttraumatic stress. Inadequate support systems and maladaptive coping strategies are associated with higher rates of mental health complications. In addition, there is currently a lack of research pertaining to evidence-based interventions following a perinatal loss and/or medical abortion. Therefore, a facilitators’ training manual was developed to provide a detailed outline for the implementation of a coping-oriented support group, utilizing a cognitive-behavioural approach. The support group is intended for individuals/couples who have endured a medical termination or experienced a perinatal loss. Coping skills targeted in the manual include: goal setting, cognitive-restructuring, mindfulness training, relaxation training, assertiveness training, healthy lifestyle, and exposure therapy. It is recommended to measure the effectiveness of the group and make modifications based on the facilitators’ and the participants’ feedback.
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Chapter I – Introduction

Progress in the field of medical genetics has made it possible to detect an array of fetal abnormalities at an early stage of prenatal development (Kersting et al., 2004). The risk of a birth defect is between 2% to 3% for every pregnancy, regardless of the mother’s maternal age (The Genetics Education Program, 2007). A birth defect ranges in severity and can refer to a fetus with an extra toe or a fetus with a severe heart condition. At the age of 40, the risk of a genetic abnormality in the general population is approximately 1 in every 60 births (Hook, 1981). Consequently, prenatal screening is becoming widely available despite the lack of research concerning potential psychological and emotional implications (Sahin & Gungor, 2008). Various screening options are available throughout a woman’s pregnancy to identify potential problems with a fetus. A screening test is a non-invasive procedure that provides an estimate of the fetus developing common abnormalities (Rowe, Fisher & Quinlivan, 2009). A diagnostic test is an invasive procedure that confirms the existence or non-existence of congenital abnormalities (Dinc & Terzioglu, 2006). Although advancements in the field of medical genetics have permitted individuals to make informed decisions regarding genetic make-up, the overall social and emotional implications are indefinite (Burgess, Laberge & Knoppers, 1998).

The loss of a desired baby is an unanticipated tragedy that parents are unprepared to cope with physically, emotionally, and psychologically. The most common causes of death among stillbirths identified by autopsy are obstetric conditions, placenta abnormalities, genetic and structural abnormalities, infections, umbilical cord abnormalities, hypertensive disorders, and other maternal medical conditions (Bukowski, 2011). The majority of individuals terminate a pregnancy when the fetus is diagnosed with a severe congenital abnormality that has minimal treatment options (Kersting et al., 2005). According to Gaudet (2009), approximately 30% of all pregnancies end in a perinatal loss or a medical abortion. Due to the ambiguity of the loss, perinatal grief is severe, prolonged, and complicated, having detrimental effects on an individual’s health (Lang et al., 2011). Perinatal deaths and medical terminations are associated with increased levels of complicated grief, depression, and posttraumatic stress (Kersting et al., 2004).

According to Boelen (2010), 15% to 20% of individuals who encounter bereavement will develop a serious mental health condition. Maladaptive coping strategies following a perinatal loss increases an individual’s risk for developing depression, posttraumatic stress, and complicated grief (Bennett, Litz, Maguen & Ehrenreich, 2008). In addition, dysfunctional thought and behaviour patterns prevent the occurrence of typical bereavement rituals, causing severe emotional and functional impairments (Boelen, 2006). Interventions that target and promote coping strategies provide individuals with the proper tools to deal with their grief in an adaptive manner. Cognitive-behavioural therapy is an empirically validated approach that helps individuals identify and modify maladaptive thoughts and behaviours. Finally, social support is recognized as a critical feature of the recovery process following a traumatic loss (Umphrey & Cacciatore, 2011). Group CBT provides individuals with a unique opportunity to share their painful experience with individuals who are enduring a similar situation.

Purpose

Individuals who endure a medical abortion or experience a perinatal loss are at an increased risk for developing complicated grief, depression, and posttraumatic stress. Inadequate support systems and maladaptive coping strategies are associated with higher rates of mental health complications. Therefore, the development of a training manual surrounding the implementation
of a coping-oriented support group should have a positive effect on short-term and long-term psychological outcomes. The term perinatal loss will refer to miscarriages, stillbirths, and neonatal deaths. The term medical abortion will refer to the termination of a pregnancy because of a confirmed syndrome that is isolated or genetic, fetal abnormalities identified by ultrasound, and/or fetal infections due to teratogen exposures.

**Rationale**

There is currently a lack of empirical research pertaining to an effective intervention following a medical abortion and/or perinatal loss. In addition, there are minimal community services that provide direct support and assistance to individuals who are dealing with perinatal bereavement. The definitive goal is to develop a facilitators training manual for the implementation of a coping-oriented support group for individuals who are experiencing perinatal bereavement. The content is based on a cognitive-behavioural approach and incorporates a variety of coping skills. The purpose of the support group is to (a) provide individuals with a conceptual framework for understanding loss (b) normalize and validate thoughts and feelings and (c) teach a variety of coping strategies for actively dealing with grief.
Chapter II – Literature Review

Genetic Counselling

Traditional genetic counselling is a nondirective approach that provides affected and at-risk individuals with information regarding an abnormality (Lehtinen, 2005). The goal of genetic counselling is to educate the client by presenting genetic and medical information in a style that the client will comprehend in order to facilitate informed decisions (Rantanen et al., 2008). According to Pilnick (2002), the responsibility of the counsellor is to establish the topic of testing and emphasize the implications for both optimistic and pessimistic results. Due to the complexity of information and time constraints, only a modest amount of time is devoted to addressing the clients’ immediate thoughts, feelings, and emotions (Liden et al., 2003). A follow-up appointment is not required and minimal clients receive counselling services. Cappelli et al. (2009) explored the impressions of several genetic service providers concerning the mental health needs of individuals who were at-risk for adult onset genetic disorders. When health providers were questioned about the availability of mental health services, 76% reported lacking or inadequate psychosocial services within their hospital facilities. Furthermore, Geller, Rushton, Francomano, Kolodner, and Bernhardt (2010) investigated how comfortable genetic professionals felt when dealing with bereavement. The results of the study indicated that approximately 29% of respondents felt they had received inadequate training pertaining to bereavement and grief. Currently, a substantial discrepancy exists between obtaining genetic counselling in addition with community support services to assist with the initial bereavement period.

Prenatal Diagnosis

In recent years, a steady incline has become apparent in the utilization of prenatal screening and diagnostic testing to detect congenital abnormalities (Kersting et al., 2005). Information regarding a fetus’s health status provides time for parents to prepare for a baby with special needs or plan for a medical termination (Kaiser et al., 2002). Consenting to testing is considered part of good prenatal care and is in the best interest of the baby (Kaiser et al.). Many women consent to prenatal testing to obtain reassurance concerning their baby’s health (Sahin & Gungor, 2008). However, many individuals are unaware of the perpetual implications that may arise from their decision (Kersting et al., 2005). Diagnostic testing is acknowledged as a stressful event, in which parents anxiety levels peak prior to receiving the test (Ng, Lai, & Yeo, 2004). Durand, Stiel, Boivin, and Elwyn (2010) conducted several interviews with women considering amniocentesis. The majority of participants reported the decision as difficult and complex. When an anomaly is identified, parents are forced to make the ultimate decision of continuing or terminating a desired pregnancy.

Societal Misconceptions

Advancements in hospital technology and precision in the ability to detect fetal abnormalities has led to an increase in medical abortions and a decrease in infant mortalities (Sunderland & Greenfield, 1984). Perinatal deaths have declined over the years to 1 death in every 100 births in the United States and United Kingdom (Badenhorst, Riches, Turton & Hughes, 2006), leading to greater expectations surrounding a successful and healthy pregnancy (Keefe-Cooperman, 2004). Consequently, the diagnosis of a fetal abnormality is an unanticipated tragedy that triggers severe emotional turmoil (Sutan et al., 2010). Society processes many misconceptions concerning the risk and prevalence of fetal abnormalities, which creates unrealistic expectations among parents.
(Keefe-Cooperman, 2004). First, many individuals believe that a fetus with a serious health condition will naturally miscarriage within the first twelve-weeks of gestation (McCoyd, 2007). Therefore, women experience a sense of relief and anticipate a healthy baby when they surpass an invisible twelve-week marker. Furthermore, the ultrasound is portrayed as a positive experience, where the mother and father are able to see their baby for the first time (Thomas, 1995). However, individuals disregard the fact that the true purpose of an ultrasound is to detect and identify problems with the fetus. As a result, many couples attend their ultrasound expecting to find out the sex of their baby, feeling misled and betrayed when an abnormality is identified (McCoyd). Finally, Down Syndrome is the most prevalent and recognized genetic disorder. This reflects society’s assumption that if a mother is young and healthy at the time of conception, her offspring will be healthy. However, many lethal chromosomal abnormalities occur by chance and are not dependent on a mother’s maternal age (Adolfsson & Larsson, 2010). Societal misconceptions create unrealistic expectations among parents that make the diagnosis of an abnormality a devastating tragedy.

**Fetal Attachments**
Empirical studies have illustrated that women instantly form emotional bonds with their fetus immediately following a confirmed pregnancy (Alhusen, 2008). Technological advancements have permitted women to detect a pregnancy earlier than ever recorded, leading to emotional attachments at an exceptionally fragile stage (Keefe-Cooperman, 2004). Typical culture patterns encourage mothers to bond with their baby prior to birth, by performing several rituals during each trimester (Keefe-Cooperman, 2004). During the first trimester, women become suspicious of their pregnancy and confirm it by telling friends and family members. According to Keefe-Cooperman (2004), women resolve their initial uncertainty surrounding the pregnancy and begin to review one’s own childhood memories. During the second trimester, women are able to see their baby by ultrasound and begin to anticipate the perfect child. During the third trimester, the mother takes on a caregiver role and prepares herself for the birth of a healthy child. Other rituals include communicating with the baby, partaking in a baby shower, and decorating a nursery. According to McCoyd (2007), women are forced to break these societal rules or become vulnerable to the severe emotional repercussions if they are denied a healthy child.

**Grief**
Grief is a complex, emotional reaction that arises when an individual is confronted by the death of someone with emotional attachments (Beutel, Deckardt, Rad, & Weiner, 1995). Every person will experience grief at some point in his or her life (Para, 2009). Central features of grief include feelings of painful despair and seclusion, often accompanied by losing sense of purpose and meaning (Keefe-Cooper, 2004). Common behavioural symptoms of grief include: crying, agitation, avoidance behaviours, and social withdrawal (Love, 2007). Common physical symptoms of grief include: somatic complaints, energy loss, sleep disturbances, and appetite changes (Boelen & Huntjens, 2008). Cognitive symptoms of grief include: preoccupation with the deceased, feelings of hopelessness, self-blame, negative self-judgments, and difficulty in memory and concentration (Boelen & Huntjens 2008). Uncomplicated or typical grief is considered a normal reaction, in which an individual experiences moderate disruptions in their daily emotional and cognitive functioning (Adolfsson & Larsson, 2010). However, individuals are able to work through acute grief, adapt to the situation, and integrate the loss into their lives. Complicated grief is considered a debilitating clinical condition (Boelen, van den Hout, & van
den Bout, 2006) that has detrimental effects on an individual’s health (Zisook & Shear, 2009). Complicated grief occurs when the bereavement process is disturbed (Para, 2009). Underwood (2004) illustrated that complicated grief is more likely to transpire if the loss is traumatic, unexpected, and sudden with an insufficient amount of time for anticipatory grief. Individuals with complicated grief are often preoccupied with the deceased, experience posttraumatic stress and depression, and avoid reminders of the painful experience (Zisook & Shear). In addition, individuals have difficulty adjusting and accepting the loss, which creates major discrepancies in a person’s social and occupational functioning (Para, 2009). The majority of individuals who experience complicated grief receive a diagnosis of major depression, posttraumatic stress, adjustment disorder, and personality disorders (Para).

**Perinatal Loss**

Worldwide, there are approximately 3 million stillbirths and 6.3 million neonatal deaths each year (Carlo et al., 2010). The terminology and definition of perinatal loss varies in literature; however, for this paper perinatal loss will refer to a stillbirth, miscarriage, or neonatal death. A stillbirth is an intra-uterine death of a fetus after 20-weeks’ gestation (Badenhorst et al., 2006). Neonatal death refers to the death of a baby within the first 28 days following birth (Badenhorst et al.). Approximately 15% to 20% of all identified pregnancies result in a spontaneous miscarriage, which is the death of a fetus under 20-week’s gestation (Brier, 2008). Several research studies have indicated that parents experience severe psychological and emotional distress following a perinatal loss. Parents are more prone to depression, complicated grief, posttraumatic stress, and anxiety. Women who endure a perinatal loss have a 3-fold increase for developing depression (Gausia et al., 2011). Bereaved parents have a 6-fold increase for developing anxiety and an 8-fold increase for developing depression, 2-months preceding a neonatal death (Vance et al., 1991). Furthermore, 2-months following a stillbirth, parents have a 3-fold increase for developing anxiety and a 6-fold increase for developing depression (Vance et al.). Armstrong, Hutti, and Myers (2009) conducted a study and found parents displayed moderate levels of posttraumatic stress during a subsequent pregnancy, following a previous loss. Mothers conveyed re-occurring experiences of intrusive thoughts regarding their baby’s health (Armstrong et al.). Grief reactions are similar among women who have experienced a miscarriage, stillborn, and neonatal death. A study conducted by Fraser and Cooper as cited in Sutan et al. (2010), found no significant differences in grief reactions, regardless of the manner in which the pregnancy ended. Vance and Najman (1995) found similar results while exploring the long-term psychological effects of a neonatal death, a stillbirth, and a neonatal death. At an 8-month follow-up interview, there were no significant differences in severity of psychological symptoms. According to Thomas (1995), reviewing one’s memories of the deceased plays a prominent role in the recovery process of bereavement. Keefe-Cooperman (2004) demonstrated that perinatal grief is difficult to resolve because there is no visible baby to attend to and minimal shared memories. Additionally, society does not acknowledge a perinatal loss as a traumatic event, which complicates grief and makes it difficult for bereaved parents to discuss (Lang et al., 2011). However, studies have shown that grief experienced by women who have had a perinatal loss resembles grief of women who have lost an older child. Overall, emotional and psychological stress is a significant concern following a perinatal loss. It is imperative for couples to receive counselling services following a perinatal loss.
Medical Termination

The majority of individuals choose to terminate a desired pregnancy following the confirmation of a severe abnormality with minimal treatment options (Ballantyne, Newson, Luna & Ashcroft, 2009). In a study conducted by Kukulu et al. (2006), 67% of participants who underwent amniocentesis stated they would accept abortion if necessary. The diagnosis of a congenital condition is sudden and unexpected, which forces parents to make a difficult decision between continuing a pregnancy with health issues and terminating a desired pregnancy (McCoyd, 2007). Lloyd and Laurence (1985) conducted a study and found 77% of women experienced acute distress following a termination of a pregnancy, in which the fetus was diagnosed with a congenital abnormality. Continuing a pregnancy with a severe and untreatable condition has perpetual effects on all aspects of life. However, electing a medical termination can produce severe guilt as a direct result of selecting to end a child’s life (Keefe-Cooperman, 2005). When considering a medical termination, Ahmed et al. (2008) established the most influential factor was the parents’ perceptions of the quality of life for their child. Quality of life was based on whether a child would suffer physically, emotionally, and psychologically. McCoyd (2007) demonstrated that women who endure a medical abortion and women who experienced a spontaneous miscarriage exhibit similar grief reactions. Similar findings were illustrated by Keefe-Cooperman (2004) who reported equivalent measurements on different grief scales. Suddenness of loss, prior knowledge of the problem, and being given a reason for the loss are factors that do not influence the severity or intensity of guilt among bereaved parents (Keefe-Cooperman). Factors that influence the severity and intensity of grief include feeling responsible or guilty, employment outside the home, and intervention of counselling. Kersting et al. (2009) explored the psychological impact of a medical termination for a fetal abnormality during the second and third trimester. Following a medical termination, 22.2% of women met DSM diagnostic criteria for a psychiatric disorder. In addition, Krestling et al. (2005) explored the long-term effects of a medical termination of a pregnancy due to fetal abnormalities. The study involved 83 women 2 to 7 years after the procedure, 60 women 14 days after the procedure, and 65 women who delivered a healthy child. Each participant completed an impact of event scale and prenatal grief scale. There was no significant difference between scores in both groups who received a medical termination. Consequently, women exhibit symptoms of posttraumatic stress and symptoms of grief several years after a medical termination. Similar findings were illustrated by Korenentopm et al. (2005), who examined the long-term implications of a medical termination. Diverse questionnaires and scales were utilized to measure grief, posttraumatic stress, somatic complaints, and psychological complaints. The results indicated that 17% of the participants displayed symptoms of posttraumatic stress 2-7 years after the procedure. Grief and posttraumatic stress were equally distributed among the participants. However, grief was more prevalent in women with an advanced maternal age at the time of the pregnancy. Women who had lower educational backgrounds and received minimal support from their partners had the worst psychological outcomes. The death of a child defies the chronological ordering of life events, leaving couples grieve stricken over the loss of a desired baby (Rogers, Floyd, Seltzer, Greenberg, & Hong, 2008). Psychiatric and emotional distress is prevalent in parents who receive a medical termination following the identification of a fetal abnormality. Overall, mental health problems are detectable several years following a medical termination and intervention should be warranted.
Gender Differences
The death of a child is one of the most tragic events parents will encounter. Individuals experience different symptoms and emotions, which fluctuate in intensity levels overtime. Gender is a common factor that directly influences the expression of grief following a perinatal loss or medical termination (Franche & Bulow, 1999). Men and women employ different coping strategies to deal with their emotions and pain. Women express grief overtly while men express their grief discreetly (Sintson et al., 1992), which often leads to marital stress and conflict. In a bereavement support group conducted by Reilly-Smorawski, Armstrong, and Catline (2002), women reported becoming agitated with their husbands for lack of expression in regards to their loss. However, several husbands disclosed experiencing emotional breakdowns when they were alone. Empirical studies have illustrated that grief experienced by mothers is more intense, prolonged, and guilt filled (Badenhorst et al., 2006). Incongruent grieving can have detrimental effects on a relationship (Swan & Scott, 2009). Women often feel that their bodies have betrayed them, which causes severe self-blame and guilt. According to Condon (2010), men are not prone to self-blame or guilt. Many couples employ avoidant emotional-focused strategies to cope with their loss, which makes them vulnerable to posttraumatic stress and complicated grief (Swan & Scott). Gold, Sen, and Hayward (2010) found a slightly higher divorce rates and marital dissatisfaction following a perinatal loss compared to non-bereaved couples. However, studies have demonstrated couples who endorse a strong communication pattern report heightened levels of marital satisfaction following a traumatic loss (Swan & Scott, 2009). Following a traumatic loss, couples should receive support to assist with the initial bereavement period.

Social Support
Social support improves a person’s overall emotional, social, and physical well-being across multiple situations and settings (Harel, Shechtman, & Cutrona, 2011). Social support is considered an essential aspect for positive psychosocial outcomes following a traumatic loss (Cacciatore, 2010). Engler and Lasker (2000) conducted a study and found perceived support and emotion-focused coping strategies predicted the prevalence of grief in bereaved mothers following a neonatal loss. Bereaved parents who perceive their support system as strong and employ emotion-focused strategies are more likely to adjust to a traumatic loss. However, bereaved mothers who refuse to discuss their loss have a 4-fold increase for developing maternal depression three years following a neonatal loss (Surkan, Radestad, Cnattingius, Steineck, & Dickman, 2009). Bereaved fathers have a 50% decrease in their risk for developing depression when provided with an opportunity to discuss their loss. Kavanaugh et al. (2004) demonstrated that women benefit from talking to individuals who have endured a similar experience. Sutan et al. (2010) found a significant relationship in psychosocial impact and perceived social support from family members and friends. According to Steiner (2006), it is common for family members and friends to be uncomfortable around bereaved couples. Stigma associated with terminating a pregnancy due to an abnormality has a negative impact on an individual’s support system (McCoyd, 2007). McCoyd (2007) conducted a study in which women reported leaving out certain information in fear of being judged by family members and friends. Similar findings were illustrated by Thomas (1995), demonstrating that couples found it easier to tell friends and family that their pregnancy ended in spontaneous miscarriage. Extended family members suffer from grief, which may interfere with their ability to provide adequate support (Thomas). A person’s social network is compromised following a traumatic loss. In a study conducted by De Montigny, Beaudet, and Dumas, (1999), women reported permanent strains on relationships with
friends, family members, and co-workers. Insensitive or trivial comments worsen a bereaved mother's experience and can cause more damage than intended. Women who had a miscarriage reported lack of information, insensitive comments, and lack of empathy as negative experiences following a miscarriage (Rowlands & Lee, 2010). Engagement, acknowledgement, and support were rated as positive experiences following a miscarriage. Lack of social support intensifies and lengthens the grieving process (Plagge & Antick, 2009) and is considered a major risk factor for complicated grief (Zisook & Shear, 2009). Couples benefit in situations with open and honest discussion (DeBackere, Hill, & Kavanaugh, 2008) where they can allocate their entire story (McCoyd, 2007).

**Cognitive- Behavioural Therapy**

Brief counselling is acknowledged as the most effective intervention for individuals suffering from grief (Para, 2009). Short-term CBT increases self-esteem, mental health, social functioning, and decreases symptoms of grief (Para, 2009). CBT is empirically supported intervention to reduce typical symptoms of grief in the population. Counselling following a medical termination or perinatal death functions as a protective barrier that facilitates the initial bereavement period. CBT is suggested to be an effective intervention that normalizes grief and promotes social interaction. Group counselling offers individuals a unique opportunity to share their painful thoughts and feelings in a safe environment with others who are enduring a similar situation (Thomas, 1995). Cognitive-behavioural therapy is an empirical validated approach that can be used to assist with maladaptive thoughts and behaviour patterns following a traumatic loss (Boelen, 2006). Trauma-focused CBT encourages an individual to expose themselves to a traumatic memory and modify maladaptive thoughts (Ponniah & Hollon, 2009). Trauma-focused CBT was originally developed for children who suffered from sexual abuse; however, has recently generalized to a larger population with a wider range of traumatic experiences (Allen, Oseni, & Allen, 2011). Components of trauma-focused CBT included: psychoeducation, parenting skills, relaxation skills, affect modulation skills, cognitive-restructuring, trauma narration, in-vivo or imaginal exposure, conjoint child-parents sessions, and personal safety (Allen, Oseni, & Allen). Forbes et al. (2007) developed several recommendations for the implementation of a trauma-focused intervention with approval from the multidisciplinary reference panel. First, a 90-minute session is required for the application of in vivo exposure. Secondly, treatment should be 8 to 12 sessions in duration. Allen, Oseni, and Allen implemented a trauma-focused cognitive-behavioural intervention for a 16-year-old boy diagnosed with chronic posttraumatic stress. The client displayed symptoms of posttraumatic stress, anxiety, depression, anger, and somatic complaints. The aim of trauma-focused cognitive-behavioural therapy was to educate the client about grief and help the client develop applicable coping skills. At the end of therapy, the client reported a significant decrease in his internalizing symptoms and a demonstrated a significant decline in posttraumatic stress. Ponniah and Hollon (2009) conducted a review of the literature to identify effective interventions following a traumatic experience. Results identified that trauma-focused CBT as an effective and acceptable intervention for posttraumatic stress. CBT has illustrated to be an effective intervention for a range of mental health disorders (Bieling et al., 2006). According to Boelen (2006), maladaptive thought and behavioural patterns prevent typical bereavement processes and causes emotional turmoil and mental health problems. CBT teaches clients to acknowledge, identify, and restructure maladaptive thought and behaviour patterns. Couples who experienced a perinatal loss often develop negative beliefs, catastrophic misinterpretations, and self-blame (Boelen,
Forrest, Standish, and Baum (1982) demonstrated that aversive psychiatric symptoms associated with perinatal bereavement were reduced when couples received social support and counselling. Boelen et al. (2007) conducted a study and found that cognitive-behavioural therapy was a more effective intervention for reducing symptoms of complicated grief, in comparison to the sole delivery of supportive counselling. Cognitive-behavioural therapy is an established and effective treatment for depression, posttraumatic stress, and anxiety (Bieling et. al.). Cognitive-behavioural therapy in groups, enhance installation of hope, universality, altruism, and catharsis. Members are able to learn how other bereaved parents have been dealing and coping with their loss. Cognitive-behavioural groups enhance an individual’s social support system, which creates barriers against stress, isolation, and loneliness through many of the group’s dynamic processes (Bieling et al.). Cognitive-behavioural group therapy offers an environment that facilitates and encourages learning, skill development, free exchange, and mutual trust (Harel et al., 2011). Furthermore, couples benefit from a behavioural group setting, as they are able to learn and acquire applicable skills through a variety of behavioural techniques, such as modeling, behavioural rehearsal, and feedback (Bieling et al.).

**Group Counselling**

Following a traumatic loss, individual’s become isolated and estranged from their social network (Para, 2009). Vlasto (2010) explored the advantages and disadvantages of individual and group bereavement counselling. Vlasto collected data from nine different bereavement counsellors using a semi-structured interview. Advantages that were identified for group counselling included; social contact, behavioural rehearsals, challenge of differences, honest sharing, and normalization of grief. Perceived disadvantages for group counselling included; non-disclosure of feelings and information, competition, and over-exposures. According to Bieling et al. (2006), a therapist can encourage disclosure by relating a person’s thoughts and experiences to other group members’ experiences and by asking direct questions that require a more detailed response. A therapist can balance time and manage a member who is monopolizing the group by employing containment strategies (Bieling et al.). Subtle containment techniques have shown to be an effective and positive method for dealing with a member who is considered overbearing. Competition mainly arises when there is diversity within the group and can be managed by incorporating a co-facilitator to observe and monitor group processes. In general, potential disadvantages can be avoided by acknowledging group differences at the preliminary stage, emphasizing similarities, and addressing concerns (Bieling et al.). Benefits that were identified for individual counselling included safety, formation of a therapeutic relationship, sharing extreme emotions, and overcoming barriers to access deeper material. Disadvantages identified for individual counselling include power imbalance and intensity between the counsellor and the client. A power balance mainly occurs when the therapist imposes limits on the relationship or when the therapist is unable to relate to a situation. Communication between the counsellor and client may become intense, as there is no other person to intervene. According to Vlasto (2010), both individual and group counselling are beneficial, however, provide different opportunities. Groups are a considered a social intervention that discourage isolation and encourage normalization of grief. Groups provide an environment for catharsis and imparting of didactic information (Bieling et al.), where members can learn a variety of coping techniques and methods to manage stress (Para, 2009). Vlasto (20120) recommended that individuals should attend one individual counselling session and can be referred to a support group for further assistance.
Coping Skills
Perinatal bereavement has aversive effects on an individual's coping mechanisms as they experience a discrepancy in their daily abilities (Mathews & Marwit, 2004). Bereaved parents who experience prolonged grief have difficulty thinking rationally in other areas of their life (Coleman et al., 2007). Interventions targeting coping skills provide participants with tools to assist them in solving problems and managing emotions (Brown, 1983). Coping skills have demonstrated to enhance and maintain a quality with life up to 1-year following training (Brown, 1983). Maladaptive coping skills are associated with an increased risk for depression, anxiety, posttraumatic stress, and complicated grief following a perinatal loss (Bennett et al., 2008). In situations where there is diminutive potential for change, Cote and Pepler (2004) stress the importance of teaching emotion-focused strategies. Long and Bluteau (1988), conducted a coping skills group for 38 individuals diagnosed with generalized anxiety, panic disorder, agoraphobia and panic disorder, major depression, and depressive neurosis. Coping skills include; psychoeducation, goal setting, progressive muscle relaxation, differential relaxation, identifying maladaptive cognitions, modifying maladaptive cognitions, and preparation for the future. There were 10 sessions that were 90 minutes in duration and participants were randomly assigned to one of the six groups. Following treatment, 91% of participants reported the group as being beneficial. There was a clinically significant decline in the General Health Questionnaire from pre-assessment to post-assessment. Participants’ scores on the Symptom Questionnaire decreased on the somatic, cognitive, and behavioural avoidance subscales following treatment. McQueeney, Stanton, and Sigmons (1997), illustrated that both emotion-focused coping strategies and problem-focused emotion strategies are useful interventions for women with infertility problems. Emotion-oriented coping strategies focus on regulating a person's emotions surrounding a traumatic experience. Problem-oriented coping skills focus on ways a person can modify or change the problem (McQueeney et al.). Fleming and Thornton (1980) demonstrated that cognitive, behavioural, and non-directive workshops were equally effectively in decreasing depression, which was maintained at a 6-week follow-up session. Participants on a waiting-list who did not receive an intervention showed no decline in their depressive symptoms. Tolman and Rose (1985) identified several coping skills that assist individuals adjust and adapt to stressful events. Coping techniques that have shown to assist individuals adjust to a stressful event include; relaxation training, cognitive restructuring, exercise and recreation, nutrition, avoidance strategy, time management, and social skills training. Overall, maladaptive coping skills are a predictor of poor adjustment and mental health concerns. Coping-oriented behaviour has shown to decrease mental health concerns and enhances a successful adaptation to a traumatic loss.

Goal Setting. The goal setting theory is an empirically recognized approach for motivating clients within a counselling setting to pursue highly desirable goals (Kleingeld, Mierlo, & Arends, 2011). Creating goals help re-establish daily routines, set priorities that require energy, and create a sense of purpose (Clark, Crowe, Oades, & Deane, 2009). The most commonly used method for establishing goals is the acronym SMART. First, goals should be specific so the individual can recognize and identify an endpoint. According to Werle (2010), a client will be more successful at attaining a goal that is specific. Secondly, goals should be measurable so the client can track and monitor their progress in order to maintain motivation. Furthermore, goals enhance self-confidence and self-efficacy when completed; therefore, goals
should be realistic and attainable to avoid aversive outcomes of unaccomplished goals. Finally, goals should be timely and not take an excessive amount of time before the individual is reinforced.

**Cognitive-Restructuring.** Several empirical studies have illustrated that bereaved individuals engage in self-defeating automatic thoughts (Boelen, 2006). Negative automatic thoughts can elicit painful emotional reactions and dysfunctional behaviours (Wright, Basco, & Thase, 2006). Bereaved individuals typically adopt negative attributions concerning their self, the world, and their future. Following a perinatal loss or medical termination, bereaved parents experience severe guilt and self-blame (McCoyd, 2007; Keefe-Cooperman, 2004). Maladaptive thinking and behavioural patterns prevent the occurrence of typical bereavement rituals (Boelen, 2006). According to Deacon et al. (2011), the purpose of cognitive-restructuring is to teach clients a more accurate and adaptive technique for interpreting life events. During cognitive restructuring, the client is encouraged to recognize, identify, and challenge negative automatic thoughts by utilizing several diverse behavioural techniques. A common behavioural technique used to determine whether a thought distorted is to gather evidence for and against the automatic thought. Thought records are frequently utilized to help the client monitor and track automatic thoughts. Cognitive-restructuring has demonstrated to be an effective and preventive intervention for a wide range of mental and mood disorders (Szentagotai & Freeman, 2007). Cognitive-restructuring prevents and assists with depression, stress, posttraumatic symptoms, and complicated grief.

**Mindfulness Training.** Positive emotions and a positive attitude have beneficial effects on mental and physical health (Geschwind, Peeters, Drukker, Van, & Wichers, 2011). Mindfulness training involves an awareness and steady concentration on present-moment experiences (Christopher & Maris, 2010). During mindfulness training, the individual is encouraged to acknowledge and accept all thoughts, emotions, and sensations that break concentration without judgments or criticism (Christopher & Maris, 2010). Once the individual has acknowledged the distraction, they can return their focus back to the present moment. The purpose of mindfulness training is to teach an individual to focus on the present and refrain from preoccupation with past events (Geshwind et al., 2011). Mindfulness has demonstrated to be an effective barrier against depression, pain, and negative affectivity (Geshwind et al., 2011). There are two commonly used methods for teaching mindfulness. The first method is mindfulness breathing, which requires the client to focus on their breath (Feldman, Greeson, & Senville, 2010). The second method is body scanning, which requires the client to become aware of bodily sensations (Michalak, Troje, & Heidenrenreich, 2011). The individual learns to attend to their entire body in a non-judgmental manner.

**Relaxation Training.** The death of a baby is considered one of the most stressful life events that an individual will encounter (Greer, 2010). Stressful events cause a physiological reaction in the body that increases an individual’s sympathetic nervous system causing emotional arousal (Arnette, 1996). Empirical research has illustrated that severe psychological stress has aversive effects on a person’s immune system (Arnette, 1996). Relaxation training is an evidenced-based treatment that help individuals cope with emotional arousal (Young, 2009), by creating a state of mental and physical calmness (Wright, Basco, & Thase, 2006). Many different relaxation techniques have been used to help an individual regain control of their emotions such
as; progressive muscle relaxation, imagery, and deep breathing. Teaching new relaxation methods and enhancing pre-existing relaxation methods is beneficial following a traumatic event (May, House, & Kovacs, 1982). Relaxation techniques decreases stress symptoms, increase self-efficacy, and promotes the ability to talk about the deceased without the occurrence of emotional arousal (Arnette, 1996). During progressive muscle relaxation, the individual concentrates on their breathing and body, systematically tensing and releasing each of the main muscle groups. Progressive muscle relaxation is acknowledged as a useful relaxation tool that reduces stress and emotional arousal. The main limitation concerning this technique is time consumption, as it requires 20-minutes to complete. Therefore, teaching progressive muscle relaxation with a more convenient relaxation technique will provide flexibility in application. During imagery, the client is encouraged to visualize a relaxing mental image or place that will distract them from their worrisome thoughts (Wright et al., 2006). Finally, deep breathing requires the client counting from 10 while inhaling and exhaling through their nose. Overall relaxation techniques decrease stress symptoms, increase self-efficacy, and promotes the ability to discuss the deceased without the occurrence of emotional arousal (Arnette, 1996).

**Problem-Solving.** Emotional overloads can diminish an individual’s ability to effectively problem-solve (Wright et al., 2006). Bereaved parents experiencing prolonged grief have difficulty thinking rationally in other areas of their life (Coleman et al., 2007). Maccallum and Bryant (2010) found individuals diagnosed with complicated grief experienced deficits in their ability to problem-solve. Problem-solving is acknowledged for having a positive impact on a person’s ability to adjust and cope with stressful life events in a resourceful manner (Maccallum & Bryant, 2010). Problem-solving involves a variety of cognitive process that encourages an individual to visualize multiple methods for dealing with traumatic experiences or everyday hassles (Maccallum & Bryant, 2010). Problem-solving teaches an individual to utilize a systematic approach to solve a difficult or emotionally challenging problem. The five main steps of problem-solving include; identifying the problem, brainstorming possible solutions, evaluating possible solutions, choosing the best solutions, and implementing the solution (Bieling et al., 2009).

**Assertiveness Training.** Individuals who have experienced a traumatic loss typically become isolated and estranged from their social networks (Para, 2009). Typically, bereaved parents feel that their situation is not acknowledged or well understood by family members and friends. According to Steiner (2006), it is common for family members and friends to become uncomfortable around bereaved couples, as many people are unfamiliar with perinatal bereavement. Many family members and friends offer trivial comments as empathetic statements, such as; it was meant to be or you can try again. However, insensitive and trivial comments worsen a bereaved mother’s experience, causing relationship strains (De Montigny, Beaudet, & Dumas, 1999). In addition, couples experience grief in different ways, which can elicit conflict. Assertiveness training can help individuals communicate their thoughts, feelings, emotions, and needs in an assertive manner. In addition, it can assist individuals talk about their loss when they feel ready and understand the parameters they feel comfortable sharing.

**Healthy Lifestyle.** Proper nutrition, adequate sleep, social contact, and exercise all contribute to a healthy lifestyle. A healthy lifestyle enhances an individual’s mood and decreases vulnerability to problems with mental health (Merrill, Aldana, Greenlaw, & Diehl, 2008). An
insufficient amount of sleep heightens a person’s risk for mental health problems, impaired cognitive functioning, and emotional distress (Steptoe, Dockray, & Wardle, 2009). Regular contact with friends and family members and enjoyable activities decreases a person’s risk for developing a mental and mood disorders (Steptoe et al., 2009). In addition, physical activity has been associated with an increased quality of life, reduced concerns regarding mental health, and prolonged life. Finally, poor nutrition is associated with fluctuation in mood, stress, and depression (Merrill et al. 2008). A weekly activity schedule is a commonly utilized behavioural technique that enhances and promotes motivation.

Exposure Therapy. Avoidance behaviours are common among bereaved individuals (Boelen, 2006). According to Boelen (2006), individuals may avoid people, places, and activities that remind them of their traumatic loss, which prevents successful integration. Avoidance behaviours are strengthened with time because it provides immediate emotional and physical relief (Wright et al., 2006). Imaginal exposure is a commonly used technique decrease emotional arousal associated with avoidance behaviours. During exposure therapy, the client creates a hierarchy of situations that provoke distressing thoughts and emotions (Wright et al., 2006). Each step is rated using a scale from 1-100, indicating the degree of difficulty. Typically, an exposure hierarchy varies in difficulty and consists of 8 to 12 steps. Finally, the client is systematically desensitized to each step through repeated exposure.

Summary
Overall, couples who have experienced a medical termination or perinatal death may display significant levels of depression, posttraumatic stress, and complicated grief that have detrimental effects on health. Despite the evidence illustrating social support functions as a protective barrier, there is currently a major discrepancy between perinatal bereavement and the availability of community services. Perinatal bereavement is one of the most difficult life events couples will endure. Maladaptive coping skills and lack of social support are associated with a higher risk for developing mental health problems. Coping skills help an individual adjust to a traumatic event by teaching a variety of skills that provide a sense of control. A group provides a unique opportunity to communicate in an environment with individuals who are experiencing a similar situation. According to Coleman, Vincent, and Spence (2007) lack of opportunities to discuss a loss and lack of social support prevents resolution of grief. Bereaved parents may experience intense emotional reactions to environmental cues several years following a loss (Coleman et al.). Bereaved parents experience reduced energy, avoidance behaviours, communication difficulties, self-doubt, limited personal control, decreased self-esteem, and self-blame (Coleman et al.). A support group that enhances coping skills, using a cognitive-behavioural approach should have a positive impact by providing parents with applicable skills. The aim of this project is to create a manual that can be utilized by professionals in the field to provide a coping-oriented support group for couples following a perinatal loss.
Chapter III – Methodology

Participants
The manual is intended for use with bereaved couples and/or individuals who have experienced a perinatal loss or endured a medical abortion. Ideally, the group should include approximately 6 to 8 individuals who can be recruited by convenient sampling procedures. In convenient sampling procedures, individuals are recruited on a voluntary and availability basis. Referrals can come from a variety of sources including genetic counsellors, general practitioners, social workers, and hospice providers. Information concerning the group can also be advertised on bereavement websites and fetal assessment units in local hospitals. It is recommended that a pre-group meeting be arranged with the facilitator to discuss informed consent procedures and acquire specific information tailored the individual’s loss. Inclusion criteria should consist of couples/individuals who have endured a medical abortion or experienced perinatal loss. Essentially, all types of loss can be incorporated into one group; therefore, it is important that individuals are willing to support other members, regardless of their type of loss. Exclusion criteria should consist of extended family and friends, social terminations, and individuals who are reluctant to support other members. In addition, individuals who are displaying psychotic symptoms or suicidal tendencies should not be eligible to participate and referred to mental health professionals with certified training. Verbal and written consent should be obtained during the pre-group interview, which can be conducted with the member and facilitator. The facilitator should explain and review the consent form in-depth, clarifying potential risks and benefits in participating. The consent form must be signed, dated, and filed for each independent member and be kept in a secure location for a minimum of seven years. It is recommended that the group facilitators have exclusive access to members’ files to enhance confidentiality. Circumstances in which confidentiality may be breached must be addressed during the meeting. Finally, the facilitator should emphasize that the group will be heterogeneous containing couples who have had a medical termination, stillbirth, miscarriage, and/or neonatal death.

Design
The facilitators training manual will assist in the implementation of a coping-oriented support group, utilizing a cognitive-behavioural approach. It is recommended that the group meet once a week for 12 continuous weeks in a setting that is accessible, quiet, and secure. Each session should be 2-hours in duration and include a 10-minute break in order to provide flexibility in starting and more opportunities for in-depth discussions (Bieling et al., 2006). A session longer than 2-hours in duration will be strenuous and members may find it hard to attend to the information and material being provided. The group should utilize a closed-based membership because there is a limited amount of sessions and an open-based membership will compromise group cohesion (Underwood, 2004). There should be a minimum of two facilitators at all times so the co-facilitator can monitor group discussions and processes to reduce competition that may arise. The initial session should be dedicated to introducing group members, building group cohesion, and establishing the concept of grief. The following sessions can be allotted to teaching a variety of coping strategies through psychoeducation, behavioural rehearsals, modelling, reinforcement, and feedback. Each session should introduce a new coping strategy that will build on the previously learned skill. The first half of a session should be dedicated to reviewing homework, bridging from the previous session, completing grief assessments, and conducting CBT on topics members want to address. The second half of each session should introduce and teach a new coping technique. The final session can be dedicated to addressing
concerns members may have in regards to the termination of group and reviewing members overall experiences. The role of the facilitator is to insure safety, reinforce norms, provide emotional balance and support, model articulation of feelings, validate feelings, and outline realistic expectations (Underwood, 2004). The following credentials are recommended for the facilitator due to the complexity of the group. The facilitator should have extensive training and coursework in CBT models and techniques, as well as direct supervision on multiple individual cases (Bieling et al., 2006). The facilitator should have prior experience working with groups having experience as a co-facilitator (Bieling et al., 2006). Furthermore, the facilitator should be comfortable with group processes, displaying a degree of confidence with socratic and collaborative dialogue (Bieling et al., 2006). Suicide intervention training is considered an asset. Finally, the facilitator should have prior exposure with unresolved grief and possess a basic understanding surrounding the role of genetics in prenatal care.

Measures
Assessment screening procedures will be conducted during the pre-group interview. First a semi-structured interview will be completed by each individual to obtain knowledge concerning where individuals are in regards to the grieving process, what type of support system they have in place, circumstances surrounding their loss and demographic information. In addition, each individual complete the 33 Item Short Version Prenatal Bereavement Scale by Toedter and Lasker (2001). The short version prenatal bereavement scale measures bereavement and identifies vulnerable individuals following a loss. It contains three subscales active grief, difficulty coping, and despair (Toedter & Lasker, 2001). The purpose of conducting screening and assessments is to provide facilitators with knowledge about group members, screen individuals who are at risk for suicide, and determine the effectiveness of the support group.

Procedures
A review of literature revealed minimal evidence-based interventions for this particular population. Therefore, coping skills were selected through careful analysis of effective interventions for symptoms and mental health concerns associated with this particular population. Coping strategies targeted in the manual include; goal setting, cognitive restructuring, mindfulness training, relaxation training, problem-solving, assertiveness training, healthy lifestyle, and behavioural exposures. Coping techniques can be taught and reviewed in a group setting using psychoeducation, modeling, reinforcement, behavioural rehearsals, feedback, and reinforcement. It is recommended that members reflect on their experience once an activity is completed.
Chapter IV – Results

The following manual provides a detailed outline surrounding the implementation of a coping skill based support group to assist with bereavement.
Chapter V – Discussion

Summary
The purpose of the current thesis is to create a manual to assist with the future implementation of a support group that enhances emotion-focused coping strategies following a perinatal loss or medical termination. Although the support group could not be implemented, the following training manual provides a detailed outline for future application. Empirical research has illustrated that depression, posttraumatic stress, and complicated grief are common in bereaved parents. However, minimal research has been conducted pertaining to an evidence-based intervention following a perinatal loss or medical termination. Consequently, coping skills were selected through careful analysis of effective interventions for symptoms associated with a traumatic loss. Social support and coping strategies are suggestive of a successful adaptation following a traumatic loss.

Strengths
There are minimal community support services for bereaved parents following a perinatal loss or medical termination. The following manual provides a detailed outline pertaining to an intervention for this population. Groups are cost-efficient, time-efficient, and capable of treating more people by trained therapists in a shorter amount of time. In addition, groups provide a unique opportunity for individuals to meet others who are enduring a similar situation. Furthermore, groups promote and enhance altruism, instillation of hope, universality, imitative behaviours, and group cohesion. Grief varies person to person and normalization of grief is more likely to transpire within a larger group. Finally, the coping techniques were selected through careful analysis of empirical research.

Limitations
The main limitation is that the support group could not been implemented. As a result, feedback could not be acquired from members or facilitators to determine the effectiveness of the program. In addition, the support group incorporates a wide range of material with a short amount of time to teach the material. More time may be required to teach the necessary components of each skill and have additional time to practice the coping skill within the session.

The second limitation is the manual is intended all types of losses, which may interfere with the groups dynamic processes. However, multiple precautionary steps have been addressed within the manual to minimize potential conflict. The precautionary steps could not be determined, as the group was not implemented.

Finally, there was a major inconsistency in regards to terminology used in pre-existing literature. The terms and definitions of perinatal loss, miscarriage, stillbirth, and neonatal loss varied amongst peer-reviewed articles.

Multilevel Challenges to Service Implementation
At the client level, motivation, participation, and mental health are potential barriers facilitators may encounter when implementing the support group. Mental health is a major concern following a perinatal loss; therefore it may be more difficult for individuals to attend to the information and are less likely to be motivated to participate. Facilitators should recognize and address these issues as they arise and determine an effective method to address them. If members are experiencing severe depression, facilitators may confer to members about discussing symptoms with their doctor to determining what is beneficial for them. Medication
can be an effective intervention in conjunction with cognitive-behaviour therapy. Perinatal loss is a private event and difficult to discuss, especially in a group setting. Ultimately, this may lead to passivity and lack of disclosure. Finally, a group will consist of members with all different types of losses. This is a concern on the client level as members may have strong feelings and opinions about particular types of losses. This also can effect a client’s motivation to share personal information if the group process has been compromised due to lack of universality.

The major challenge at the organizational level is participation and training facilitators. Perinatal loss is a sensitive topic, which may affect participation. In addition, it may be difficult to acquire a facilitator with knowledge in behavioural techniques, perinatal bereavement, and genetics.

The major challenge at an organizational level is funding. Funding is a major concern because of the potential expenses of a support group. Location, materials, facilitators, and length were concerns expressed by the agency.

Finally, the major challenges at a societal level include lack of recognition following a perinatal loss. In our society, a perinatal loss is not perceived as significant loss when compared to the death of an older child. This can directly influence whether a person will seek out and receive assistance. In addition, bereaved parents may be reluctant to attend group in fear of being judged, especially if they had a medical termination.

Contributions to the Behavioural Psychology Field
The following manual contributed to the behavioural psychology field by creating an intervention for couples following a perinatal loss. During a review of existing literature, minimal research was available pertaining to effective interventions for this particular population. This manual provides a starting point for creating an effective intervention following a perinatal loss or medical termination.

Recommendations
The manual is intended to incorporate all losses to meet the needs of the agency; however, it can be separated into smaller homogenous groups based on the type of loss. Separating the groups based on loss may enhance group cohesion, universality, and trusting relationships. Overall, when implementing the support group that encompasses all types of loss it is very important to monitor and detect any conflict that may be arising. It is important to address these differences and emphasize the commonality of losing a child. There are groups that incorporate all types of losses into one group, as grieving over a wanted child is similar across losses. It is recommended that the effectiveness of the group be measured by client feedback to improve on the existing manual. In addition, the allotted time for each activity may need to be adjusted. In conclusion, the manual should assist with the future implementation of a support group to assist bereaved individuals by enhancing coping strategies utilizing a CBT approach.
Reference List


Appendix A: Grief Symptoms Checklist

Behavioural
- Spontaneous crying
- Avoidance of places, people, or things that remind you of your loss
- Withdrawing from social activities
- Behaving in ways that are not typical for you
- Other:

Physical
- Severe headaches
- Loss of appetite
- Difficulty sleeping
- Weakness
- Energy loss
- Fatigue/Exhaustion
- Somatic complaints (Aches and pains)
- Other:

Emotional
- Worry
- Anxiety
- Frustration
- Anger
- Guilt
- Disbelief/ Shock
- Denial
- Depressed
- Other:

Cognition
- Yearning
- Negative self-judgments or blame
- Thoughts of suicide
- Preoccupation with deceased
- Difficult in memory and/or concentration
- Negative beliefs about world
- Feelings of hopelessness and/or helplessness
- Sense of unreality
- Other:

Spiritual
- Questioning the reason for your loss
- Questioning the purpose of pain and suffering
- Questioning the purpose and meaning of death
- Other:

Coping-Oriented Support Group Training Manual
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**Introduction to Manual**

This program is designed for individuals and/or couples who have endured a medical termination or experienced a perinatal loss. For this program, the term medical termination will refer to the termination of a pregnancy because of an abnormality identified by ultrasound, a confirmed syndrome that is isolated or genetic, or a fetal infection due to teratogen exposures. The term perinatal loss will refer to couples who have experienced a miscarriage, stillbirth, or neonatal death. The overall purpose of the support group is to (a) provide a conceptual framework for understanding loss (b) validate and normalize thoughts and feelings and (c) teach a variety of coping skills for actively dealing with grief. The following manual provides a detailed outline surrounding the implementation of a coping skill based support group to assist with bereavement.

**Importance**

Perinatal loss is an unanticipated tragedy that parents are unprepared to cope with physically, emotionally, and psychologically. Perinatal bereavement and the termination of a desired pregnancy are associated with an increased risk of depression, posttraumatic stress, and complicated grief (Zisook & Shear, 2009). Inadequate support systems and maladaptive coping strategies are associated with higher rates of mental health problems. The loss of desired baby is considered one of the most difficult events couples will encounter in their life (Matthews & Marwit, 2004). Currently, there are minimal community services in the surrounding area that provides social support to assist with perinatal bereavement. Therefore, an educational support group that enhances coping techniques, utilizing a cognitive-behavioural approach, will allow members to acquire applicable skills in a supportive environment.

**Best Practices**

Cognitive-behavioural therapy is an empirically validated approach that helps clients recognize, identify, and modify maladaptive thought and behavioural patterns. CBT is a well-established intervention for treating several mood disorders such as anxiety, depression, and posttraumatic stress (Wright, Basco, & Thase, 2006). Complicated grief is more likely to transpire when a loss is traumatic causing an insufficient acceptance of the loss, severe yearning for the deceased, negative or catastrophic beliefs and assumptions, and/or avoidant behaviours (Boelen, 2006). A review of the literature revealed inconsistencies in terminology and results pertaining to an effective intervention for complicated grief following a perinatal loss and medical termination. Some studies have illustrated CBT to be an effective intervention for both typical and complicated grief (Matthews & Marwit, 2004). Therefore, coping skills were selected centered on evidence-based behavioural techniques for symptoms of bereavement. Boelen, Keijser, van den Hout, and van den Bout (2007) illustrated that CBT is more effective at reducing grief symptoms than the sole deliverance of supportive counselling. Maladaptive thought patterns and avoidant behaviours are believed to prevent typical bereavement rituals from occurring causing severe emotional turmoil (Boelen, 2006). CBT utilizes cognitive and behavioural interventions to challenge irrational beliefs and reduce avoidance behaviours (Wright, Basco, & Thase, 2006). Group CBT provides individuals with a unique opportunity to share their story with individuals who are enduring similar situations. CBT encourages social support, skill development, mutual trust, and free exchange. The enhancement of coping skills reduces the overall negative impact of a traumatic event (Holaday & Smith, 1995). Teaching coping skills provides individuals with the proper tools to manage their anxiety and problems in an active manner (Brown, 1983). Cote and Pepler (2004) noted that in a situation where there is minimal potential for change, coping
strategies should be emotion-oriented. The lack of emotion-focused strategies is associated with a decreased state of mental health (Schnider, Elhai, & Grey, 2007). Schnider, Elhai, and Grey (2007) found complicated grief and posttraumatic stress positively correlated with avoidant emotion-focused coping strategies.

**Participants**
Ideally, the group would consist of six to eight individuals or couples who have endured a medical termination or experienced a perinatal loss. Essentially, all types of loss should be incorporated into the group; therefore, members must be willing to support other members, regardless of their type of loss. Members should exclusively consist of bereaved parents and not extended family members. Exclusion criteria would consist of social terminations and individuals who are reluctant to support other members. Finally, individuals would not be eligible to participate if they are displaying psychotic symptoms and/or are at risk of suicide. If individuals begin to display suicidal tendencies, they should be immediately assessed and referred to mental health professionals with certified training.

**Facilitators**
The group is designed to be implemented by two facilitators. This allows one facilitator to teach the group, while the co-facilitator attends to group processes. In addition, it should reduce potential conflict that may arise as a result of diversity surrounding cause of loss. The following credentials are recommendations for the facilitator, due to the structure and complexity of the group.
1. Training and coursework in CBT models and techniques.
2. Direct supervision on multiple individual cases utilizing CBT models and techniques.
3. Prior experience as a co-facilitator in a CBT group.
4. Familiar and comfortable with group processes.
5. Experience in dealing with bereavement and grief.
6. Understands the role of genetics in prenatal loss.
7. Suicide intervention training.

**Format and Setting**
It is recommended that the group be implemented once a week for 12 consecutive weeks. The duration of each session should be 2-hours and held in a location that is quiet and accessible. Members should be permitted a 10-minute break each session in which refreshments will be provided. The group should be held at a time that is convenient for members, preferably in the evening after work hours. During the initial interview, it would be beneficial to inquire what time is most convenient for members. The first half of the session should be dedicated to reviewing homework, bridging from the previous session, completing assessments, and discussing topics members want to address. Due to time constraints, homework will be an important element of group. Homework can be handed in at the start of each session which will allow time for the co-facilitator to provide structured feedback by the end of each session. The second half of each session can be allotted to addressing and teaching a new coping skill. A new coping skill should be introduced each session and build on the previously learned skill. Within-group structure will be similar for all sessions, with the exception of the initial and final session.
Within Group Structure
1. Arrival/ Status Check
2. Bridging from Previous Session
3. Grief Symptom Checklist
4. Set Agenda/ Conduct CBT on Agenda Items
5. Break
6. Introduce Coping Skill and Rationale
7. Psychoeducation
8. Model Skill
9. Group Activity
10. Group Discussion
11. Homework

Summary and Recommendations
The original format was designed to incorporate all types of loss to meet the needs of the agency. The following format can be divided into smaller homogenous groups based on members’ type of loss. Separating members based on type of loss can potentially heighten group cohesion and universality. If time is being used inefficiently, facilitators can readjust outline.

General Preparation
The following list entails the facilitators’ roles and responsibilities before and after the each session.

Before
- Review session outline
- Assign roles and responsibilities
- Ensure all required materials are obtained
- Enough photocopies for all members
- Set up chairs in a circle in the middle of room
- Set up snack table

After
- Debrief how overall session went
- Review main points and observations during session
- Review any questions and/or concerns members had
Session 1: Introduction

Objective
The goal of session one is to establish the concept of grief and provide an opportunity for group members to build group cohesion by forming trusting relationships.

Materials
• Pencils and pens
• Chart paper
• Markers
• Tape
• Grief symptom checklist
• Coffee, tea, and snacks
• Condiments for coffee and tea
• Table
• Chairs
• Binders for each member
• Clip boards for all members and facilitators

Arrival/ Introduction (15 min)
Welcome members as they arrive to group. Once all members are present, have the facilitators and group members introduce themselves. After introductions are complete, explain the overall purpose of group and provide a short summary of what members can expect in upcoming weeks. It is important that diversity is addressed and similarities are emphasized.

Ice Breaker Activity (15 min)
Have members break into dyads and share five interesting features about themselves with their partner. Once members have completed the activity, encourage each individual to share one interesting fact about their partner with the rest of the group.

Group Rules and Norms (10 min)
Encourage members to establish rules and norms for the group. The facilitator should document the rules and norms on chart paper as members elicit ideas. The co-facilitator should place the chart paper in a visible location prior to the start of each session. The following list entails areas that should be discussed when establishing group norms and rules; confidentiality, compliance with homework, protocols for missing group, contact outside of group, heterogeneous members, and taking precautions by attending to emotional needs.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Group Discussion (20 min)
Provide members with an opportunity to share the circumstances of their loss and what brought them to group. Members will be provided with multiple opportunities throughout group to share, if they are not comfortable during the initial session. Facilitators should validate experiences and highlight common thoughts, feelings, and emotions shared among members. The following list
entails possible topics the facilitator can address, if the group does not elicit a discussion.

- Possible topics include circumstances of the loss, life since loss, and current support systems. This list is in no means exhaustive.

**Break (10 min)**
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break. A snack table provides a great opportunity for members to initiate conversations.

**Psychoeducation: Introduction to Grief (35 min)**
1. Kubler-Ross: Five stages of grief
2. Worden: Four tasks of grief
3. Complicated grief
4. Polarities of grief

**Group Discussion (10 min)**
Encourage members to share their thoughts, feelings, and emotions about participating in-group and their overall expectations. In addition, encourage members to share their coping techniques that they have employed to deal with their grief.
Kubler-Ross Five Stages Grief

1. **Denial**: Denial is a temporary defense mechanism that occurs when a bereaved individual is symbolically in denial. Individuals are considered to be in shock.

2. **Anger**: Anger has no boundaries and is typically redirected at the person who died and/or someone who was unable to save him/her.

3. **Bargaining**: Bargaining occurs when bereaved individuals adapt a “what if” and “if only” mindset in which they truly believe they could have controlled the ultimate outcome.

4. **Depression**: Individuals feel intense sadness and hopelessness, withdrawing from their daily activities and social life.

5. **Acceptance**: The individual recognizes the changed state in his or her lives and accepts it into their life.

Worden: Four Tasks of Grief

1. Accept reality of the loss.
2. Work through the pain and grief.
3. Adjustment to an environment in which the deceased is absent.
4. Relocate the deceased emotionally and move on with the life.

## Typical & Complicated Grief

<table>
<thead>
<tr>
<th>Normal Grief</th>
<th>Complicated Grief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary disruption in normal functioning and daily routines</td>
<td>Intense and prolonged yearning</td>
</tr>
<tr>
<td>Adapts and integrates the loss</td>
<td>Disruptions in normal functioning abilities</td>
</tr>
<tr>
<td>Temporary inability to concentrate and make decisions</td>
<td>Present for six months</td>
</tr>
<tr>
<td>Pain is reflective of the loss</td>
<td>Difficulty accepting and integrating the loss</td>
</tr>
<tr>
<td>Responsive to support</td>
<td>Bitterness</td>
</tr>
<tr>
<td>Mood fluctuations</td>
<td>Loss of trust</td>
</tr>
<tr>
<td>Temporarily preoccupation with deceased</td>
<td>Emotional numbness</td>
</tr>
<tr>
<td>Agitation and restlessness</td>
<td>Life losses meaning and purpose</td>
</tr>
<tr>
<td>Fewer cognitive distortions</td>
<td>Difficulty reengaging in activities</td>
</tr>
<tr>
<td>Emotional numbness</td>
<td>Maladaptive thoughts, emotions, and behaviour</td>
</tr>
<tr>
<td>Coping abilities are sufficient to overcome grief</td>
<td>Anxious and/or depressive avoidance behaviours</td>
</tr>
<tr>
<td>Temporary confusion and memory problems</td>
<td>Loss feels unreal</td>
</tr>
<tr>
<td>A variety of emotional reactions that subside with time such as sorrow,</td>
<td>Severe preoccupation with deceased</td>
</tr>
<tr>
<td>fear, anxiety, guilt, anger, relief, helplessness</td>
<td></td>
</tr>
<tr>
<td>Physical symptoms such as nausea, headaches, loss of appetite, difficulty</td>
<td>Occurs more if the loss is traumatic and sudden where there is minimal</td>
</tr>
<tr>
<td>breathing, ect.</td>
<td>time for anticipatory grief such as a violent death, or the death of a</td>
</tr>
<tr>
<td>Distance self from others</td>
<td>Severe isolation</td>
</tr>
<tr>
<td>Symptoms diminish overtime</td>
<td>Prone to depression and posttraumatic stress</td>
</tr>
</tbody>
</table>

Session 2: Goal Setting

Objective
The goal of session two is to help members re-establish a daily routine, set priorities that require energy, and provide an overall sense of purpose by pursing highly desirable goals.

Materials
- Pencil and pens
- Goal setting worksheet
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share a weekly progress report.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of the session. Agenda items should be reserved for topics members want to discuss. If the group does not provide a variety of topics, the following list entails possible topics that are associated with the coping skill taught in the second half of the session.

- Possible agenda items include life since loss, motivation since loss, routine since loss, and sense of purpose since loss. This list is in no means exhaustive.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break. In addition, a snack table provides an opportunity for members to initiate conversations with each other.

Establish Rationale (5 min)
Have the facilitator introduce the rationale and benefits associated with goal setting.

- Re-establish daily routine
- Set priorities that require energy
Create a sense of purpose

**Psychoeducation: Teach Steps of Skill (20 min)**
Utilizing the SMART acronym heightens the likelihood of successfully achieving the desired goal.
1. Specific
2. Measurable
3. Attainable
4. Realistic
5. Timely

**Model Skill (10 min)**
Encourage members to provide examples of highly desirable goals. Select one of the examples provided and model completing each SMART step on a whiteboard. Prior to selecting an example, ask members if they have a certain example they find extremely challenging. Attempt to select an example that has potential to elicit a group discussion and can be generalized to other members (Bieling, McCabe, & Antony, 2006).

**Group Activity (15 min)**
Have members create one personal short-term goal and one personal long-term goal using the goal handout provided. Once goals are completed have members identify potential barriers that may prevent them from obtaining the goal and brainstorm solutions.

**Group Discussion (10 min)**
Encourage members to share their experience completing the activity with the group to elicit feedback, advice, and reinforcement.

**Assign Homework (5 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment, such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in the process of assigning homework.
- Possible homework: Goal Monitoring/ Goal Setting
## SMART Goals

**Draft Goal:**

<table>
<thead>
<tr>
<th>Specific</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the desired result? (who, what, when, why, how)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• How can you quantify (numerically or descriptively) completion?</td>
<td></td>
</tr>
<tr>
<td>• How can you measure progress?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Achievable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What skills are needed?</td>
<td></td>
</tr>
<tr>
<td>• What resources are necessary?</td>
<td></td>
</tr>
<tr>
<td>• How does the environment impact goal achievement?</td>
<td></td>
</tr>
<tr>
<td>• Does the goal require the right amount of effort?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the goal in alignment with the overall mission or strategy?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time-bound</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the deadline?</td>
<td></td>
</tr>
<tr>
<td>• Is the deadline realistic?</td>
<td></td>
</tr>
</tbody>
</table>

**Final Goal:**

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Session 3: Identifying Negative Automatic Thoughts

Objective
The objective of session three is to teach members how to recognize and identify irrational automatic thoughts.

Materials
- Pencils and pens
- Dysfunction thought record
- Checklist of common thought distortions
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of the session. Agenda items should be reserved for topics members want to discuss. If the group does not elicit a variety of topics, the following list entails possible topics. Topics are associated with the coping technique introduced in the second half of the session.
- Possible agenda items include self-blame, thoughts, feelings, and emotions surrounding their loss.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Introduce the rationale and benefits associated with identifying irrational automatic thoughts.
• Learn and identify cognitive errors
• Learn to distinguish realistic and unrealistic thought patterns
• Reduce painful automatic thought.
• Decrease risk for mental health illnesses
• Reduce self-blame

Psychoeducation: Teach Steps of Skill (20 min)
1. Illustrate and discuss the connection between thoughts, feelings, and behaviours. Provide an example illustrating how thoughts, feelings, and behaviours are interconnected.
2. Introduce automatic thoughts and common thought distortions.
   • Provide a definition of automatic thoughts.
   • Distinguish negative automatic thought from positive automatic thoughts.
   • Emphasize automatic thoughts are typically private, rapid, and undetected.
3. Illustrate several common thought distortions. Have the group elicit examples.
4. Introduce thought record.

Model Skill (10 min)
Encourage the group to provide examples of negative automatic thoughts. Select a common thought distortion and model completing the first three columns of a dysfunctional thought record while explaining each step in detail.

Group Activity (10 min)
Have members break into dyads and complete the first three columns of a dysfunctional thought record for an example of their choice.

Group Discussion (15 min)
Encourage members to share their examples with the group to elicit feedback, reinforcement, and advice from other members. Finally, encourage members to share their thought distortions in regards to their loss with the group.

Assign Homework (5 min)
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
   • Possible Homework: Dysfunctional Thought Record
### Cognitive Distortions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>ALL-OR-NOTHING THINKING</strong>: You look at the things in absolute black and white categories. If your performance falls short of perfect, you see yourself as a total failure.</td>
</tr>
<tr>
<td>2.</td>
<td><strong>OVERGENERALIZATION</strong>: You view a single negative event as a never-ending pattern of defeat.</td>
</tr>
<tr>
<td>3.</td>
<td><strong>MENTAL FILTER</strong>: You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened, like the drop of ink that colours the entire beaker of water.</td>
</tr>
<tr>
<td>4.</td>
<td><strong>DISQUALIFYING THE POSITIVE</strong>: You reject positive experiences by insisting they “don’t count” for some reason or other. In this way you can maintain a negative belief that is contradicted by you every day experiences.</td>
</tr>
</tbody>
</table>
| 5. | **JUMPING TO CONCLUSIONS**: You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.  
   a. *Ming reading*. You arbitrarily conclude that someone is reacting negatively to you, and you don’t bother to check this out.  
   b. *The Fortune Teller Error*. You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact. |
| 6. | **MAGNIFICATION (CATASTROPHIZING) OR MINIMIZATION**: You exaggerate the importance of things (such as your goof-up or someone else’s achievement), or you inappropriately shrink think until they appear tiny (your own desirable qualities or the other fellow’s imperfections). This is also called “binocular trick.” |
| 7. | **EMOTIONAL REASONING**: You assume that your negative emotions necessarily reflect the way things really are: “I feel it, therefore it must be true.” |
| 8. | **SHOULD STATEMENTS**: You try to motivate yourself with should and shouldn’ts, as if you had to be whipped and punished before you could be expected to do anything. “Musts” and “oughts” are also offenders. The emotional consequence is guilt. When you direct should statements towards others, you feel anger, frustration, and resentment. |
| 9. | **LABELING AND MISLABELING**: This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: “I’m a loser.” When someone else’s behaviour rubs you the wrong way, you attach a negative label to him: “He’s a goddam louse.” Mislabling involves describing an event with language that is highly coloured and emotionally loaded. |
| 10. | **PERSONALIZATION**: You see yourself as the cause of some negative external even which in fact you were not primarily responsible for. |

## Dysfunctional Thought Record

| Outcome | a. Specify and rate subsequent emotion(s), 0%-100%.  
| a. Specify and rate subsequent emotion(s), 0%-100%.  
| b. Describe changes in behavior.  
| Rational response | a. Identify cognitive errors.  
| a. Identify cognitive errors.  
| b. Write rational responses to automatic thought(s).  
| b. Write rational responses to automatic thought(s).  
| c. Rate belief in rational responses, 0%-100%.  
| Emotion(s) | a. Specify sad, anxious, angry, etc.  
| a. Specify sad, anxious, angry, etc.  
| b. Rate degree of emotion, 1%-100%.  
| Automatic thought(s) | a. Write automatic thought(s) that preceded emotion(s).  
| a. Write automatic thought(s) that preceded emotion(s).  
| b. Rate belief in automatic thought(s), 0%-100%.  
| Situation | a. Describe actual event leading to unpleasant emotion or unpleasant physiological sensations.  
| a. Describe actual event leading to unpleasant emotion or unpleasant physiological sensations.  
| b. Stream of thoughts leading to unpleasant emotion or unpleasant physiological sensations.  

Session 4: Modifying Automatic Thoughts

Objective
The objective of session four is to teach members how to modify and restructure negative automatic thoughts.

Materials
- Pencils and pens
- Ten ways to untwist your thinking
- Examining the evidence for automatic thoughts
- Dysfunctional thought record
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/Status Check (5 min)
Welcome members as they arrive to the group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members want to discuss. If the group does not elicit a variety of topics, the following list entails possible topics that are associated with the coping skill taught in the second half of the session.
- Possible agenda items include the difference between facts and opinions.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Have the facilitator establish the rationale and benefits associated with modifying irrational
thoughts.

- Learn a variety of techniques to reduce and cope with maladaptive thoughts and emotions
- Increase adaptive thought patterns, feelings, and emotions
- Improve mood and attitude
- Become an active member in thought process

**Psychoeducation: Teach Steps of Skill (20 min)**

1. Introduce several common methods to modify maladaptive thought patterns
2. Introduce gathering evidence for and against the thought. Discuss the process for gathering all evidence that supports the automatic thought and that does not support the automatic thought.

**Model Skill (10 min)**

Encourage members to provide examples of common automatic thoughts and gather evidence for and against, while the facilitator demonstrates how to complete the examining evidence worksheet. Once the worksheet is completed have the facilitator model completing the last three columns of a dysfunctional thought record while explaining the process in detail.

**Group Activity (10 min)**

Have members break into dyads and encourage pairs to select a re-occurring negative thought of their choice. Have pairs complete a dysfunction thought record and gather evidence for and against the automatic thought.

**Group Discussion (15 min)**

Encourage members to share their experiences with the group to elicit feedback, advice, and reinforcement.

**Assign Homework (5 min)**

Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.

- Possible Homework: Gathering Evidence for and Against/ Dysfunctional Thought Record
# Appendix L: Ten Ways to Untwist You’re Thinking

<table>
<thead>
<tr>
<th></th>
<th>Method</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify the Distortion</td>
<td>Write down your negative thoughts so you can see which of the ten cognitive distortions you’re involved in. This will make it easier to think about the problem in a more positive and realistic way.</td>
</tr>
<tr>
<td>2.</td>
<td>Examine the Evidence</td>
<td>Instead of assuming that your negative thought is true, examine the actual evidence for it. For example, if you feel that you never do anything right you could list several things that you have done successfully.</td>
</tr>
<tr>
<td>3.</td>
<td>The Double Standard Method</td>
<td>Instead of putting yourself down in a harsh condemning way, talk to yourself in the same compassionate way you would talk to a friend with a similar problem.</td>
</tr>
<tr>
<td>4.</td>
<td>The Experimental Technique</td>
<td>Do an experiment to test the validity of your negative thought. For example, if during the episode of panic you become terrified that you’re about to die of a heart attack, you could jog or run up and down several flights of stairs. This will prove to you that your heart is strong and healthy.</td>
</tr>
<tr>
<td>5.</td>
<td>Thinking in Shades of Grey</td>
<td>Although this method might sound drab, the effects can be illuminating. Instead of thinking about your problems in all-or-nothing extremes, evaluate things on a range of 0 to 100. When things don’t work out as well as you hoped, think about the experience as a partial success rather than a complete failure. See what you can learn from the situation.</td>
</tr>
<tr>
<td>6.</td>
<td>The Survey Method</td>
<td>Ask people questions to find out if your thoughts and attitudes are realistic. For example, if you believe that public speaking anxiety is abnormal and shameful ask several friends if they ever felt nervous before they gave a talk.</td>
</tr>
<tr>
<td>7.</td>
<td>Define Terms</td>
<td>When you label yourself “inferior” or “a fool” or “a loser,” ask, “What is the definition of a fool?” You will feel better when you see that there is no such thing as a “fool” or a “loser.”</td>
</tr>
<tr>
<td>8.</td>
<td>The Semantic Method</td>
<td>Simply substitute language that is less colorful and emotionally loaded. This method is helpful for “should statements.” Instead of telling yourself “I shouldn’t have made that mistake,” you can say “It would be better if I hadn’t made that mistake.”</td>
</tr>
<tr>
<td>9.</td>
<td>Re-attribution</td>
<td>Instead of automatically assuming that you are “bad” and blaming yourself entirely for a problem think about the many factors that may have contributed to it. Focus on solving the problem instead of using up all your energy blaming yourself and feeling guilty.</td>
</tr>
<tr>
<td>10.</td>
<td>Cost-Benefit Analysis</td>
<td>List the advantages and disadvantages of a feeling (like getting angry when your plane is late), a negative thought (like “No matter how hard I try, I always screw up”), or a behavior pattern (like overeating and lying around in bed when your depressed). You can also use the Cost-Benefit Analysis to modify a self-defeating belief such as “I must always try to be perfect.”</td>
</tr>
</tbody>
</table>


18
Experiencing the Evidence

**Instructions**
1. Identify a negative or troubling automatic thought.
2. Then list all the evidence that you can find that either supports (“evidence for”) or disproves (“evidence against”) the automatic thought.
3. After trying to find cognitive errors in the “evidence for” column, you can write revised or alternative thoughts at the bottom of the page.

<table>
<thead>
<tr>
<th>Automatic Thought:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence for Automatic Thought: Evidence Against Automatic Thought:</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
</tbody>
</table>

Cognitive errors:

Alternative thoughts:

Session 5: Mindfulness Training

Objective
The objective of session five is to increase emotional awareness by teaching members how to focus on the present moment.

Materials
- Pencil and pens
- Mindfulness of breath script
- Body scan instructions
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators
- Pre-recorded audio tapes for all scripts

Arrival/ Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share with the group how their week went. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of the session. Agenda items should be reserved for topics members want to address. If the group does not elicit a variety of topics, the following list entails possible topics.
- Possible agenda items include emotions and attitudes since loss, worries since loss and concentration since loss.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Have the facilitator establish the rationale and benefits of mindfulness training.
• Enhances concentrate on the present
• Reduce preoccupation with worries of past events
• Protective barrier for depression, pain, and negative affectivity

**Psychoeducation: Teach Steps of Skill (10 min)**
1. Maintaining a steady concentration
2. Acknowledging and accepting all feelings, thoughts, emotions, and sensations that break concentration without judgment or intent to change them.
3. Returning concentration back to previous activity

**Model Skill (5 min)**
Have the facilitator read a short section of the script while the co-facilitator followings the instructions.

**Group Activity (25 min)**
Have members sit in a circle and follow the instructions while the facilitator reads the mindfulness script. Due to time constraints, the facilitator can only complete one script/activity. Have the facilitator explain each activity and encourage members to select which mindfulness activity they are most interested in completing during the session. Assign the other mindfulness activities for homework.

**Group Discussion (10 min)**
Encourage members to share their experiences with the group to elicit feedback, advice, and reinforcement. Reflect on how members felt prior to completing the activity and how they felt after completing the activity.

**Assign Homework (10 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create the parameters such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
Possible Homework: Pre-recorded audio tapes
Mindfulness of Breath Script

1. Settle into a comfortable sitting position, either on a straight-backed chair or on a soft surface on the floor, with your buttocks supported by cushions or a low stool. If you use a chair, it is very helpful to sit away from the back of the chair, so that your spine is self-supporting. If you sit on the floor, it is helpful if your knees actually touch the floor; experiment with the height of the cushions or stool until you feel comfortable and firmly supported.

2. Allow your back to adopt an erect, dignified, and comfortable posture. If sitting on a chair, place your feet flat on the floor, with your legs uncrossed. Gently close your eyes. It may help to imagine a light thread attached to the back of your scalp pulling your head gently upwards and allowing your spine to lengthen.

3. Bring your awareness to the level of physical sensations by focusing your attention on the sensations of touch and pressure in your body where it makes contact with the floor and whatever you are sitting on. Spend a minute or two exploring these sensations.

4. Now bring your awareness to the changing patterns of physical sensations in the lower abdomen as the breath moves in and out of your body (When you first try this practice, it may be helpful to place your hand on your lower abdomen and become aware of the changing pattern of sensations where your hand makes contact with your abdomen, Having "tuned in" to the physical sensations in this area in this way, you can remove your hand and continue to focus on the sensations in the abdominal wall.)

5. Focus your awareness on the sensations of slight stretching as the abdominal wall rises with each inbreath, and of gentle deflation as it falls with each outbreath. As best you can, follow with your awareness the changing physical sensations in the lower abdomen all the way through as the breath enters your body on the inbreath and all the way through as the breath
leaves your body on the outbreath, perhaps noticing the slight pauses between one inbreath and the following outbreath, and between one outbreath and the following inbreath.

6. There is no need to try to control the breathing in any way—simply let the breath breathe itself. As best you can, also bring this attitude of allowing to the rest of your experience. There is nothing to be fixed, no particular state to be achieved. As best you can, simply allow your experience to be your experience, without needing it to be other than it is.

7. Sooner or later (usually sooner), your mind will wander away from the focus on the breath in the lower abdomen to thoughts, planning, daydreams, drifting along—whatever. This is perfectly OK—it’s simply what minds do. It is not a mistake or a failure. When you notice that your awareness is no longer on the breath, gently congratulate yourself—you have come back and are once more aware of your experience! You may want to acknowledge briefly where the mind has been ("Ah, there's thinking"). Then, gently escort the awareness back to a focus on the changing pattern of physical sensations in the lower abdomen, renewing the intention to pay attention to the ongoing inbreath or outbreath, whichever you find.

8. However often you notice that the mind has wandered (and this will quite likely happen over and over and over again), as best you can, congratulate yourself each time on reconnecting with your experience in the moment, gently escorting the attention back to the breath, and simply resume following in awareness the changing pattern of physical sensations that come with each inbreath and outbreath.

9. As best you can, bring a quality of kindliness to your awareness, perhaps seeing the repeated wanderings of the mind as opportunities to bring patience and gentle curiosity to your experience.
10. Continue with the practice for 15 minutes, or longer if you wish, perhaps reminding yourself from time to time that the intention is simply to be aware of your experience in each moment, as best you can, using the breath as an anchor to gently reconnect with the here and now each time you notice that your mind has wandered and is no longer down in the abdomen, following the breath. You may wish to focus your concentration by counting your breaths. On the outbreath say “one” quietly to yourself and then “two” on the next outbreath. When you reach “ten”, start at the beginning again, saying “one”, “two”, “three” on the outbreaths.

11. Mindfulness exercises are best done before eating eg before breakfast or the evening meal. If you have had a drink or used any other drugs, allow their effects to wear off before trying to meditate

**Body Scan Script**

1. Sit in a chair as for the breath awareness or lie down, making yourself comfortable, lying on your back on a mat or rug on the floor or on your bed. Choose a place where you will be warm and undisturbed. Allow your eyes to close gently.

2. Take a few moments to get in touch with the movement of your breath and the sensations in the body. When you are ready, bring your awareness to the physical sensations in your body, especially to the sensations of touch or pressure, where your body makes contact with the chair or bed. On each outbreath, allow yourself to let go, to sink a little deeper into the chair or bed.

3. Remind yourself of the intention of this practice. Its aim is not to feel any different, relaxed, or calm; this may happen or it may not. Instead, the intention of the practice is, as best you can, to bring awareness to any sensations you detect, as you focus your attention on each part of the body in turn.

4. Now bring your awareness to the physical sensations in the lower abdomen, becoming aware of the changing patterns of sensations in the abdominal wall as you breathe in, and as you breathe out. Take a few minutes to feel the sensations as you breathe in and as you breathe out.

5. Having connected with the sensations in the abdomen, bring the focus or "spotlight" of your awareness down the left leg, into the left foot, and out to the toes of the left foot. Focus on each of the toes of the left foot in turn, bringing a gentle curiosity to investigate the quality of the sensations you find, perhaps noticing the sense of contact between the toes, a sense of tingling, warmth, or no particular sensation.
6. When you are ready, on an inbreath, feel or imagine the breath entering the lungs, and then passing down into the abdomen, into the left leg, the left foot, and out to the toes of the left foot. Then, on the outbreath, feel or imagine the breath coming all the way back up, out of the foot, into the leg, up through the abdomen, chest, and out through the nose. As best you can, continue this for a few breaths, breathing down into the toes, and back out from the toes. It may be difficult to get the hang of this just practice this "breathing into" as best you can, approaching it playfully.

7. Now, when you are ready, on an outbreath, let go of awareness of the toes, and bring your awareness to the sensations on the bottom of your left foot—bringing a gentle, investigative awareness to the sole of the foot, the instep, the heel (e.g., noticing the sensations where the heel makes contact with the mat or bed). Experiment with "breathing with" the sensations—being aware of the breath in the background, as, in the foreground, you explore the sensations of the lower foot.

8. Now allow the awareness to expand into the rest of the foot—to the ankle, the top of the foot, and right into the bones and joints. Then, taking a slightly deeper breath, directing it down into the whole of the left foot, and, as the breath lets go on the outbreath, let go of the left foot completely, allowing the focus of awareness to move into the lower left leg—the calf, shin, knee, and so on, in turn.

9. Continue to bring awareness, and a gentle curiosity, to the physical sensations in each part of the rest of the body in turn - to the upper left leg, the right toes, right foot, right leg, pelvic area, back, abdomen, chest, fingers, hands, arms, shoulders, neck, head, and face. In each area, as best you can, bring the same detailed level of awareness and gentle curiosity to the
bodily sensations present. As you leave each major area, "breathe in" to it on the inbreath, and let go of that region on the outbreath.

10. When you become aware of tension, or of other intense sensations in a particular part of the body, you can "breathe in" to them—using the inbreath gently to bring awareness right into the sensations, and, as best you can, have a sense of their letting go, or releasing, on the outbreath.

11. The mind will inevitably wander away from the breath and the body from time to time. That is entirely normal. It is what minds do. When you notice it, gently acknowledge it, noticing where the mind has gone off to, and then gently return your attention to the part of the body you intended to focus on.

12. After you have "scanned" the whole body in this way, spend a few minutes being aware of a sense of the body as a whole, and of the breath flowing freely in and out of the body.

13. If you find yourself falling asleep, you might find it helpful to prop your head up with a pillow, open your eyes, or do the practice sitting up rather than lying down.

14. You can adjust the time spent in this practice by using larger chunks of your body to become aware of or spending a shorter or longer time with each part.

Session 6: Relaxation Training

Objective
The objective of session six is to help group members cope with emotional arousal by maintaining an active state of relaxation and self-awareness.

Materials
- Pencils and pens
- Deep muscle relaxation script
- A safe place guided imagery script
- Deep breathing exercises
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to the group. Once all members are present, provide members with an opportunity to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of the session. Agenda items should be reserved for topics members want to discuss. If the group does not provide a variety of topics, the following list entails possible topics.
- Have the group members discuss the current ways they relax, discuss their anxiety/worry levels, what times of the day they feel most tense, and in what situations do they feel most tense. This list is in no means exhaustive.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Establish the rationale and the benefits of relaxation training.
- Decreases emotional arousal
Adapt a relaxation response to stress
- Creates a state of physical and mental calmness
- Regain control of emotions
- Increase self-efficacy

**Psychoeducation: Teach Steps of Skill (15 min)**
1. **Deep Breathing**
2. **Techniques of Progressive Muscle Relaxation**
   - Step one: Preparation
   - Step two: Tighten and relax
   - Step three: Relax fully and breathe
   - Step four: Body scan
3. **Imagery**

**Model Skill (5 min)**
Have the facilitator and co-facilitator model a small section of the script.

**Group Activity (25 min)**
Have members sit in a circle and get comfortable. Once members are in a comfortable and relaxed position, have members practice deep breathing. Once members have completed the deep breathing exercise, the facilitator read the deep muscle relaxation script slowly.

**Group Discussion (10 min)**
Encourage members to share their experiences with the group to elicit feedback, advice, and reinforcement.

**Assign Homework (10 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create the parameters such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
Possible Homework: Imagery Script Tape/Progressive Muscle Relaxation/ Deep Breathing
## Progressive Muscle Relaxation Script

<table>
<thead>
<tr>
<th>Major Muscle Group and Area of Tension</th>
<th>Tensing and Relaxing Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Hand and Arms</strong>&lt;br&gt;Hand: The back of your hand, fingers, and the wrist</td>
<td>Tense the muscles in the right hand and loser arm by making a tight fist. Hold for at least five seconds. Feel the tension. Now relax. Notice the difference between the tensing and relaxing. Repeat the same procedure. Now do the same thing with your left hand. Finish by tensing and relaxing both hands together.</td>
</tr>
<tr>
<td><strong>Lower Arm:</strong> The forearm and the wrist</td>
<td>Hold both arms out in front of you with palms up, bend the hands down. Feel the tension in the hand, wrist, and forearm. Then relax. Repeat the same procedure. Now extend your arms out in front of you but with palms down. Bend your hands up. Feel the tension. Relax. Repeat the same procedure. Now let both arms hang loosely at your side.</td>
</tr>
<tr>
<td><strong>Upper Arm:</strong> The bicep muscles</td>
<td>Start with your right arm. Bend the elbow, touch your shoulder with your fingers, and tense the bicep just like you want to show off your muscles. Feel the tension, then relax and notice the contrast. Repeat the same procedure. Now do the same thing with your left arm. Finish by tensing, then relaxing both arms together. Now let both arms hang loosely at your side.</td>
</tr>
<tr>
<td><strong>2. Head, Face, and Throat</strong>&lt;br&gt;Forehead and Scalp: The entire forehead and scalp area</td>
<td>Wrinkle your forehead by raising your eyebrows as high as you can. Feel the tension in the forehead and scalp area. Now relax. Notice the difference between tension and relaxation. Repeat the procedure. Next frown by pulling your eyebrows down as far as you can. Feel the tension, then relax. Repeat the same procedure. Let go of all the tension, then relax. Let go of all the tension in the forehead and scalp area. Feel the smoothness of the muscles.</td>
</tr>
<tr>
<td><strong>Eyes and Nose:</strong> The eyelids and muscles around the eyes, nose, and upper checks</td>
<td>Squeeze your eyes shut and at the same time wrinkle up your nose. Feel the tension, then relax. Repeat the procedure. Next roll your eyes left and right, up and down or rotate them in both directions. Finish by opening your eyes as widely as you can, then relaxing them. Now feel the relaxation of muscles around your eyes.</td>
</tr>
<tr>
<td><strong>Mouth and Jaw</strong></td>
<td>The area around the mouth and the lower face</td>
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<tr>
<td>Bite your teeth together and pull the corners of your mouth back. Feel the tension, then let go. Now press your lips tightly together and extend them as though you are sucking a straw. Feel the tension and relax. Next open your mouth widely, then relax. Now pull your mouth to the left side of your face, then to the right. Repeat any of the above exercises until this part of your face is deeply relaxed.</td>
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<table>
<thead>
<tr>
<th><strong>Throat and Jaw</strong></th>
<th>Muscles inside the mouth and throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push your tongue against the roof of your mouth. Feel the tension, then relax. Clench your jaw tightly, then relax.</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>Entire Head and Facial Area</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Try a final tensing and relaxing by making a face. Scrunch up your face so your eyes squint, you nose is wrinkled up and your mouth is pulled back. Now your face feels smooth and relaxed as you let go of any tension left over.</td>
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<tr>
<th><strong>3. Neck and Shoulders</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neck</strong></td>
</tr>
<tr>
<td>Drop your chin down against your chest. Press down hard enough so you feel tension under your chin and at the back of your neck. Now lift your head and press it backward. Roll your head to the right, then forward to your chest, then to the left and back to there you started. Go slowly and gently. Repeat this at least twice in the same direction. Next, do the same exercise in the other direction. Relax with your head in a normal position, stretching it in whatever way you need for working out remaining tension spots.</td>
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<tr>
<th><strong>4. Chest, Shoulders, and Upper Back</strong></th>
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<tbody>
<tr>
<td><strong>Muscles in the Chest, Shoulders, and Upper Back Area</strong></td>
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<tr>
<td>Take a deep breath, hold it and at the same time pull the shoulders back, trying to make the shoulder blades touch. Feel the tension around your ribs, shoulders, and the upper back. Exhale slowly and feel the relaxation as you return to a natural position. Now pull your shoulders as far as you can, then as far up, as far back, and as far down as you can, making a kind of circular motion. Repeat this at least twice. Feel the tension and relaxation. Next go in the opposite direction in your rotation of the shoulders. Sense the looseness and relaxed feeling in this part of your body.</td>
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<tr>
<th><strong>5. Lower Back, Stomach, and Hips</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Lower Back</strong></td>
</tr>
<tr>
<td>Begin by taking a deep breath and sitting up straight. Pull your shoulders back and arch your back so your stomach sticks out. Exhale and let all the air and tension flow out. Repeat this procedure. Next bend forward arching your back the other way with your head down to your knees and your hands touching the floor. Feel the muscles stretching. Return to a normal sitting position and feel the relaxation. Repeat the procedure.</td>
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</table>
### 6. Hips, Legs, and Feet

#### Hips and Upper Legs:
The muscles in the upper and lower parts of the thighs

- Take a deep breath and hold it as you make your stomach muscles hard. Just tighten them up as though you were going to hit yourself in the stomach. You should feel a good deal of tightness in the stomach area. Breathe out and feel the relaxation as you do. Let go of this tension. Repeat the procedure. Next breathe out as far as you can, feeling the tension in your stomach area as you hold your breath. Now let go and allow yourself to breathe naturally, noticing the difference between tension and relaxation.

- Gently hold fast to the bottom of your chair. Press your heels down hard on the floor. Feel the tension around your hips and the hardness of the large upper leg muscles. Relax and notice the difference between tension and relaxation. Repeat the procedure.

#### Lower Legs:
The muscles from the knees to the ankles

- Hold both legs straight out in front of you. Point your feet and toes away from your head. Feel the tension in your legs and on top of your feet. Relax and drop both feet on the floor. Now extend your legs again, but point your feet and toes toward your head. Feel the tension in the calf muscles and around your ankles. Relax and drop both feet. Notice the relaxed feeling.

#### Feet:
The muscles around the ankles, over the top of the feet, the arch and ball of the feet, and the toes.

- Extend both feet, toes pointed away from you. The turn both feet inward and at the same time curl your toes. Gently tense the muscles just enough to feel the tension and relax. Now try moving each foot in a circular motion, feeling the stretching and tensing. Relax. Repeat but reverse the direction and relax! Try spreading your toes, then relaxing, letting all the tension go out of your feet. Now put both feet flat on the floor, take a deep breath and relax.

### 7. Body Review

- Scan your whole body and recognize how it now feels more relaxed. Let the muscles of your body relax even more as you do a body scan from head to toe. Muscles that still feel a bit tight can be tensed, then relaxed.

- Next, try tensing your whole body at one time. Take a deep breath and feel the tension all over your body. Hold for several seconds, then let go. Let all the air out and feel the deep relaxation coming over your entire body. The tension is flowing out like the air escaping from a balloon. Enjoy the relaxed feeling.

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Young, M. (2009). Curative factors and advanced change techniques: Part II. In M. Fossel, & M. Vigilante (Eds.), *Learning the art of helping building clocks and techniques* (pp. 341-343). New Jersey: Personal Education.
A Safe Place Guided Imagery Script

1. Sit comfortably, with your back and neck completely supported. Allow the floor, or chair, or whatever you are sitting on to hold you. Let tension melt away as you bring your attention to your breath. With each breath in . . . feel your diaphragm moving down toward your feet . . . and your lower abdomen beginning to expand . . . With each breath out . . . as your abdomen relaxes . . . feel the muscles in your neck and shoulders drifting down with gravity . . . and relaxing even more deeply.

2. Take a mental journey now, through your body, beginning at the bottom of your feet.

Tighten the muscles of your feet, your toes, then let them relax and release the day’s tension. . . . Next tighten your calves and thighs, then loosen them. Move your attention slowly to the top of your head in this way, letting go of any tightness or restriction you find. (Pause about one minute.)

3. Your mind has just moved through your body, connecting with it, giving it attention, soothing the tense, tired places. Now let your mind move to a still point, a place of pure peace and calm. In your imagination, think of a place that is safe and comfortable. . . . a place where you can retreat and care for yourself. . . . a place where you can go to replenish your body and spirit. . . . a place that is absolutely your own, secure and private. The place that you choose will be uniquely yours . . . It can be a place you have been to before, or somewhere you would like to find. . . . It may be a beautiful outdoor scene. . . . a beach, a meadow, an ancient forest. . . . or it may be a special room. . . . a childhood bedroom, a music room, a chapel. . . . it may be a bubble in the clouds. You may decorate this place any way you wish. Imagine it with all your senses, smelling the fragrance of flowers, incense, or the ocean breeze. . . . Feel the texture of the surface under your feet and against the skin of your hands,
your arms. . . Hear all the sounds of this place . . . birds singing, wind blowing, waves on the beach or beautiful classical music or jazz. See the colors and shapes as you turn full circle to get a complete view. Let this place be a safe and nurturing hideaway, full of color, music, all the things that you need to feel sheltered and cared for.

4. Find a place to sit, on an old hollowed-out log or a rock that feels as if it were contoured just for you, in a billowy cloud-chair, or whatever fits in your special place. Make yourself very comfortable. For in this place of safety, only you are allowed. In this place of safety, no one can come without your invitation. In this place of safety, you are always at peace…. Allow the images to come…. Notice the color of the sky at your favorite time of day. And in this place, at this most perfect time of day, at the season and the temperature that you like on your skin, allow your senses to become more and more alive. Look around at the surroundings and allow yourself to see; if not with your eyes, then sense with your heart…. Each time you come to your safe place, you may develop it and allow it to become more and more beautiful. Allow yourself to see, feel and hear what is here today…. Let yourself bask in the safety and the peace…. 

5. Allow yourself to walk around, to be in this place, to notice more and more, to create more and more in this place…. Perhaps you would like to build a shelter of some kind, a cottage, a cave, a tent, a tree house. And if it’s already there, you may add to it…. Plant flowers, adding a splash of color. Add special places or rooms to your safe place…. Create special places for special kinds of feelings that need to be healed, special places to wash away fear and pain…. Create a waterfall or a pool of healing water. Stand under the waterfall to wash away the fear…. Let the healing waters wash away what you’d like to be finished with. Each time you come to the waterfall or the healing pool of water, you can wash away more
and more of the past…. Each time you come, you are cleansed and rejuvenated, shame is washed away. Wash away the pain. Wash all of it away, as you are ready. [Long pause.] When you are finished, step out of the water and you will find a robe or a towel to dry and warm yourself.

6. Now allow yourself to continue walking around your safe place….You might find a place for a healing garden, a place that is just for your healing. You can plant anything you would like…. You can plant wishes and dreams for the future. You can plant seeds of your healing. And you can weed out what you want to be finished with. Take some time to work with your garden now. [Long pause.]

7. And now, find your favorite place in all of safety. Walk around until you find just the right place. [Long pause.] Sit down, and get comfortable…. Breathe in the safety and the peace. Breathe out the fear…. Breathe in the safety and peace. Breathe out the fear…. Breathe in the safety and peace. Breathe out the fear…. And just be in this place as you breathe and heal…. Stay in this place as long as you would like…. And when you are ready, simply count yourself out by counting from one to five. When you reach the number five, your eyes will open. And you will be awake and alert, and feeling safe and at peace. One…. two…. three, take a deep breath…. four…. and five.
Deep Breathing Exercises

When a person becomes stressed, their breathing adapts to a shallow and rapid pattern. Taking a deep breath is a convenient technique that allows a person to regain control of their breathing rhythm.

1. Have the individual inhale through their nose counting to ten slowly.
2. Encourage the individual to expand their stomach, as opposed to their chest.
3. Once the individual reaches the count of ten inhaling through their nose, have them exhale through their nose slowly, again counting to ten.
4. Encourage the individual to concentrate on their breathing.
5. Have them repeat this task five to ten times.

Session 7: Problem-Solving

Objective
The objective of session seven is to teach members how to implement a systematic approach when dealing with challenging problems and evaluate all potential possibilities in order to select the best solution.

Materials
- Pencils and pens
- Problem-solving steps
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (20 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members want to discuss. If the group does not elicit a variety of topics, the following list entails possible topics that are associated with the coping skill introduced in the second half of the session.
- Possible topics include stress, distressing problems, and current problem-solving practices.
  
  This list is in no means exhaustive.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Establish the rationale and benefits of problem-solving.
• Effectively problem-solve in a variety of areas
• Positive impact on a person’s ability to adjust and cope
• Learn to address stressful life events in a resourceful manner.

**Psychoeducation: Teach Steps of Skill (15 min)**
1. Define the problem
2. Brainstorm possible solutions
3. Evaluating the possible solutions
4. Choose the best solution
5. Implementing the solution

**Model Skill (15 min)**
Encourage members to provide an example of a current problem they find challenging and have the group collaboratively solve the problem by utilizing the steps outlined above. The facilitator should record the group’s ideas on a white board.

**Group Activity (15 min)**
Encourage members to provide examples of problems they are finding extremely difficult. Randomly select a problem that was identified. Have the facilitator write down the problem on the white board. Once the problem has been identified, have members break into dyads and solve the problem using the steps outlined above.

**Group Discussion (10 min)**
Encourage members to share their ideas and experiences with the group.

**Assign Homework (10 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.

• Possible Homework: Solve a current problem using the steps outlined above.
Problem-Solving Steps

1. Define the problem: The first step in involves identifying the specific problem to be solved. Clients are encouraged to replace problems that they describe in vague or general terms (e.g., “I hate my job”) with a list of more specifically defined problems (e.g., “I would like to find a job that will allow me to use my background in design”). If the client identifies multiple problems, he or she is encouraged to prioritize the list and to use the problem-solving strategies to work through each problem, one at a time, starting with the most important one.

2. Brainstorming possible solutions. This stage involves having the client list as many solutions to the problem as possible, without filtering, censoring, or judging solutions that come to mind. All possible solutions (good and bad) should be recorded at this stage. When teaching problem-solving in groups, all clients in the group should be encouraged to generate possible solutions to problems raised.

3. Evaluation the possible solutions. At this stage, clients are taught to evaluate the advantages and advantages of each solution generated in step 2. Through this process, clients work at reducing the length of their lists by eliminating solutions that are impossible or impractical to implement, that are unlikely to work, or that can on only be implemented at great cost. The remaining list should include only those solutions that are reasonable options.

4. Choosing the best solution. Next clients should select the best solution (or solutions) from their list, based on the evaluation completed in step 3.

5. Implementing the solution. The final step involves implementing the selected solutions.

Upon implementing the solution, clients may encounter various obstacles. If this occurs, he or she should use the same problem-solving approach to get around any problems that may arise along the way.

Session 8: Assertiveness Training

Objective
To objective of session eight is to help individuals communicate their thoughts, feelings, and emotions in an assertive manner.

Materials
• Pencils and pens
• Communication styles
• Assertiveness tips
• White board
• Dry erase markers
• Coffee, tea, and snacks
• Condiments for coffee and tea
• Table for coffee, tea, and snacks
• Chairs
• Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (30 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members wish to discuss immediately. If the group does not elicit a variety of topics, the following list entails possible topics.
• Reactions from family members and friends, barriers and difficulties members experienced when talking about their loss, when and how did members share the information, what information did they decide to share, how has their relationships changed since the loss, social support systems, going back to work
• It is important that the facilitator emphasize that members get to decide when, where, what, and how they share information with others.
• Before break have group members share a certain memory that makes them happy and one that makes them sad such as finding out they were pregnant or attending the ultrasound. This exercise will assist members become more comfortable discussing their loss.
Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Establish rationale and benefits associated with assertiveness training.
- Communicate thoughts, feelings, emotions, and needs in an assertive manner
- Increase communication skills

Psychoeducation: Teach Steps of Skill (15 min)
1. Types of communication styles
2. Tips for becoming more assertive.

Role Play (10 min)
Have the facilitator and co-facilitator role-play three different conversations, illustrating the three communication styles.

Group Activity (20 min)
Encourage the group to elicit assertiveness rights and have the co-facilitator record the ideas on chart paper. Place the chart paper in a visible location for the following sessions as a visual reminder of the members’ assertiveness rights. Provide a handout for the next session that entails all of the ideas the group provided. Once a list of assertiveness rights are compiled have members break into dyads and take turns practicing communicating their needs in an assertive manner.

Group Discussion (10 min)
Once members are completed the activity, have members share their experience with the group. Discuss potential communication roadblocks that may prevent a smooth conversation from occurring. Brainstorm potential ideas and methods to overcome potential barriers.

Assign Homework (5 min)
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
<table>
<thead>
<tr>
<th></th>
<th>Aggressive</th>
<th>Assertive</th>
<th>Passive</th>
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</thead>
<tbody>
<tr>
<td>Defensive reactions</td>
<td>Open, direct, and honest</td>
<td>Avoids confrontation</td>
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</tr>
<tr>
<td>Utilizes power, manipulation, and intimation to achieve goals</td>
<td>Effective communication skills</td>
<td>Fails to express thoughts and feelings</td>
<td></td>
</tr>
<tr>
<td>Induces guilt</td>
<td>Respects others rights and opinions</td>
<td>Fails to state opinions and ideas</td>
<td></td>
</tr>
<tr>
<td>Achieve what one desires at the expense of others</td>
<td>Negotiates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over-expressive</td>
<td>Expresses thoughts and feelings</td>
<td>Allows others to take advantage of them</td>
<td></td>
</tr>
<tr>
<td>Violates others rights</td>
<td>Achieves goals productively and respectfully</td>
<td>Violate own rights</td>
<td></td>
</tr>
<tr>
<td>Loud, abusive, and over-powering</td>
<td>Acknowledged limits and boundaries</td>
<td>Timid, apologetic, and quiet</td>
<td></td>
</tr>
<tr>
<td>Disrespects others ideas and opinions</td>
<td>Confident</td>
<td>Learned helplessness</td>
<td></td>
</tr>
<tr>
<td>Tackles issues immediately</td>
<td>States opinions and ideas</td>
<td>External locus of control</td>
<td></td>
</tr>
</tbody>
</table>

Assertiveness Guidelines

1. Express thoughts, feelings, and emotions
2. Utilize “I” statements
3. Express ideas and opinions
4. Contribute to the outcome
5. Learn to refuse unreasonable requests
6. Respect others’ opinions, ideas, thoughts, and emotions
7. Realize individuals are unique and have different points of views
8. Utilize logic and a problem-solving approach to achieve goals
9. When having a conversation maintain good eye-contact
10. Be confident, direct, and clear while speaking
11. Learn to negotiate and compromise
12. Remember you can refuse to discuss

Session 9: Healthy Lifestyle

Objective
The objective of session nine is to help individuals maintain a healthy lifestyle in order to reduce their vulnerability to depression and anxiety.

Materials
- Pencils and pens
- Weekly activity schedule
- Canada’s Food Guide
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to the group. Once all members are present, provide each individual with the opportunity to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members want to discuss. If the group does not elicit a variety of topics, the following list entails possible.
- Possible topics include personal health, exercise, sleeps schedules, and enjoyable activities since loss.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Establish rationale and benefits associated with a healthy lifestyle.
- Increase mood and attitude
- Increase energy and health
- Decrease risk for mental/medical illnesses
- Increase productivity

**Psychoeducation (20 min)**
It would be beneficial a nutritionist to attend this particular session and discuss the following topics.
1. Exercise
2. Adequate sleep
3. Proper nutrition
4. Humour
5. Social contact
6. Activities that are enjoyable

**Model Coping Skill (10 min)**
Have the facilitator model filling out a behavioural activation sheet while explaining the steps in detail.

**Group Activity (10 min)**
Have members collaboratively identify activities they find enjoyable. Encourage each member to fill in a minimum of three activities for the week using the handout provided.

**Group Discussion (10 min)**
Once members have completed the activity, encourage members to identify potential barriers that may prevent them from completing the assigned activity and brainstorm possible solutions.

**Assign Homework (10 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
- Homework: Behavioural Activation Sheet
| 9:00 P.M. | 8:00 P.M. | 7:00 P.M. | 6:00 P.M. | 5:00 P.M. | 4:00 P.M. | 3:00 P.M. | 2:00 P.M. | 1:00 P.M. | 12:00 A.M. | 11:00 A.M. | 10:00 A.M. | 9:00 A.M. | 8:00 A.M. |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Sunday    |           |           |           |           |           |           |           |           |           |           |           |           |
| Monday    |           |           |           |           |           |           |           |           |           |           |           |           |
| Tuesday   |           |           |           |           |           |           |           |           |           |           |           |           |
| Wednesday |           |           |           |           |           |           |           |           |           |           |           |           |
| Thursday  |           |           |           |           |           |           |           |           |           |           |           |           |
| Friday    |           |           |           |           |           |           |           |           |           |           |           |           |
| Saturday  |           |           |           |           |           |           |           |           |           |           |           |           |

Session 10: Avoidance Behaviours

Objective
The objective of session ten is to have members create an exposure hierarchy of stimuli that elicits emotional arousal causing avoidant behaviours.

Materials
- Pencils and pens
- Tips for developing a hierarchy
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to the group. Once all members are present, provide members with an opportunity to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members wish to discuss immediately. If the group does not elicit a variety of topics, the following list entails possible topics.
- Avoidance behaviours, distressing thoughts, emotions, and behaviours, anxiety, people, places, or situations that members have avoided since their loss, physical symptoms, intrusive memories.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Introduce and establish the rationale and benefits of actively dealing with avoidance behaviours.
- Identify cues/triggers that elicit emotional arousal and intrusive memories.
• Identify avoidance behaviours and safety-seeking behaviours.
• Recognize automatic thoughts associated with triggers and cues.

Psychoeducation (20 min)
A. Avoidance behaviours
B. Triggers and anxiety symptoms
C. Exposure Therapy
D. Safety Behaviours
   Distressing thoughts and emotions can elicit strong emotional responses. Due to the sensitivity of this exercise, safety behaviours should be reviewed. Members should be reminded that this activity is not mandatory and do not have to participate in this particular activity. If the activity becomes too overwhelming they are encouraged to leave and attend to their needs. Facilitators’ are encouraged to make themselves available after group if anyone needs to talk. In addition, members can be referred to individual counselling if necessary.
E. Review guidelines for creating a hierarchy
F. Review previously learned techniques such as relaxation training

Model Coping Skill (10 min)
Have the facilitator model creating a hierarchy on a white board, while explaining each step in detail. In addition, brainstorm safety behaviours that the group utilizes.

Group Activity (10 min)
Have members begin to create a hierarchy.

Group Discussion (10 min)
Once members are completed the activity, encourage members to share their experience and identify potential barriers and solutions that may prevent the success of exposure therapy.

Assign Homework (10 min)
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
Homework: Finish creating hierarchy
Tips for Developing a Hierarchy

1. **Be Specific:** Help each member create clear absolute steps for their hierarchy.

2. **Rate the Degree of Difficulty.** Have each member rate the degree of difficulty numerically for each individual step. Encourage members to use a scale ranging from 1 to 100 making 1 being not difficult at all and 100 being the most difficult step.

3. **Multiple Steps Varying in Difficulty.** A hierarchy usually has 8 to 12 steps varying in degree of difficulty. Have members identify several individual steps and encourage the members to choose steps that vary in difficulty level.

4. **Choose Steps Collaboratively.** If a member is having difficulty coming up with ideas have the open group discussion to elicit ideas, opinions, feedback, and reinforcement. Have members share their individual hierarchies with the group once they are completed.

Session 11: Exposure Therapy

Objective
The objective of session eleven is to reduce avoidant behaviours and emotional arousal by utilizing previously learned relaxation techniques in conjunction with exposure therapy.

Materials
- Pencils and pens
- White board
- Dry erase markers
- Coffee, tea, and snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/ Status Check (5 min)
Welcome members as they arrive to the group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Dedicate a short amount of time for members to ask questions and share their personal reactions from the previous session. If members have a distressing concern they would like to discuss in-depth place it on the agenda. This will provide an excellent opportunity to review homework concerns as a group.

Grief Symptom Checklist (5 min)
Have each member complete the grief symptom checklist. The co-facilitator should quickly scan over each checklist to identify any concerns that need to be addressed within the session.

Set Agenda/ Conduct CBT work on Items (25 min)
Once the initial tasks are completed, have members set an agenda for the first half of group. Agenda items should be reserved for topics members wish to discuss immediately. If the group does not elicit a variety of topics, the following list entails topics that are associated with the coping skill being taught in the second half of the session.
- Future pregnancies, putting away baby items, anniversaries, and holidays, and ways to remember you baby.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Establish Rationale (5 min)
Introduce and establish the rational and benefits of exposure therapy.
- Reduce emotional arousal
- Reduce intrusive thoughts, memories, and feelings
• Reduce avoidance behaviours
• Reduce safety-seeking behaviours

**Model Coping Skill (10 min)**
Have the facilitator and co-facilitator demonstrate imaginal exposure therapy utilizing the hierarchy created in the previous session.

**Group Activity (30 min)**
Have members sit comfortably within the group. Have the facilitator utilize imaginal exposure encouraging members to use all senses in order to have a realistic effect. Have members nod once they are able to visualize the person, place, and/or memory. Encourage members to utilize previously learned relaxation skills to reduce their anxiety and emotional arousal.

**Group Discussion (10 min)**
Encourage members to share their experiences with the group to elicit feedback, advice, and reinforcement.

**Assign Homework (10 min)**
Collaboratively assign homework. Most homework is predetermined. In this case, have members create parameters surrounding the homework assignment such as how much time should be spent on the assigned homework and/or how many examples should be provided for next week. This provides members with a sense of control and participation in assigning homework.
  • Homework: Continue working on hierarchy
Session 12: End of Therapy

Objective
The objective of session twelve is to review what members have learned and prepare for the termination of group.

Materials
- Pencil/Pens for all members and facilitators
- White board
- Magic marker
- Coffee, tea, snacks
- Condiments for coffee and tea
- Table
- Chairs
- Clip boards for all members and facilitators

Arrival/Status Check (5 min)
Welcome members as they arrive to group. Once all members are present, provide an opportunity for members to share a weekly progress report. Have the co-facilitator collect all homework assignments and provide feedback by the end of the session.

Bridging From Previous Session (10 min)
Once the facilitator has completed a status check, provide a short opportunity for members to ask questions and share their personal reactions in regards to the previous session. Encourage members to share their experience completing homework and address questions and/or concerns as a group. Have members hand in completed homework to the co-facilitator. The co-facilitator should review homework and provide feedback prior to the end of session.

Grief Symptom Checklist (5 min)
Have each member independently complete the grief symptom checklist. Get the co-facilitator to scan over the checklists to determine pressing issues that should be addressed within the session.

Set Agenda/Conduct CBT work on Items (35 min)
Once the initial tasks are completed, have members set an agenda for the first half of the session. Agenda items should be reserved for topics members wish to discuss immediately.

Break (10 min)
Set up a table with coffee, tea, and snacks to ensure members have an enjoyable and constructive break.

Group Discussion (40 min)
Members should reflect on their overall experience and progress in group. Explore members’ thoughts, feelings, and emotions surrounding the termination of group. Have members reflect on what they have learned in group and how they plan to incorporate the skills into their daily life. In addition, feedback should be acquired by asking the group to provide written or verbal feedback on the support group topics and format so the group can be improved for future
implementation. Finally, outline rules and guidelines surrounding means of contact. Members should be encouraged to share their plans for the upcoming months. The facilitators should reinforce change and progress.

**Complete Prenatal Bereavement Scale**
Have members independently complete the prenatal bereavement scale. Once, the prenatal bereavement scale is complete reinforce members strength for participating and end group. The following scale is copyright protected; however, can be obtained with proper permission on the following website. http://www.kemh.health.wa.gov.au
References


