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A Relational Group Intervention for Teen Pregnancy

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Abstract

This dissertation project involved the program development and evaluation of a group intervention designed for pregnant and mothering teens. Current services for teenage mothers have significant problems with utilization. This is especially true for teen mothers living in rural regions. Research on service utilization demonstrates that many programs for teen mothers lack integrated understanding of this population's needs as adolescents, and their needs as new mothers. The present group intervention, *Mothering: A Beginners' Group* (MBG), integrates conceptual frameworks including empowerment, psychoeducation, and relational therapy in an effort to address the complex needs of teen mothers. A group space was designed to allow participants to examine their current relationships, and to form new relationships with fellow mothering teens. An action research framework was utilized to enlist the help of group participants in the evaluation of MBG. It was believed that participation would provide teens with additional social support and help them develop coping skills to meet the demands of their lives. Seven teenagers living rural New England participated in this group.

Evaluation of MBG was completed through a mixed-methods design. Descriptive data was obtained on the demographics of the group. Additionally, quantitative data was obtained through completion of a self-efficacy measure before and after the intervention. These measures were correlated with participants' level of group attendance. A significant positive correlation ($r = .86$, $p \leq .058$) was found between increased group attendance and increased self-efficacy. Finally, qualitative analysis of postintervention questionnaires and researcher process notes indicated pertinent themes of social isolation, relational stress, and the stresses of transitioning into motherhood. Findings suggest that MBG provides an increased sense of social support to pregnant and mothering teenagers. Implications of these results bring attention to the complexity

of the competing developmental goals of adolescence and motherhood; support the use of relational group interventions with populations of pregnant and parenting teenagers; and indicate the need for integration of the lived experience of teenage mothers into the design of programs which serve this population.

Chapter 1:

The Development and Evaluation of Mothering: A Beginners' Group

This dissertation project involved the development and evaluation of a group intervention designed to address the psychological needs of pregnant teenagers and teenaged mothers. Teenage mothering has been a focus of the psychological field for over 45 years (Gottschalk, Titchener, Piker, & Stewart, 1964). Psychological research on the topic has yielded numerous findings about the potential consequences of adolescent motherhood. Consistently, research findings have demonstrated that the lives of teen mothers include more hardship than older mothers, and nonparenting teens. Further, pregnant and mothering teenagers have been shown to have less access to important services to assuage these hardships. More recently, the psychological community has begun questioning the roots of problems faced by teenage mothers, and the lack of appropriate services available to this population. This dissertation project has been involved with the concern of how to best serve the needs of teenage mothers on a local level through the design of a group intervention, the implementation of this intervention with a group of pregnant and mothering teenagers, and an evaluation of the helpfulness of this intervention.

Teen Pregnancy in the United States

According to the National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP), 34 of every 1,000 teenage girls in the United States will give birth during their adolescence. This translates to roughly 340,000 adolescents between the ages of 15 and 19 giving birth every year (Hamilton & Ventura, 2012; Meade, Kershaw, & Ickovics, 2008). Research conducted by the NCPTUP posits that, "One out of every three American girls will become pregnant at least once before the age of twenty" (NCPTUP, 2010, "National Data").

Adolescent pregnancy is considered a social problem in the United States for a variety of reasons. The most common and pressing of these issues are the disadvantages encountered by teenaged mothers and their children. More recent studies have found that the teenage birth rate in the United States has gone down slightly in the last ten years (Hamilton & Ventura, 2012). However, the U.S continues to have the highest teen birth rate of all developed nations by a significant margin (Key, Gebregziabher, Marsh, & O'Rourke, 2008).

The psychological community, in particular, views teen pregnancy as a social problem due to the increased risks these individuals have for social and psychological difficulties. The lives of teen mothers have been shown to be rife with poverty, higher rates of mental illness, social isolation, a lack of higher education and job training compared to peers, a lack of prenatal care, complications during pregnancy, low birth weight babies, and infants with more health complications than the infants of older mothers (Coontz, 1992; Holgate, Evans, & Yuen, 2006; Leiderman & Almo, 2006; Meade et al., 2008; Moffitt and the E-Risk Study Team, 2002; Musick, 1993).

A specific example of the problems encountered by teen mothers is seen in research by Nuisus, Casey, Lindhorst, and Macy (2006). The researchers conducted a study of 236 pregnant adolescents regarding their identity. While gathering data, they asked the participants about their experiences with violence. Results indicated that every one of these 236 participants reported that they had experienced physical or sexual violence or had been threatened with these types of violence on at least one occasion. Literature reviewed by Liederman and Almo (2001) also exemplifies the connection between interpersonal violence and teen pregnancy. Their review noted that approximately two-thirds of pregnant and mothering adolescents had experienced sexual or physical abuse during their childhood or in their current relationship. Additionally,

they write, "A substantial number (no fewer than one-fourth and as many as 50-80%) of adolescent mothers are in violent, abusive, or coercive relationships just before, during, and after their pregnancy, according to several studies" (p. 9).

Research on populations of pregnant and mothering teens suggests that these ill effects are often passed down to the next generation. The psychological consequences suffered by children of adolescent mothers is an area of great concern. Later in life, the children of adolescents are more likely than children of older parents to grow up and drop out of school, face unemployment, and participate in violent crimes (Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001). Research also shows that these children are more likely to show poorer cognitive functioning, and to become teen parents themselves (Brooks-Gunn & Furstenberg, 1986; Furstenberg, Brooks-Gunn, & Morgan, 1987; Osofsky, Eberhart-Wright, Ware, & Hann, 1992). While the risks for teenaged mothers and their children are obvious, the underlying causes of these risks are more obfuscated.

This past decade has given rise to important research on adolescent mothering. However, current literature still lacks a comprehensive understanding of how social, developmental, and psychological factor have an impact on teenage mothers' stability and potential. On the social level, they experience marginalization as a result of their gender, age, and class. In terms of development, there is a lack of appreciation for the competing developmental tasks that the teenaged mother is balancing. This balance involves the process of transitioning to both adulthood and motherhood. On the psychological level, the teen mother holds simultaneous memberships in these two groups, postpartum mothers and adolescents — each of which has increased risks for mental illness. These issues result in what could be termed a "perfect storm" of internal stresses and external pressures. It is apparent, then, that the social and psychological problems present in this population are caused by an amalgamation of factors.

Literature on teen mothers notes that poor service utilization is indicative of the need for more interventions which adequately respond to the problems faced by this population (Flynn, Budd, & Modeleski, 2008). As such, there is a growing interest in the psychological community for new ways to understand and address the problems pregnant and mothering teens encounter. Researchers have begun to recommend a deeper understanding of the various changes which occur when adolescents become mothers (Nuisus, Casey, Lindhorst, & Macy, 2006). It is believed that more in-depth exploration into the lives of teenage mothers will produce more relevant and valuable services. This new focus differs from previous research trends which have focused on the negative outcomes associated with teen motherhood. As Shanok and Miller (2007) note, "A disproportionate emphasis on studying pathology rather than resilience and treatment mirrors and fuels these young mothers' experiences of discrimination rather than support" (p. 259). This problem-focused approach often appears to draw a causal connection between teen pregnancy and the subsequent difficulties faced by this population. Further research that fails to incorporate the complexity of the teen mother's lives impedes the development and delivery of appropriate intervening services. A paradigm shift in the psychological community is needed to break this pattern.

Therefore, this dissertation project has been specifically designed to examine the experiences of pregnant and mothering teens. This includes a comprehensive consideration of the psychological, developmental, and social factors that may have an impact on their lives. Such critical factors were integrated into the development of a group therapy curriculum for pregnant and mothering teens, this curriculum was implemented with a small sample, and its helpfulness was measured.

Chapter 2: Literature Review

Numerous factors affect the lives of pregnant and mothering teens. In this review of the professional literature, I focus first on issues of adolescent development and the contextual factors present in teenage motherhood. Next, I explore the developmental transition to motherhood. After this discussion, the focus shifts to a consideration of how these individuals fare in society. This includes an exploration of the impact of community and government policy on this population, the cycle of teen motherhood, regional considerations regarding rural teenagers, and problems in providing services for pregnant and mothering teens.

Adolescence

Adolescence is the stage of growth between childhood and adulthood (Berk, 2001). It begins during puberty with various physical changes. This process includes hormonal changes which affect physical and emotional development. Adolescence is also a period of cognitive growth, as teenagers begin to think differently about themselves and the world. On a more conceptual level, Blos (1979) states that adolescence is the second period of individuation which occurs in one's life, the first being when the infant individuates from their primary caregiver. During the initial individuation infants becomes aware that they are separate and distinct physical entities from their caregivers with different needs and desires. During adolescence, individuals realize that they are distinct psychological entities from their family of origin with unique and complex identities. Individuation is now considered by development experts to be an outdated concept derived from research which largely neglected girls and women (Martha Straus, personal communication, May 16, 2012). This process of adolescent identity formation, though, continues to be considered a central task, amidst other wide-ranging changes that this stage includes.

Berk (2001) explains that the emotional, cognitive, and relational changes that occur during adolescence often cause tension between adolescents and their parents. Cognitive gains during this period give teenagers a deeper sense of the complexity of their world. This is seen through teenagers' use of *hypothetical-deductive reasoning,* in which many possibilities are assessed and the most appropriate choice is determined through comparison (Berk, 2001). While this cognitive process allows teens a greater awareness of the diversity of their worlds, their thinking is still characterized by concrete descriptions. An example of this reasoning is seen in teenager's negotiation of social relationships. They are aware of different social groups and use hypothetical-deductive reasoning to decide which group best matches their sense of self (i.e., jocks, preps, or goths). However, once they have chosen their memberships, their concrete reasoning compels them to strictly abide by the social rules of their clique, even when group boundaries conflict with their personal values.

The complexity of a changing cognitive structure, increased relational tension, and the influence of activated hormones often leave adolescents with rapid and dramatic mood swings. Mood swings, along with the other stresses of adolescence, put this age group at higher risk for mental health issues, substance abuse, and suicide when compared to younger children and adults (Keyes, 2006; Se´guin, Lynch, Labelle, & Gagnon, 2004; Wilson, 2010). Keyes conducted a study which explored the mental health of adolescents in the United States. The researcher reports that approximately 20% of adolescents in the United States have symptoms which fit into a psychological diagnostic classification. However, an additional 40% of his sample experienced psychological stress that was not severe enough to warrant a diagnosis. Based on Keyes' findings, fewer than half of American adolescents could be considered "psychologically healthy." It can be inferred from the high percentage of adolescence

experiencing psychological stress that the processes inherent in adolescence can have unhealthy consequences for youth.

The developmental task of identity formation, which often takes years to complete, is now considered to include two developmental stages: adolescence and *emerging adulthood*. Arnett (2011), one of the leading theorists on the topic of emerging adulthood, explained that it occurs as one steps out of adolescence and towards adulthood. An interesting characteristic of emerging adulthood is that it is typically only found in industrialized cultures where secondary education is common. This suggests that teens in industrialized cultures are allowed more time for the process of maturation.

Arnett (2011) described five features that make emerging adulthood distinct from young adulthood. He noted that emerging adulthood is an age of self-explorations, instability, self-focus, feeling "in-between," and a sense of possibilities. These characteristics succinctly show both the exuberance and the vulnerability of this age. Whereas the adolescent individual tried out different identities by changing their clothing styles or group of friends, the emerging adult changes jobs, college majors, or long-term partners. The emerging adult often feels ready to meet the world, but is unsure of how to manage themselves within it. It is in this space of readying one's self for the responsibilities of adulthood, around the ages of 17 through 19, that most teen pregnancies occur (NCPTUP, 2010).

Female adolescence. When considering adolescent psychological development and the transition to adulthood, it is important to be aware of the influence of gender. Within the psychological literature on adolescence it is notable that discourse on the topic prior to the 1980s gave limited attention to the impact of gender. Often female populations were scarcely mentioned and, as a result, male development became understood as "normal development" (Matlin, 2000). Beginning in the 1980s, the pioneering work of Carol Gilligan was one of the

first to explore the distinct and complex ways in which young women come of age. She re-evaluated many prevalent development theories including Kolhberg's work on morality, and Erickson's work on social development (Gilligan, 1982). She concluded that the female progression through adolescence is not a lesser version of the male experience, but an explicitly different one.

Specifically, Gilligan (1982) and her colleagues noted that young women tended to experience their sense of self through their connections to others. This sense of relation begins early in life with the girl's connection to her caregiver who, in American culture, is traditionally female (Chodorow, 1978). Because girls see obvious similarities between themselves and their mothers, who are also relational in nature, they tend to maintain their relational stance. Boys, on the other hand, are pushed to individuate more rapidly from their mothers due to the gender difference. Boys are then socialized to embrace masculinity, a cultural gender role which is manifested in individuality.

Relationships between females are especially strong in early adolescence when friendships are integral to one's sense of self (Gilligan & Brown, 1993). During later adolescence, conflicts between personal knowledge and relational bonds often cause young women to sacrifice parts of their identity in order to maintain connection with their female friends. This can result in a sense of lost connection with one's self and which can be psychologically damaging. Baker Miller (1993) uses the term *self-in-relation* to describe the facet of one's personality which is open to connection with others. It is this part of the adolescent girl which feels torn by the need for continued connection and the awareness of differing personal values. Girls need to develop skills in appreciating difference in the context of relationships to navigate these tensions.

Framework for viewing female adolescence. In 1996, therapists Beth Hossfeld and Giovanna Taromira developed Girl's Circle (GC), an organization that develops group interventions for girls age eight through eighteen. Hossfeld and Taromira were interested in creating interventions specifically for use with girls during childhood and adolescence. The GC curriculums have been shown to produce positive effects in girl's self-esteem, body image, resiliency, and self-efficacy, as well as reducing the incidence of risk-taking behavior (Girls Circle, 2010). Thus, these curriculums have been specifically employed as building blocks in the development of this dissertation project's group curriculum.

The GC curriculums are based on areas of female adolescence that have been proven to be of great importance with the population. GC currently has ten curriculums for adolescent girls. These curriculums include: *Friendship; Being a Girl; Body Image; Honoring Our Diversity; Mind, Body, Spirit; Expressing My Individuality; Relationships with Peers; Who I Am;* and *Paths to the Future.* These curricula seek to promote positive self-discovery by increasing girls' resiliency and their connection to others.

Beth Hossfeld graciously supported integrating the pertinent aspects of the GC curricula into the present dissertation project in order to produce an intervention which would meet the needs of pregnant and mothering teenagers (personal communication, May 5, 2009). In an effort to better understand the focus of the GC curricula, I have distilled them into three themes: a) *Defining the self* (Being a Girl, Who I am, Expressing My Individuality, Paths to the Future); b) *Exploring relationships* (Friendship, Relationships with Peers); and c) *Adolescents in their social context* (Body Image; Honoring Our Diversity; Mind, Body, Spirit). Each of these three themes demonstrates the reciprocal nature of how young women define themselves through their connections.

Defining the self. A primary task of adolescence is to develop a cohesive sense of self. This is an important task as a positive self-concept and is linked to good mental health (Ybrandt, 2008). However, as Straus (2007) notes, the concrete reasoning used by adolescents creates difficulty when integrating their differing roles. For adolescent girls, their self-concept is typically rooted in the roles which describe their relationships to others (i.e., friend, sister, and teammate). Adolescence can be a difficult time as a young woman's changing social relationships cause her sense of self to feel less consistent. Furthermore, some of the new roles that are available in adolescence are in conflict with previously held roles. For example, being a "good girlfriend" may interfere with being a "good friend."

Self-esteem is a distinct element of one's sense of self and can be thought of as one's appraisal of personal worth. Self-esteem is often examined when trying to assess the mental health of adolescent girls. For example, Biro, Striegel-Moore, Franko, Padgett, and Bean (2006) conducted research that showed that African-American girls typically have higher self-esteem than Caucasian girls. They also found that around age eleven Caucasian girls have a significant drop in their self-esteem. Girls in general tend to have a more negative self-image than boys (Knaus, Paxton, & Alsaker, 2007). Furthermore, girls who attend coeducational schools have been shown to have lower self-esteem then girls who attend all female schools (Egbochuku & Aihie, 2009). These studies demonstrate that the adolescent girl's self-esteem is often mitigated by social groups and culture.

Self-esteem is generally thought to remain the same through adolescence (Biro et al., 2006). However, it has been shown to increase via specific interventions. For example, Egbochuku and Aihie (2009) tested girl's self-esteem before and after their involvement with a peer counseling group and found that participant's self-esteem was significantly higher after this intervention. Increases in self-esteem through such group interventions are a good example of

how positive relationships can produce positive changes in internal aspects of adolescent girls' mental health. This provides evidence that even girls who belong to social groups where low self-esteem is prominent, such as teen mothers, interventions may be beneficial.

While most adolescents are busy developing self-esteem and solidifying their sense of self, adolescent mothers also have to integrate the new role of mother into their emerging identities. Nurius et al. (2006) completed a longitudinal study on the development of self-concept on a large group of pregnant teens. They examined the teen's sense of self, self-esteem, and their expectations of how mothering would change their identity. The researchers concluded that pregnant teens are a group with diverse identities. They urged that future research take a "more nuanced approach to understanding adolescent mothers who are often treated as a homogenous and stigmatized group" (p. 113). Their research revealed that pregnant teens vary widely on their view of themselves as individuals, and as mothers. The researchers emphasized that the female adolescent self is dynamic in nature and molded by their interactions with others. The study concluded that an important implication for intervention with this population is aiding them in developing positive views of themselves.

Development of a positive self-view is a complicated goal. Research on resiliency suggests that factors such as self-esteem, self-efficacy, perceived social support, locus of control, and body image all contribute to one's ability to rise above adversity (Steese, Dollete, Phillips, Hossfeld, Matthews, & Taormina, 2006). McKnight and Loper (2002), who conducted research on predicting delinquent behavior in teen girls, note that in the last decade there has been a shift from focusing on risk factors to focusing on resiliency factors. There is evidence to suggest that self-efficacy is one of the most potent resiliency-building traits.

Self-efficacy can be defined as one's perceived ability to control one's life and overcome difficulties (Beets, Pitetti, & Forlaw, 2007). It has been found to have surprisingly wide-ranging

positive effects. These include promoting better bone growth, increased physical exercise, higher likelihood of getting important gynecological care, and increased ability to communicate with partners regarding safe sex practices (Beets et al. 2007; McKee, Fletcher, & Schechter, 2006; Salazar et al., 2004; Sharma, Hoelscher, Kelder, & Hergenroeder, 2009). Self-efficacy has been found to be stronger in individuals who have a supportive peer environment (Beets, et al., 2007). As such, self-efficacy is considered a good marker for resiliency in young women and was considered when designing intervention and evaluation in the present dissertation project.

Exploring relationships. During adolescence teenage girls begin exploring romantic relationships as a source of connection while also deepening their connections to friends and family. These types of relationships are central to the process of identity formation. Youth who have a lack of peer relationships or sense rejection from a peer group experience more emotional and behavioral problems in adolescence (Doll, 1996, as cited by Straus, 2007). In this way, positive peer relationships can be considered a protective factor for young women. In childhood, girls have been found to be more likely to have a best friend and to be part of a small clique than their male peers. In adolescence, though, this appears to change with adolescence girls reporting larger numbers of friends (Urberg, Değirmencioğlu, Tolson, & Halliday-Scher, 1995). These relationships with friends often shape teenage girls' self-concept.

Friendship is clearly an important part of adolescent girls' lives; however, it does not come without complications. As mentioned, Gilligan and Brown (1992) report that adolescent girls are often faced with the choice of staying true to themselves or giving up some part of themselves to foster peer relationships. Additionally, relationships between girls can be rife with competition and aggression. It was previously thought that girls were not as aggressive towards one another as their male peers. This was largely based on the absence of physical altercations seen in girls. It appears, however, that aggression in girls simply looks different. Girls have

been found to use relational aggression as frequently as boys use physical aggression (Talbot, 2002, as cited by Crothers, Field, & Kolbert, 2005). Relational aggression is defined as the withdrawal or threat of withdrawal of social connection in order to control someone else's behavior (Rhys & Bear, 1997).

The use of relational aggression appears to be related to cultural gender expectations. After conducting research on the gendered personality types, Crothers et al. (2005) concluded that girls who see themselves as more traditionally feminine are more frequent instigators of relational aggression. The researchers believed that this occurs because girls are often socialized to get along with everyone and to avoid conflicts. The relational aggression, then, is a subversive way to manipulate power in a way that does not overshadow one's femininity. This theory was supported by Coyne, Archer, Eslea, and Liechty (2008) who found that, after viewing similar videos of boys and girls being aggressive, young boys and girls were more likely to rate the boy as being justified in his actions than the girl's in theirs. Relational aggression demonstrates the ways which cultural norms affect social functioning in teen girls. Straus (2007) writes that the impact of relational aggression on teen girls is long lasting and psychologically damaging. Teenage girls with a supportive network of peers and high self-esteem are more likely to avoid the damage caused by relational aggression.

For teenage mothers increased social support, such as having close friendships, has been shown to have a positive effect on outcomes for both mother and infant (Turner, Grindstaff, & Phillips, 1990). Unfortunately, developing these friendships is difficult for pregnant and mothering teens, due to the social isolation they experience (Holgate, 2006). One reason for this isolation from peers may be adolescents' tendency to base friendships on actual and perceived similarities (Linden-Andersen, Markiewicz, & Doyle, 2009). Because teenage pregnancy is not

a socially sanctioned in most communities, adolescents who become pregnant are seen as "different." Thus, there are fewer similarities upon which to build friendships.

Interestingly, there is a lack of research that specifically examines the quality of friendships experienced by teen mothers and pregnant teens. This lack of research is especially surprising because there is consensus in the field that social support, regardless of age, is a protective factor during pregnancy (Austin et al., 2008; Zlotnick, Johnson, Miller, Pearlstein, & Howard, 2001). The absence of research about friendships between mothering teenagers may be indicative of the culture's tendency to overlook part of this specific developmental stage. Rather than being considered a teenager, who is highly dependent on friendships, the teen mother is thought of solely as a mother, whose primary relationship is more often with her child or partner.

Romantic relationships can be a large support for pregnant and mothering teens; however, they tend to be much less stable than friendships. Romantic relationships typically begin later in adolescence and can overshadow even established friendships. Flam-Kuttler and La Greca (2004) found that as age increases the likelihood of engaging in a romantic relationship increases. These researchers examined the effects of romantic relationships on female friendships and found that, while casual dating increases connection to friends, adolescent girls in committed relationships were less likely to demonstrate closeness with their friends. Thus, there appears to be a tradeoff where serious relationships cause a decrease in connection with friends. A similar finding from this study showed that younger girls are more likely to use their best friends as their main resources regardless of how serious they considered their relationship, but older girls were more likely to name their boyfriends as their main supports. This is important to note as many adolescent romantic relationships end as a result of pregnancy. The romantic relationship may have decreased the sense of connection to friends and after it is over

the teenager is left with limited social support. Thus, the all-consuming nature of adolescent romantic relationships may be the first step towards social isolation in teen motherhood.

Romantic relationships for teen moms are significantly more complicated after the pregnancy is discovered. For example, Thompson (1995) conducted in-depth interviews with teen mothers about relationships and sexuality. She found that her participants were surprisingly ambivalent towards sex, and tended to view it as a means of solidifying love in relationships. Reproduction, then, was often considered the ultimate in romantic commitment. Paradoxically, though, many of these young women found themselves alone after the baby was born.

Thompson's participants' reactions to their deteriorating partnerships demonstrate the diversity among adolescent mothers. Some girls swore off men and focused on becoming parents, others continued to look for romantic love through sex and found themselves having more children, and still others struggled to make their relationships work while relying on networks of family for support. Thompson concluded that the majority of the young mothers she interviewed would not change having their child if they had the chance; but, instead, they were very committed to helping their children separate the concepts of sex and reproduction so the new generation did not experience the same confusion with these ideas.

Of importance, Seiffge-Kreke, Shulman, and Klessinger (2001) found that positive romantic relationships in early adulthood were associated with positive relationships with parents during adolescence, and positive body image during middle adolescence. This suggests that, although adolescents are practicing relational skills on one another during these years, it is still their attachment to their parental figures which has a larger impact on their romantic success as adults.

The notion that teenagers' relational skills are dependent upon their experiences with parents is supported by a recent study. Hershenberg et al. (2011) examined the relationship

between a strong parent-teenager attachment and positive interpersonal skills in the teenagers. Parent-teenager dyads were first interviewed alone about a topic that was considered by both parties to be an area of disagreement. They were then observed while the dyad met together with the intention of resolving this conflict. The observations from each dyad were correlated with the results of a child-report measure on the security of their attachment to their parent. Observations from each dyad were evaluated for specific behaviors which indicated positive interpersonal skills. Teens who were more securely attached to their parent demonstrated more positive interpersonal skills. The researchers stated that these findings imply that the security of relationships between teens' and their parents has a significant effect on the teens' ability to develop and maintain relationships outside of the family as well. Thus, the strength of one's attachment to a caregiver also has a significant effect on one's ability to develop and maintain other intimate interpersonal relationships.

The social lives of teen mothers. Relationships are created within the context of communities and cultural values. The social constructivist perspective posits that individuals develop their sense of self, as well as their frame for understanding the world, from the social context in which they are embedded. Cultural values which shape personal frameworks are present in various places such as literature, television, music, and advertising. This manner of cultural referencing occurs a great deal for female adolescents who are found to have heightened concern for how they are perceived by their social group (Strahan, Lafrance, Wilson, Ethier, Spencer, & Zanan, 2008). One concept which succinctly demonstrates the interaction of cultural values and personal beliefs in adolescent girls involves her "body image."

For example, Strahan et al. (2008) researched the degree to which adolescent girls base their opinions of themselves on the social and cultural norms of their society. They focused specifically on the issue of body satisfaction. Their results indicate that teenage girls are less

likely than boys to feel satisfied with their bodies, and more likely to show concern about their body image. The girls who adopted the American culture's belief that thinness is equal to beauty were even more likely to be dissatisfied with their bodies. Furthermore, the researchers found that the degree to which girls base their self-worth on appearance is mediated by their exposure to socio-cultural values in the media.

Strahan et al. (2008) also reported on a second study they conducted with female middle school students. They conducted a workshop with one group of students describing the unrealistic expectation set for body image in the media. A second control group received a workshop on volunteerism. Afterwards, both groups were shown pictures of models with unrealistically thin bodies. They found that the group that had received information leading them to question cultural norms about beauty was more likely to endorse satisfaction with their own bodies than the group that was taught about volunteering. They understood these results to support their claim that adolescent girls base their feelings about body image and satisfaction largely on the cultural values presented by their society. These results indicate that in adolescent populations negative cultural impact can be reversed through exposure to differing beliefs. This is a hopeful message that speaks to the resiliency of this age group.

For pregnant adolescents in the United States, the social messages that they receive about their growing bodies are more complicated. While they are immersed in the American culture which values thinness, they are also exposed to confusing social messages about the acceptability of sexuality during adolescence. While a large number of teenagers are sexually active, only pregnant and mothering teenagers are unable to hide this personal information from those around them. This makes them easy targets for attacks on their morality and decision-making ability. Body image is only one example of how cultural values impact personal values.

The wide-ranging and complicated impact of negative social perspectives towards teen pregnancy is presented later in this chapter. In addressing pregnant adolescent development, though, it should be noted with importance that the effects of social and cultural prejudices towards teen pregnancy are exacerbated by the adolescent girl's own heightened focus on social perception.

Concluding thoughts on female adolescence. Gilligan and Brown (1993) titled their book on female adolescence, *Meeting at the Crossroads*. They elaborated on this name by stating that the adolescent girl is standing between childhood and adulthood, but no longer, and not yet completely, within either stage. The metaphor of a crossroads is succinct in capturing both the uncertainty and potential of this developmental time. The adolescent girl's emphasis on relationships is seen in how she develops her sense of identity, how she functions in relationships, and how she is affected by cultural beliefs. The difficult road from girlhood to womanhood is even more complex for pregnant and mothering teens. The following section explores this transition to the mothering role.

The Transition to Motherhood

Identity goes through dramatic changes on the path towards parenthood. Numerous books on pregnancy attempt to describe the process of embracing the mothering role. The ease of this transition for teenage mothers appears to depend on stability of their self-concept prior to this role change, and their access to social support before, during, and after they become mothers. The essential elements of this transitional process and its implications related to attachment are now considered.

Maternal role attainment. During the last thirty years, interest in the developmental path from woman to mother has grown. Mercer (2004) compiled a literature review on the transition to motherhood which is commonly referred to in the field of developmental

psychology as, *maternal role attainment*. She notes that research on the transition to motherhood was pioneered by Reva Rubin. Rubin (1967) viewed this phenomenon as an important developmental milestone for a woman, which begins with pregnancy.

The process of maternal role attainment is believed to consist of different stages in which the woman reorganizes her goals as a mother, draws from examples of other mothers, tries out acting the part of mother, and seeks out useful information. Mercer (2004) has applied Thornton and Nardi's stages of role acquisition to the transition to motherhood. The *anticipatory stage* involves the mental work the mother does before the infant arrives. The *formal stage* takes place in the first few weeks of the infant's life as the mother strives to do exactly as the experts prescribe. This new information is then filtered through the woman's original ideals to reveal her concept of motherhood. The *informal stage* occurs as the mother recognizes that she has her own way of mothering. The final stage, called the *personal stage,* occurs when the mother feels a, "sense of harmony, confidence, satisfaction in her role and attachment to her infant" p. 227). As the woman incorporates the mothering role into her sense of self, she also lets go of the aspects of her personality which no longer have a place in her life. Mercer describes the marker of role attainment in Rubin's model as, "a woman having a sense of belonging in her role, along with a sense of comfort about her past and future" (p. 227). Thus, the mature mother integrates her new feelings and beliefs as a mother with her previous sense of self and her future goals.

Mercer (2004) states that the complex and powerful process of becoming a mother is influenced by several factors. Mothers who appear to have an easier time transitioning had positive relationships with their own parents, felt that their baby's father was a good parent, and had babies with fewer health complications at birth (Mercer, 2004). Similarly, mothers who have a more difficult time during this transition had low self-esteem, were described as more immature, and experienced more depression and anxiety before the birth.

Transitions within transitions. Becoming a mother during adolescence puts young women in a state that Kaiser and Hays (2004) call, "dual developmentalism," (p. 6). By this they mean that this population is simultaneously managing two competing developmental tasks. Kaiser and Hays conducted research that followed teen mothers' progress through this process. The researchers reported that teenagers' journey to motherhood generally includes four themes: *gaining acceptance of the pregnancy, planning for the future, viewing the self as a mother,* and *growing up*.

For a teen mother, gaining acceptance of her pregnancy from her family and friends has significant repercussions. Shanok and Miller's (2007) research noted that mother's approval of her daughter's pregnancy was correlated with less depression in the new mother after the infant was born. The acceptance of family and friends about her decision to have a baby will determine the level of social support that the teenage mother will have later on. Rolfe (2008) who conducted interviews with teenaged mothers about their identity as mothers concluded, "young mothers, with sufficient support, can experience motherhood as positive and can do well" (p. 310). The success of a teenage mother appears to be greatly dependent on how much social support she has available. Social support from family members appears to be among the most reliable and important factors for positive transitions into motherhood for pregnant adolescents (Shanok & Miller, 2007; Rolfe, 2008).

The importance of social support is seen in Thompson's (1995) interviews with teenaged mothers as well. She states that when the father of the baby left it was family and friends whom the new mother relied upon for security and support. Similarly, Taubman-Ben-Ari, Shlomo, Sivan, and Dolviski (2009)conducted quantitative and qualitative research with pregnant and mothering teens and concluded that increasing the social support of these young women during pregnancy is likely to improve their mental health and coping abilities.

Arnett (2011) wrote that in the emerging adulthood stage teen's benefit greatly from older mentors who can give them example of responsible adult behavior. The presence of a mentor who is also a mother would give pregnant and mothering teens a role model who could demonstrate examples of good parenting. Mentors and other forms of social support can have significant effects on the mental health of teen mothers. Providing extra social support throughout pregnancy should be a serious consideration for health care providers looking to aid adolescents in this transition to motherhood. Social support is a factor while provides teen mothers with caring relationships which provide practical help while also bolstering the teens' self-image by sending her the message that she is someone who is worth looking out for. The more that a teenager mother is able to be supported in this way, the more she will be able to send this same message of positive regard towards her child through their attachment.

The impact of attachment. How a mother transitions into her new role of caretaker also has important ramifications for her infant. The term *attachment* has been used to refer to the nature of the bond between infant and caregiver. John Bowlby, who studied differences in children raised in orphanages, was among the first to write about attachment (Berk, 2001). Bowlby noted that these orphans who lacked a loving care giver suffered significant health consequences. The high mortality rates and poor development of these orphans lead Bowlby to theorize that a loving attachment is a crucial health need for infants.

Mary Ainsworth broadened Bowlby's theory to examine the impact of different styles of attachment. She documented at least three different types of attachment: secure, anxious, and avoidant. A fourth attachment type, disorganized/disoriented, has been hypothesized by Solomon and Main (Siegel, 1999). These attachment types exist on a continuum of health with the securely attached infants having the most appropriately responsive parents and the disorganized infants having more inconsistent and possibly abusive parents.

According to the neurologist Daniel Siegel (1999), '"Attachment' is an inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant care giving figures" (p. 67). This system compels the infant towards engagement with their caregiver. This engagement increases the infant's chance of survival as well as provides the blueprints for advanced brain functioning such as emotional regulation. Gerhardt (2004) elaborated on this by stating that in an infant's first months it is essentially neurologically programmed by its environment and caregivers. Through this programming it develops an arousal set point, among other things, which informs its central nervous center when to activate. While all infants come into the world with an internal genetic map for potential, it is their experience with the outside world that determines the path on which they will embark.

Healthy attachment, then, can be considered one of the most important mental health needs for infants. The mother's ability to form a healthy attachment to her infant is largely determined by her own history of healthy attachments to others and to her sense of comfort and empowerment in the mothering role. Teen mothers are more likely to provide healthy attachments to their infants when they feel supported by their friends, family, and community. Therefore, it should be a primary focus for care providers to help teenagers by offering services that provide social support that helps teen mothers have a healthy transition to motherhood.

Teen Mothers in a Social Context

Having explored the personal world of the adolescent and how this world is changed by pregnancy, the focus of this literature review now shifts to an exploration of the societal influences present in the lives of pregnant and mothering teens. This contextual frame includes cultural beliefs, social policy, and community services that affect the lives of pregnant and mothering teens.

The teen mother's experience involves the combination of two of the most psychologically taxing developmental life events: adolescent development and the transition to motherhood. Facing these milestones in a society that views teen pregnancy as a problem can exacerbate hardships. A growing body of research has begun to raise awareness of the deletious affect of cultural prejudices against teen moms. For example, Shanok and Miller (2007) conclude their research on teenaged mothers by reporting, "Finally, health workers should also be aware that prejudice affronts are common experiences for pregnant teens. Interventions should help mothers defuse hurtful messages and validate their pregnancies" (p. 261). It is clear from this statement, that these researchers feel that it is the responsisbility of care providers to hold an awareness of these prejucides. The history and current manifestation of these prejudices are examined below.

Adolescent birth rates in the United States reached their apex in 1957, when 97 out of every 1,000 adolescent women gave birth (Coontz, 1992). This is more than double the current adolescent birth rate (NCPTUP, 2010). Interestingly, during the 1950s teen pregnancy in the context of early marriage was not considered a decomposition of American morality, or even a social problem. The important difference between adolescent motherhood then and adolescent motherhood in present day is the presence of a husband. In the 1950s, fewer than 15% of all teen births occurred to unwed mothers, in present day as many as 84% of teen mothers are unwed (Coontz; http://www.thenationalcampaign.org/). Thus, when evaluating the current challenges of adolescent mothers, the discourse includes mostly single mothers. It is important to remember teen mothers' status as single parents when unpacking the stigma attached to teen motherhood--a good deal of it likely stems from American culture's disapproval of unmarried mothers and of teenage sexuality.

Prejudice encountered by pregnant and mothering teens often involves an assumption that the pregnancy or child was the cause for all of the problems in the young mother's life. SmithBattle (2006) pointed out that many of the problems that are associated with teen pregnancy, such as poverty and lack of educational attainment, were actually present in the teen's life prior to the pregnancy. SmithBattle summarizes, "Growing evidence now suggests that the negative outcomes of teen mothering for mothers and their children are due primarily to mothers' prior disadvantages and not young maternal age." (p. 131). Rather than understanding the intricate difficulties that these young women were facing before their pregnancies, researchers have typically assumed that the pregnancy was the tipping point of many problems to come.

For example, Shanok and Miller (2007) believed that the issue with research on this population is the methodology: "Teen-parenting literature is dominated by studies comparing the demographics and life trajectories of teen mothers versus nonparenting teens or parenting adults" (p. 252). Importantly, they noted that when socioeconomic status was controlled for by comparing teen mothers to other teens in the same socioeconomic-status group, most of these differences disappear. The problems in the lives of teenage mothers, more often than not, are common problems of poor teens regardless whether they have children or not.

Influence of class. One of the largest overlooked factors about teen parents is their socioeconomic status (SES). As mentioned, many of the risks that teenaged mothers face such as higher rates of mental illness, higher incidence of violence, decreased educational attainment, and increased dependence on public welfare, are risks for poor teenagers regardless of whether or not they have children. Interestingly, teenagers who are in low SES brackets have been shown to be more likely to continue their pregnancies than young women in middle and upper SES brackets (Thompson, 1995). Jewell and Brown (2000) conducted research on teen's access to

abortion. They refer to research on abortion decision-making and concluded that teenage girls and women typically chose abortion if they viewed pregnancy as a barrier to their expected economic security. For example, they found that teenagers who have higher paying jobs and who receive good grades in school are more likely to get an abortion. Teens who have no jobs and whose school achievement is poorer are more likely to continue the pregnancies. The researchers concluded from this that one reason poor teens choose to become mothers is that they view pregnancy as an opportunity rather than an obstacle.

Influence of social policy. The social sphere within which one lives also has an impact on the health information available to individuals and their feelings towards this information. This comes into play for teenaged mothers in two important ways: first, the information regarding reproductive health that they receive; and second, their access to safe and legal abortions.

Sexual education. In the United States, federal funding for sex education programs has been limited to abstinence-only programs since 1996 with the introduction of Section 510(b) of Title V of the Social Security Act. As a result, the percentage of American teens receiving abstinence-only sex education has risen from 9.3% in 1995 to 23.8% in 2008 (Kohler, Manhart, & Lafferty).

Much of the support for these programs comes from the unfounded public fear that giving information to teens about safe sex will encourage them to have sex. Kohler et al. (2008) conducted research to examine the impact of different sexual education programs. They concluded that programs which offered comprehensive sexual education reduced risks of teen pregnancy without increasing the risk of sexually transmitted diseases. Further, Duberstein, Santelli, and Singh (2006) discuss a literature review by Kirby on the effectiveness of abstinence-only programs. This research showed that, while sex education that included

abstinence as well as safe sex had some effectiveness in delaying first intercourse, the programs that used abstinence-only had no effectiveness in delaying intercourse.

With a growing number of American youth receiving abstinence-only sexual education it is not surprising that the teen birth rates are trending upwards again. Without the proper information about safe sex, and access to birth control, teenagers are left to make decisions about sex and reproduction without the necessary information or protection. Duberstein et al. (2006) go as far as to say that abstinence-only sex education deprives teens from their basic rights to information.

Abortion. A second factor that affects teenagers' decisions about pregnancy involves their access to abortion. In order for a teenager to consider this choice they must have access to non-biased information about abortion, have an abortion provider within a commutable distance, have the financial resources to pay for it, and not be deterred by the costs or the prospect of parental notification or consent. However, these conditions are swiftly disappearing for much of the country.

Public policy first began creating an impact in the lives of pregnant and mothering adolescents in 1972 with the passage of Title IX of the Educational Amendment Act. Among other things, this legislation made it illegal for schools to ban pregnant girls from attending school (Thompson, 1995). As a result, the rates of pregnant high school students tripled. A year later in 1973, the Supreme Court passed legal abortion with the Roe v. Wade decision. However, only four years later the Hyde Amendment was passed which prohibited federal funding for abortion services. Thompson described its impact as such: "the Hyde Amendment, which restricted federal funding for abortion, put the service beyond the reach of the very girls traditionally most likely to become mothers — poor girls" (1995, p. 111).

In 1981, Congress passed the Adolescent Family Life Act, which is commonly referred to as the Chastity Bill (Thompson, 1995). This act funded abstinence-only sexual education as well as prenatal and postnatal care for teenage patients. Unfortunately, this funding was only available to programs that did not provide family-planning counseling or abortion services. While American society seems to view pregnancy during adolescence as a problem, there is also a confusing message present in this legislation about ending a pregnancy.

In the last twenty years there have been additional restrictions on access to safe abortions, especially for teenagers. According to the National Abortion and Reproductive Rights League (NARAL): Pro-choice America, a nonprofit organization for reproductive rights, 43 states have put into effect parental notification or consent laws which state that any women under the age of 18 must have documented notification or consent from their legal guardian. Reproductive rights activists view this as a large barrier to abortion. Their reasoning is that teenaged patients who have safe relationships with their families tend to tell their parents about their decision to terminate a pregnancy. The portion of teen patients who choose not to tell their parents tends to be those teens who fear that sharing this information would put them in danger, or compromise their ability to procure an abortion. (NARAL, 2011).

Unfortunately, legal restrictions are not the only barriers to abortion access for young women. Reporter Joyce Tang (2010) wrote a story for the online newspaper, The Daily Beast, on *Crisis Pregnancy Centers*. This term, she explains, is misleading as it suggests that abortion services or family planning services may be available. In reality, these clinics provide false medical information about terminating a pregnancy and pressure clients to continue their pregnancies. Tang cites Congressman Henry Waxman's congressional investigation into these centers which found that 20 out of the 23 surveyed gave women false medical information including, “that abortion increases the incidence of breast cancer, suicide, and fertility problems”

(Tang, 2010, p. 1). These centers are typically funded by evangelical churches. The cultural beliefs of these groups about abortion make it even more difficult for young women to make reproductive choices in an unbiased manner.

Here, again, it is apparent that there is a contradictory message to young women regarding reproduction. Many adults believe that it is inappropriate for young people to know the basics about sex, let alone engage in it. However, when one becomes pregnant there is societal pressure written in between the lines of many federal and state policies to continue the pregnancy. Conversely, the politics of reproductive health in America make it even more difficult for young women to make informed, empowered decisions.

Cycle of teen motherhood. According to Allen, Seitz, and Apfel (2007), regardless of the reasons for deciding to have a child, becoming a mother as a teenager increases the likelihood of producing a second generation of teen parents. In their study, Allen et al. followed 115 teen mothers over 15 years. They found that one third of the daughters of these teens also became teen mothers themselves, and one fifth of the sons became teen fathers. For mothers who had a second child 30 months (two and a half years) or less after the birth of their first child, the instance of second generation teen parents was even higher. In this group, half of their daughters had children during adolescence. They also found that maternal school enrollment and school success (as indicated by passing and above grades) were predictors of whether or not the children of teen mothers would go on to have children during their teens as well.

Rural adolescent mothers. Much of the research on teen motherhood involves samples from urban areas. As a result, there is a lack of knowledge about rural teen mothers. Primarily this appears to be because adolescent mothers living in rural areas face even more increased risk. This is largely because rural populations are known to have limited access to mental and physical health services. Sears, Evans, and Kuper (2003) summarize previous research which shows that

there is a high instance of mental illness in rural populations as compared to urban areas; however, there is also a lack of mental health specialists in these regions. In their writing on children and adolescents in rural areas, Nordal et al. (2003) report that 23 percent of youth in rural areas live in poverty. Other research shows that rural youth are more likely than urban youth to be sexually active, to have sex at a younger age, and to engage in riskier sexual practices, such as lack of protection (DiClementi et al., 1993*).*

Myers and Gil (2004) developed a framework for understanding the synergistic effect of negative social factors which result in poor rural women's higher rates of mental illness. They reported that living in a rural area increases the likelihood that one will live in poverty as well as the chances of one suffering from a mental illness. Additionally, they stated that the adolescent populations in these regions are more likely than teens in other regions to have early pregnancies and begin childrearing early which, in turn, exacerbate their economic problems. Myers and Gil (2004) referred to the concept of self-efficacy as a potential explanation for the higher rates of mental illness among rural women. They wrote, "Perceived control is associated with emotional well-being, successful coping with stress, better physical health, and better mental health over the lifespan as well as psychological hardiness," (p. 11). Social factors such as discrimination, social stigma, lack of educational opportunities, and chronic stress related to financial stability are some of the complicated issues which deteriorate rural adolescent mothers' sense of control of their lives and lead to higher instances of mental health disorders in this population.

Sears et al. (2003) suggest that a biopsychosocial model of care is best for rural areas due to the lack of mental health practitioners and multi-systemic problems affecting the population. The biopsychosocial lens encourages care providers to consider many different factors which may be influencing the client.

Utilization problems. As previously noted, the societal climate for teenage mothers and pregnant teens is often not a welcoming one due to social bias and inadequate resources in poverty stricken rural areas. It is not surprising, then, that many teen mothers are not able to effectively navigate the social sphere in order to achieve access to appropriate services. Approximately 33% - 50% of pregnant teens receive no prenatal care (Ventura, Abma, Mosher, & Henshaw, 2009). Musick (1993) wrote that, in order for interventions with adolsecent mothers and pregnant adolecents to be effective, they must involve consideration of their social and cultural context. She believed that services often have poor outcomes because programs often overlook these factors. Anderson and colleagues (2000) investigated the services available to pregnant teenagers in rural Misorri and found that lack of transportation, lack of information about the importance of serivces, and lack of health insurance acted as roadblocks in getting services to this population. It appears that, for the services to be optimal, planning must involve both pragmatic considerations (i.e., how will the teens get to the service) as well as conceptual considerations (i.e., will the services available be relevant to the population).

Services for pregnant and mothering adolescents. On a national level, the United States currently supports the needs of pregnant adolescents and adolescent mothers largely through public aid and social service programs. Unfortunately, there appear to be conceptual problems in many of these services that diminish their effectiveness.

Allen et al. (2007) reported that care providers often ignore the complex details of young mothers' lives when planning services for them. They stated that care providers tend to focus on obvious details, such as the fact that they are pregnant, rather than considering what pregnancy might mean to an adolescent. The researchers used the example that many pregnancy prevention programs that are designed to simply educate teens on the basics of reproduction have poor outcomes. They related this intervention to expecting a teen to remember what they learned in

history class months after graduating; it is irrelevant as soon as they step out of the classroom. Allen et al. noted that programs have better outcomes when they provide teens with the chance to build life-relevant skills such as teaching them to reach out to community resources, developing their communication skills, and helping them to focus their personal goals. This approach is effective because this style of learning is age-appropriate and relevant to the issues facing teenage mothers.

Liederman and Almo (2006), conducted a literature review on the link between interpersonal violence and teen pregnancy. The writers emphasize that, when designing a program for young mothers, it is important to consider all of the elements of their lives rather than merely focusing on their pregnancy. This might include their past traumas; their relationships with friends, family and significant others; their goals for the future; their connection to their community; and their changing sense of self. They believed that all of these factors will have an effect on the adolescent mother and pregnant adolescent's well-being and her ability to take in information regarding the transition to motherhood.

An example of a comprehensive intervention designed to serve pregnant and mothering teens is reported by Sangalang, Barth, and Painter (2006). This program focused on a case management program for women under age twenty who were pregnant or mothering their first child. This program's main goal was to prevent a second pregnancy which, as noted, is a significant risk factor for the wellbeing of young monthers and their first children. The group included both a case management component as well as a monthly group meeting for participating teens. The researchers found that young mothers who participated, in contrast to those teen mothers who did not participate, were more likely to have healthier birth outcomes and more likely to delay a second pregnancy.

Another program whichtargeted the prevention of second pregnancies in teenagers was developed and evaluated by Key, Marsh, Gebregziabher, and O'Rourke (2008). Their program was school-based and included a case management component with home visits, weekly in-school peer support groups, and coordinated medical care for all paticipants. This program was unique in that it considered the cultural identities of the participants and matched them with culturally similar care providers. The researchers found that, when compared to no intervention, this intervention was effective in delaying second pregnancies.

A program that has creatively managed utilization issues is the Young Mothers of Brooklyn Collective (YMBC). This organization was created by Benita Miller, a children's attorney, who wanted work to stop families from being separated because of poverty. Their organization provides case management, educational advocacy, emotional support,as well as sexuality and reproductive health education for pregnant and mothering teenagers. YMBC also offers trainings for care providers who deal with mothering adolescents. Their program stands apart from other social services for teen mothers in its commitment to making and maintaining interpersonal connections with their clients even after services have ended. YMBC strives to empower the teen mothers they serve to be in control of their lives. While YMBC has not yet conducted research regarding the impact of their services, they have managed to grow into a large service organization with significant community support.

Hannah Wohl from the YMBC reports that, while they still struggle with attrition, they have developed some strategies to keep clients involved. This is primarily accomplished through intense connection to their clients' communities. Caseworkers get involved with the whole family and use these connections when a client's attendance is dwindling. This involvement with the local community assures that a large number of the pregnant and mothering population are aware of their services (Hannah Wohl, personal communication, September 27, 2010).

YMBC's dedication to fostering relationships with clients and communities utilizes the relational nature of adolescent girls and is likely one of the causes of its success.

While the various programs mentioned above work well to prevent and/or postpone second pregnancies in populations of pregnant and or mothering teens, they are fairly limited in their focus and are more concerned with the prevention of further pregnancies than on othero adolescent relevant issues (i.e., teen relationships, body image, developing identity). Also, although these programs have taken pragmatic steps to bring services to the teen population (by running groups in school and providing in-home service), they are the exception, and not the norm. The majority of pregnant and mothering adolescents do not have have access to these services, especially in rural areas. Chapter Three details the ways in which this dissertation project's group intervention has been designed to provide conceptionally sound and easily accessible care to pregnant and mothering teen girls in rural areas.

Chapter 3: Rationale for Study

The difficulties faced by teenage mothers in American society have deleterious effects on their mental health, their ability to parent, and their future opportunities. Furthermore, the success of these young mothers significantly affects their children's wellbeing. This dissertation project has been designed with the belief that more developmentally informed support of pregnant and mothering teens will enable them to lead healthier lives and provide better care to their children.

Intervention Development Considerations

This dissertation project has been concerned with the social and psychological needs of pregnant and mothering adolescents. It involves a program development approach that employs a group curriculum for pregnant and mothering teenagers. This group curriculum focuses on psychoeducation, development of relationships, and empowerment. These themes were integrated with the hope of raising the self-efficacy of the group participants. Self-efficacy is an important factor relating to one's resiliency and sense of control. Self-efficacy is also closely related to one's self-esteem, and ability to accomplish goals. By connecting participants with peers who were also pregnant or mothering, giving them information to help make informed decisions, and valuing their experiences, this intervention was designed with the intention of assisting teen mothers as they transitioned into the maternal role.

Psychoeducation, relational theory, and empowerment are the essential aspects of the group curriculum. The eight-week curriculum addresses a different topic each week through skill-building activities, didactic instruction, and group discussions. The weekly topics included orientation to the group, social messages about teen pregnancy and motherhood, self-care, preparing for the attachment with the newborn, understanding emotions, managing relationships, and preparation for labor and delivery. The intention of the group curriculum was to provide

developmentally appropriate psychoeducation in these areas so that these young women would feel empowered to better navigate the complex needs of pregnancy, childcare, and emerging adulthood.

A group therapy approach that uses a relational frame to address perceived social support was considered a good fit for pregnant and mothering teenagers for several reasons. Research on the effects of realational group interventions on pregnant women over age eighteen suggests positive outcomes. For example, Zlotnick et al. (2001) implemented a relationally-focused therapy group for adult pregnant women. Their study hypothosized that providing this type of intervention would reduce the rates of postpartum depression in the group. Participants completed diagnostic interviews with all participants three months after they gave birth. The researchers found that none of the women who had participated in the group had symptoms of postpartum depression while 33% of the control group qualified for the disorder.

Further, a group intervention allows a number of participants to receive services at one time. It also allows participants to develop relationships that can counteract the social isolation and prejudice this population experiences. For adolescent girls, their social interactions are characterized by a profound interest and awareness of relationships (Gilligan & Brown, 1993). This eagerness to develop relationships does not lessen when a teenager becomes pregnant. On the contrary, pregnant women and new mothers aretraditaionlly interested in connecting with peers who are also pregnant or mothering. In the safety of a therapeutic group environment, the pregnant or mothering teen is able to reflect on her own experience without feeling judged due to her age. The group environment allows participants to create and maintain relationships with one another and with the group facilitator in order to feel increased social support during these important life transitions. The group facilitator acts to foster positive realtionships between the group members and also as a mentor for the group of teenagers. Having a positive female

mentor has been identified as a protective factor for pregnant teenagers, and is considered to increase pregnant teenagers' percieved social support (Perrin & Dorman, 2003; Stockman & Budd, 1997; Waller, Brown, & Whittle, 1999).

The availability of pertinent psychoeducation and the ability to develop relationships in the group context are considered to be two elements that lead participants towards a sense of empowerment. The concept of empowerment is closely related to self-efficacy in that it involves the increase of one's sense of control. Empowerment specifically addresses the impact of societal oppression on individuals. When an individual encounters bias and prejudice their sense of self-worth and their sense of individual power decreases. This has wide-ranging effects on an individual's life which can include health problems, low self-esteem, and more difficulty in accomplishing personal goals. Teen mothers face prejudice from American society largely because of social beliefs related to teenage sexual activity. Additionally, issues of class exacerbate these prejudices because many teen mothers are poor. The combined impacts of ageism and classism leave teen mothers with a diminished sense of personal worth. It is believed that through respectful intervention which explores social bias, values the experience of the teen mothers, and provides support that participants will be empowered to manage their lives effectively. This project has been designed to create a participatory frame in order to provide an empowering experience to group members. For example, in the spirit of such a frame, the group decided together on a name for the current intervention. The name of the intervention emerged from the group discussions. It was named *Mothering: A Beginners' Group* (MBG).

When designing interventions for teen mothers, the setting is often chosen with specific interest in increasing the utilization of the service. Many interventions with successful results take place in settings that do not put the burden of traveling on the teenager. Such is the case with interventions that take place in the home or in schools. The setting of MBG was the

women's health department of a local hospital where the majority of group participants were receiving services. One reason for chosing the hosptial setting was in an effort to minimize the need for the teenagers to secure transportation. This medical setting used an integrated healthcare model of treatment. Intergated healthcare includes an atmosphere in which care providers share patient information with other care providers who are also giving services. This allows the patient's health information to be up to date, even if the patient is visiting a provider they have not seen for months. This approach allowed all care providers, mainly obstetricians, nurse practitioners, and midwives to refer patients for participation in this intervention. Also, it was believed that integrated healthcare would allow the administative assisstants at the hospital to schedule the participant's medical appointments back-to-back with the group meeting. This would mean only having to travel to the hospital once during the week.

On a conceptual level, integrated healthcare is specifically designed from a biopsychosocial approach to understanding health. The biopsychosocial model involves an integration of the biological, psychological, and social causes of illness (Engel, 1977). This model of care is particularly appropriate for addressing the needs of an adolescent population. An emphasis on the social aspect of this model is well suited for the adolescent girl's relational nature. The use of the biological component of this model creates room for care providers to examine the vastness and complexity of pregnancy. Finally, the focus on psychological wellbeing in this model provides a lens with which to understand the developmental dynamics of young mothers.

Programmatic Integration

Two specific programs currently in use, one in a local setting and the other at a national level, were integrated into MBG. The Pregnancy Wellness Program (PWP) group curriculum and Girl's Circle (GC) group curriculums each have elements appropriate for an intervention for

teen mothers and pregnant teens. It was believed that, through incorporation of these programs' salient elements, a distinct and relevant intervention for adolescent pregnancy would be possible. These group curriculums are described in detail below.

The Pregnancy Wellness Program. The Pregnancy Wellness Program (PWP) was designed by Amanda (Hitchings) Houle (Hitchings, 2004) within the obstetrics and gynecology (OBGYN) unit of a small New England hospital. The aim of the PWP is to provide women with behavioral consultation throughout their reproductive lives.

The PWP functions as an important community resource for pregnant and parenting women of all ages. The PWP was designed to give women a space to manage their emotional lives so as to keep them healthier during and after their pregnancies. PWP services are available to all women seen at the OBGYN unit of the hospital. Within the frame of integrated healthcare, the program offers both individual consultation as well as group therapy.

The majority of PWP services involve individual behavioral consultation meetings. Women can access these services at any time during their pregnancies through the first two years of their child's life. Typically, women are referred early in pregnancy by the childbirth educators working in the OBGYN unit. Another common time for referral is in the immediate postpartum period. These women are generally referred by lactation consultants, midwives, or doctors. Meetings with clients are typically scheduled every other week and last approximately thirty minutes. During this time the client may speak about any of their concerns. Intervention includes brief therapy techniques which focus on the here and now of the patient's lives. Techniques include the use of cognitive behavioral therapy, psychoeducation, and mindfulness strategies. The goal of this service is to give patients the tools to better cope with stress. Behavioral consultation seeks to provide patients with an in depth understanding of the connection between their emotional lives and their physical health.

The PWP group curriculum is an 8 week session which follows the behavioral consultation model of the program. The nature of the group is primarily psychoeducational with a secondary goal of allowing expectant mothers to give and receive support from one another. The curriculum is designed for pregnant women with no specific focus on age. The topics of the group curriculum include strategies for self-care, cognitive techniques to address negative thinking, healthy relationships, wellness during pregnancy, and preparation for childbirth.

In 2004, the individual behavioral consultation aspect of this program was evaluated as part of a research project by Hitchings. The behavioral consultations were found to produce high satisfaction among clients. Similarly, care providers described this intervention to be a positive contribution to the quality of care that they are able to offer as an integrated health care system. Qualitative analysis from participants revealed that they felt more confident in dealing with the stresses of their pregnancies after utilizing this intervention (Hitchings, 2004).

Girl's Circle. Girl's Circle (GC) was developed by Giovanni Taormina and Beth Hossfeld in 1996 (Girl's Circle, 2010). It has since been adopted at a national level for various types of service implementation. Designed as a group intervention for adolescent and pre-adolescent girls, the model emphasizes girls' and women's need for connection and relation. GC was based on relational-cultural theory originated by Jean Baker Miller which purports that increased connection to others is a protective factor for all individuals and a principle organizing factor for female development (Hossfeld, 2009; Steese et al., 2006). The creators of the program describe its specific effect, "Girls Circles are uniquely positioned to address and challenge cultural messages that limit and distort girls' self-image. We have found that girls' self-expression within a safe caring environment encourages self-confidence, authenticity in relationships, and enhanced judgment skills" (Girls Circle, 2010, para 1).

The GC model seeks to identify both the core risk factors that American girls face and the resiliency factors which protect them. The developers of GC consider the building of resiliency in adolescent girl populations to be closely linked to the following issues: high self-efficacy, high self-esteem, positive body image, internal locus of control, and perceived social support (Steese et al., 2006). The developers believe that using a relational frame is the most appropriate way to help girls foster these characteristics. Their use of relational theory is influenced by the concept of empowerment. Empowerment is present in the position of equal power amongst all group participants including the group leader. This empowering experience differs from the marginalized position that these young women frequently face in other contexts. Furthermore, the developers of GC value skill-building as a manner of teaching in their groups. This allows the participants to test out the ideas that they are being exposed to during the program. By integrating relational theory, resiliency factors, and skill-building the GC model intends to enable young women to live healthier lives (Hossfeld, 2009).

The GC sessions have a predetermined schedule which includes time at the beginning and end of each group for an opening and closing ritual. These rituals may be decided by the group members or suggested by the group leaders. The rituals allow the members of the circle to mindfully step into the different relational space that the circle creates. Within the circle there is heightened awareness of relationships and of how each individual reacts to these relationships. After the beginning ritual all participants, including the group facilitator, check-in with one another. Hossfeld (2009) describes the check-in as a central part of the GC model. It is based on Native American tribal traditions which emphasize the importance of each tribe member and the connection between them. Each group session has a different theme which is first discussed and then explored through some kind of group activity. Before the closing ritual the group again discusses the theme including their reactions to the activity.

Steese and her colleagues (2006) conducted research on the GC group's ability to positively influence areas of developmental health. They found that, after participating in an eight-week group, participants between the ages of eight and eighteen had significant improvements on their self-efficacy, positive body image, perceived social support and internal locus of control. Laszlo (2001) conducted quantitative research using the GC model of group therapy on sixth and seventh grade girls. Her study indicated that the use of GC resulted in increases in self-esteem for group participants. Rafindadi (2008) used a GC group therapy curriculum with adolescent girls living in a residential treatment facility. The researcher tested participants' levels of self-esteem and locus of control before and after the intervention. She found that even in this population which was experiencing severe mental health problems there were marginal improvements in self-esteem and locus of control.

Integrating PWP and GC. Both the PWP group curriculum and the GC group curriculums have potential for intervention with populations of adolescent mothers and pregnant adolescents. However, they each have conceptual gaps which make a conceptual integration necessary. First and foremost, while the GC curriculum is specifically designed for girls and for teenagers, it includes no consideration for pregnancy during adolescence. Pregnancy includes many physical, emotional, and relational changes in one's life. Without consideration for how pregnancy and motherhood has transformed their lives, the GC model would not be relevant to pregnant and mothering teens.

Similarly, while the PWP is specifically designed for pregnant and parenting women, the adaptation of this model for use with the adolescent population was not considered. For example, the psychoeducation offered through the PWP assumes a certain amount of knowledge regarding reproduction and pregnancy. While this is appropriate for most adult women served by the PWP in the adolescent population there is much more variability in individual

understanding of reproductive health. As a result, it was believed to be important to include in this intervention age-appropriate psychoeducation about the basics of reproductive health and pregnancy. Further, while adolescents receive PWP services, they have not yet been included into the research conducted regarding the effectiveness of this program. Therefore, it was believed that the current project should assess the levels of satisfaction with a similar intervention on an adolescent population and modify certain elements of the group intervention to specifically address the needs of an adolescent population.

MBG was created by integrating the basic elements of the GC and PWP programs. The primary goals of MBG are to provide participants with relevant psychoeducation, to create an environment where pregnant and mothering teens can develop relationships with one another, and to help these young women feel empowered to lead healthy lives as teenagers and as mothers. It was believed that this intervention would help to increase the self-efficacy of participants. The problem of service utilization was managed by choosing a location for the group where most group participants were already visiting on a weekly basis.
The setting was also considered appropriate to increase service utilization because of its integrated healthcare approach.

Research Methodology Considerations

The present group intervention was designed with careful attention to the psychological and social needs of pregnant and mothering teenagers. It was a goal of this project to evaluate the helpfulness of this intervention. Contributing to research literature on the needs of teenage mothers was a second goal for this project. With these goals in mind the researcher operated within a transformative framework.

The transformative approach and action research. Different approaches to research value different types of knowledge. The transformative approach, as conceptualized by Mertens (2004), acknowledges a fundamental imbalance of power between the researcher and the participant. Mertens explained that "researchers still consist of a relatively small group of powerful experts doing work on a larger number of relatively powerless research subjects" (p. 16). The remedy for this imbalance is the frame of collaborative inquiry set by the researcher in which the researcher and the participants work together to plan and understand data. The transformative approach values positioning the researcher as a "participatory activist" (p. 20) and is especially useful when working with a marginalized population. In this participatory activist role, the researcher is able to dissect and examine socially-held constructs. By examining social constructions in this way, the researcher should be able to collaborate with participants in order to better understand the impact of stigma on teen motherhood.

The transformative approach values multiple truths rather than one answer (Mertens, 2004). With this value in mind this dissertation project used a mixed-methods approach to gathering data. Qualitative data was gathered from group participants at the end of the intervention. Open-ended questions allowed the participants to describe their own experiences in the group, their most important needs as teen mothers, what was helpful about the group, and the areas that need improvements. Quantitative data was gathered from the participants at the first group meeting regarding their demographic information so that the sample could be compared to the general population of pregnant and mothering teens. Quantitative data was also gathered on the topic of self-efficacy through the use of the GC self-efficacy scale which was collected at the first and last group meeting. This data gave the researcher a perspective on the participant's level of self-efficacy before and after the intervention as a measure of the group curriculum's degree of helpfulness.

Within the transformative approach is a specific type of research called *action research*. Action research involves the inquiry of a social problem through evaluation of clinical practices and interventions (McNiff & Whitehead, 2006). The researcher generally addresses an intervention in which they have a facilitating role. In this way, action research involves making changes in the services that the researcher and their community offer. These changes are then examined through the lens of the social problem in question. Through this use of local data, the researcher enlists participants in an active role of reflection about the effectiveness of the intervention. I was familiar with the setting of the PWP because I had previously worked as a practicum student providing behavioral consultation. This experience gave me insights into the needs of the pregnant teenager population receiving services through the program.

Action research is well-suited for the pregnant and mothering adolescent population because little existing research represents their personal perspectives. The majority of research on this population includes the voices of psychologists, scientists, and health care providers, but not the voices of the teens themselves. It was believed that the experience of actively participating in a research project that would help other teen mothers would therefore be additionally empowering for the teens involved. This type of participation is consistent with the empowerment goal of the intervention.

The researcher approach of the *local-clinical-scientist*, as described by Trierweiler and Stricker (1992) appears congruent with the transformative approach to research by assessing the needs in their communities and then delivering current research to the local level through interventions. The literature review regarding the lives of pregnant and mothering teenagers demonstrates that this is a population in need of additional support. This need was apparent on the local level in the lack of specific interventions for this population. The literature also shows that with appropriate services these teens can lead healthy lives, be competent parents, and meet

their personal goals. This dissertation project has the goal of beginning a dialogue between researchers, care providers, and teen mothers in order to develop this manner of services.

Chapter 4: Procedures

This project consisted of three parts. The first was the development of a program for the pregnant and mothering teen population at a local hospital. This was accomplished by integrating two current programs, the Pregnancy Wellness Program's behavioral health model and selected features of the Girls' Circle group therapy curriculums. Information specifically related to teen pregnancy psychoeducation was also included. Second, this intervention was implemented with a selected group of participants. This took place over a three-month period in which the group met once a week for an hour and a half. The third part of this dissertation included an evaluation of the impact of this intervention. This mixed-methods evaluation included both a quantitative analysis of the impact that the group had on participant's level of self-efficacy and an analysis of qualitative data derived from a short-answer questionnaire.

Sampling

The participants for the present study were pregnant and mothering adolescents from rural New England. Participation was limited to teenagers who were currently pregnant or who had given birth within the year. The rationale for this particular sample was that women who were currently pregnant or had recently given birth were still in the process of maternal role attainment (Mercer, 2004). By allowing teenagers at different places in the transition to motherhood there was an opportunity for the more experienced mothers to educate the newer mothers. This stratification increased the opportunity for participants to be empowered by one another and to diminish the power differential between researcher and participant.

As MBG was designed to be situated within the PWP, the manner of recruitment was primarily one of referral from their hospital-based care providers. Administrative assistants aided the researcher in collecting lists of all teens receiving services at the hospital. Additionally, the administrative assistants and the care providers were given fliers (see Appendix

A) announcing the group to provide to any interested teen patients. The researcher attempted to make telephone contact with every teen on the list to schedule a face-to-face meeting.

During this meeting the intervention was described in detail (see Appendix B). This meeting also included a description of the research process, the requirements of the group, and the risks/benefits of participation. At the end of this meeting the teen was asked if she was interested in participating in the group. If so, she was given an informed consent packet. If she was not interested she was reminded of the availability of individual behavioral consultation via the PWP. Sampling also occurred through referral from the participants, though this was not my explicit intention. This resulted in one additional group member, for whom informed consent and group screening was completed over the phone.

Informed Consent

I attained informed consent from all participants prior to the beginning of the group. Individuals who were 18 years of age or older read and signed their own consent forms (see Appendix C). For individuals who were ages 17 and younger, I attained informed consent from their parents or guardians (see Appendix C). One participant was under the age of 17, but had legally been made her own guardian; as such, she provided consent for her participation. Assent was required of the underage participants as well. While state law allows *mature minors* to receive medical treatment without the consent of their parents, the experimental nature of this group required parental consent (L. Snow Wade, personal communication, July 30, 2009). This informed consent explained both the intervention and research aspects of the dissertation project. The collaborative role of the participant was explicitly stated on the informed consent form. Also, information that detailed the researcher's institutional affiliations, supervisors, and Internal Review Board approval was provided. Participants were informed that they were free to withdraw from research at any time, with no consequence to the other care that they were

receiving at the hospital. Care was taken to protect participant's confidentiality, both in the intervention and evaluation stages of this research. Participants were informed that they were able to receive information regarding the final findings of this research project if they so desired.

Screening

During the initial informal meeting between potential participant and researcher, a brief psychosocial screening was completed to assure that the potential participants were not in need of more intensive services (see Appendix D). Intensive services were considered to be indicated if any potential participant showed suicidal or homicidal ideation. The researcher planned that, if more intensive services were indicated, the prospective participant would be referred to Dr. Amanda Houle, Director of the PWP, for behavioral consultation. If any potential participant's mental health needs exceeded the limitations of behavioral consultation, they were referred by Dr. Houle to another mental health provider in the area. Referral to Dr. Houle did not occur during the screening process. The participant's appropriateness for the group intervention was assessed during this interview as well. I screened prospective participants for potential group interfering behaviors, motivation, and relational skills (Yalom, 1995).

If a girl expressed interest in participation following the screening, she and I discussed goals, and covered any additional questions. Individuals were informed of the confidential nature of the group. Each member of the group agreed to keep the personal information shared in the group confidential. However, because the group members were also responsible for maintaining confidentiality, the researcher was unable to specifically guarantee confidentiality. Those individuals who still expressed interest in participation were considered participants once their informed consent was completed, and they had been screened for basic mental health functioning. At the conclusion of the screening process, the participants were given information about the time and location of the first meeting.

I was interested in finding between six and eight adolescents who would be invited to participate in the formation of the group. Selection was based on a first come, first serve basis. Fourteen screening and informational meetings were scheduled with prospective participants. Five of these individuals did not come to their scheduled initial meetings. Two additional individuals decided, after the initial meeting, that they were not interested in attending the group. One potential participant had interest in the group, but could not secure weekly transportation. Another individual completed informed consent materials, but decided she did not have time for the group before it began. The group started with six participants. Screenings on these participants indicated that group intervention was an appropriate intervention for them. After two weeks, one group participant referred another teen mother to the researcher. Screening was completed via telephone for this participant and informed consent was attained at her first group meeting. Thus, seven pregnant or mothering adolescents were invited to become participants in the group.

Intervention

The group met for eight, one-and-a-half hour sessions, over a period of three months. Dinner was provided to the participants as a manner of thanking them for their participation. Sessions were rescheduled during this time due to severe weather and the health needs of the facilitator. The curriculum outline for these sessions is available in Appendix E. Each group session had a different topic that was specifically designed to address the difficulties faced by the general population of pregnant and mothering teens.

The first session included collaborative goal setting between the group facilitator and the participants. During this time the group examined what they believe are appropriate rules for group conduct, and the goals of the group. Group confidentiality was explained and limits to the facilitator's capacity for confidentiality were outlined. It was the responsibility of the facilitator

to explain to participants the importance of collaboration in this group as it pertained to research goals. Additionally, it was the facilitator's role to maintain safety and support among group members. After these discussions, the facilitator and participants reviewed a "crash course" in reproduction and pregnancy in order to get a sense of each participant's knowledge in these matters.

The second session involved examining the social meaning of teen pregnancy and teen motherhood. The facilitator led a conversation by bringing in different quotes and media images which depict teen motherhood in different ways. Participants then engaged in a group activity involving creating collage murals which represent their personal feelings about being teen mothers. The third session involved the concept of preparing for motherhood. The group facilitator and participants discussed fears related to the mothering role, mothering role models, and participated in an activity where they individually wrote letters to their infants in order to establish a sense of connection and attachment with their child. The fourth session was designed around the idea of understanding emotions. This group included a discussion about the importance of emotions as signals, the mind-body connection, and an activity derived from CBT therapy which involved examining the relationship between thoughts and emotions.

The fifth session focused on self-care and personal strengths. This group session included discussions about the difficulty of feeling confident in one's own strengths, the use of personal affirmations, an art therapy activity to create a "holding container" for personal strengths, and a discussion of various self-care activities. The sixth and seventh session focused on relationships. Session six focused on the ideal types of relationships and support which participants were interested in finding. The group engaged in a discussion about how their partner choices reflected their own personal values as well as their attachment histories. Session seven examined the difficult aspects of relationships with a specific focus on conflicts in communication.

Communication skills were explored and practiced in this session. Finally, group eight involved a focus on preparation for childbirth and the postpartum period. Fears related to these topics were addressed and any participant who has previously given birth was encouraged to share her wisdom with the other participants so as to better inform them.

Each group session began with a check-in regarding how participants were feeling as they entered the group and anything else they would like to share. At the end of each meeting the members, again, all reflected on how they experienced the group and what could have made the group better. This was noted by the facilitator in weekly process notes. Each group ended with a breathing exercise led by the group facilitator.

Instruments

Three instruments were used during this intervention. The first was a demographic survey based on the GC evaluation kit's demographic survey. This took approximately ten minutes to complete. This survey was slightly modified to include questions pertinent to pregnant and mothering adolescents (see Appendix F). The demographic survey was used to attain group means about this small sample which could be used to understand the larger population of pregnant and mothering teens living in rural areas.

The second instrument was the GC Self-Efficacy Scale (see Appendix G). This instrument was adapted from Schwarzer's Self-Efficacy Scale by Steese and colleagues (2006) who were exploring the effectiveness of the GC curricula. This tool was adapted specifically for an adolescent population. The Girl's Circle Organization currently collects data on the effectiveness of their groups across the country. As this involves evaluating similar goals that pertain to this dissertation project, it was used for evaluation of MBG. The GC Self-Efficacy Scale provided pre-intervention and post-intervention data on the participants' levels of self-

efficacy. The examination of self-efficacy in the group was used to assess the goal of self-empowerment inherent in this intervention.

The third instrument included a set of open-ended questions designed specifically to address the needs of this population and their experience of this intervention (see Appendix H). These data were considered qualitative in nature and analyzed to reveal the meanings. These questions were (a) What did you find helpful about the group? (b) What does a young mother need? c) How could the group be changed to be more helpful to young mothers? (d) What would you like to have available for extra support from your community? (e) How did your experience in this group effect the way you relate to others, if at all? Additional qualitative data was also derived from the group facilitator's process notes which summarized each group session.

Data Collection

At the beginning of the first meeting participants completed the demographic information and the GC Self-Efficacy Scale. These two surveys took approximately fifteen minutes to fill out. At the end of the final session, the participants again completed the GC Self-Efficacy Scale. At this time, during the final session, they also completed the open-ended questions which took an additional ten minutes. For those participants who were not present at the final meeting, (N=5) two scenarios took place. First, the survey materials were given to the administrative assistants at the hospital. When the participants came to the hospital for other services, they were given these surveys by the administrative assistants. The completed surveys were collected by Dr. Houle, and later gathered by the researcher. In those instances in which the participants were no longer receiving care from the hospital, the surveys were sent to their homes with addressed and stamped return envelopes. These envelopes were then sent back to the hospital to Dr. Houle and later gathered by the researcher. Group facilitator process notes were accessed through the personal computer of the researcher who acted as group facilitator.

Data Safeguards

To safeguard the data collected during this study, the questionnaires I collected were maintained in a secured filing cabinet within my supervisor, Dr. Houle's, private clinical office which was located within the hospital. I removed consent forms from the measures and also replaced participant names with a random number code. Information from the questionnaires was, then, entered into a password-protected computer. Group process notes were written in the personal computer of the researcher which was also password protected. No personally identifying information was entered into this computer. The information collected for this study was used only for the purposes of conducting this study.

Data Analysis

This project yielded both qualitative and quantitative data. The data were analyzed through various methods. Quantitative data derived from the demographic survey were evaluated as descriptive information used to indicate the characteristics of the larger population. Specifically, these characteristics permitted generalization to the adolescent mother population in rural New England. Quantitative data from the Girl's Circle Self-Efficacy measure was considered alongside the subject's level of participation in the group intervention through correlation. The difference between the subject's pre- and posttest scores on the GC Self-Efficacy Scale was correlated with the number of sessions they attended. This analysis was used to evaluate the helpfulness of Mothering: A Beginners' Group (MGB).

The qualitative data used in this dissertation project were collected through the participants' responses to open-ended questionnaire and the group facilitator's process notes (see Appendices H and I, respectively). The text from these answers was analyzed through a process described by Mertens (2004) and Creswell (2007). This involved, "reducing the data into themes through a process of coding, and then condensing the codes, and finally representing the data in

figures, tables, or a discussion" (Creswell, 2007, p. 148). These writers purport that with qualitative data analysis the researcher must condense original text into smaller units, called *codes*. Next, the researcher takes note of the frequency of these codes and labels frequent codes as *themes.* Creswell and Mertens explain that these themes should then be distilled into units of meaning. For this dissertation project frequent groupings of themes were synthesized into *core concepts*. These core concepts were considered to hold important meaning related to the lives and needs of pregnant and mothering teens.

The data used in this dissertation was primarily qualitative. The decision to use qualitative data was influenced by the researcher's transformative values which emphasize the importance of the using the participants' own words (Mertens, 2004). It was, however, also considered useful to obtain a quantitative measure of the clinical changes that may or may not occur as a result of this intervention. Objective surveys were useful toward this goal because it was possible that some personal changes which occurred as a result of the intervention may not have yet been integrated into each participant's narrative. In this instance, they may have reported little to no changes on operationalized measures.

Chapter 5: Results

This chapter includes the description of participants' demographics, the relationship between changes in self-efficacy and the group members' participation in Mothering: A Beginners' Group, and the development of core concepts embedded in the group narrative.

Demographic Data

A demographic questionnaire (see Appendix F) was used to collect demographic data from participants. This data is presented in Table 1. Participants ranged in age from sixteen to nineteen, with the average age being eighteen. All were either pregnant with, or parenting, their first child. Two participants were pregnant during the group, three gave birth during the intervention, and an additional two participants had infants under one year of age. All of the participants identified themselves as Caucasian.

Pregnancy during adolescence has negative effects on teen mothers' school achievement (Holgate et al., 2006; Ickovics, 2008; Moffitt and the E-Risk Study Team, 2002). Thus, it was considered useful to collect data on the participants' level of educational attainment. In this sample, school achievement ranged from tenth grade to a high school diploma with some college classes. The average grade completed was eleventh grade. Two girls were still in high school, three had dropped out and received their GED, one had graduated high school and received a nursing certificate, and one dropped out of high school without attaining her GED.

The level of perceived social support has a large impact on the mental health of adolescent mothers (Turner, Grindstaff, & Phillips, 1990). As such, the presence of potentially supportive relationships in group members' lives was evaluated. Information regarding

Table I

Demographic Information for Participants

Ss	*Age*	*Age of Child/ Pregnancy*	*Educational Attainment*	*Living Independently versus living within a family context*	*Partnered / length of relationship*	*Employed*	*Memberships*
1	19	2 weeks old	High School Diploma	Living with friend of family	Yes-FOB/1-2 years	No	No
2	18	8th week of pregnancy	High School Diploma	Family of origin	No	Yes	No
3	18	36th week of pregnancy	High School Diploma	Family of origin	Yes-FOB/ 1-2 years	No	No
4	16	8th week of Pregnancy	10th grade (currently in school)	Family of origin	Yes-FOB/6-12 Months	No	No
5	19	32nd week of pregnancy	11th grade, GED	Family of origin	Yes/1-2 years	No	No
6	16	10 months	10th grade, GED	Independently	Yes-not FOB/1-2 years	Yes	Yes
7	18	11 months	High School Diploma	Family of origin	No	Yes	Yes

relationships was gathered by asking participants about their current living situations, their membership in organizations, and the presence and duration of romantic relationships. Although the responses gave information about the presence of relationships in their lives, they reflect neither the degree not the strength of these relationships.

Exploring the participants' living situation was believed to provide information regarding their level of support. Parents who have completely rejected their pregnant daughters often force them to leave the home. If a teen is still living with her parents, this suggests that the parents have accepted the pregnancy enough to continue their relationship with their child. Thompson's (1995) research indicated that even parents who were very much against the pregnancy tended to become supportive when the teen continued to live at home. When the baby was born, these disapproving parents typically let go of their disappointment and provided support to the new mother and infant. Lack of support from the teens' parents has been linked to higher rates of maternal depression (Shanok & Miller, 2007). Examining the current living situation also allows participants to list other friends or family members who are living in the home and who may be providing help. The home environment and the individuals living within it, whether biological family or not, can be considered a family context which the teen may perceive as supportive. Some family contexts involved teenagers living with extended family or the family of their partners. The presence of a family context is considered to be indicative of higher levels of perceived support, as compared to teens who live independently.

Five of the seven participants lived with either their family of origin or their partner's family of origin at the onset of the study. One participant had been forced out of her mother's home before she learned that she was pregnant, and was currently living with her father's ex-girlfriend. Another participant moved back and forth between her own apartment and her father's house during the time of the group. The average number of people living with

participants was four. These individuals were parents, siblings, and partners of the participants. It should be noted that two of the participants moved into their own apartments during the course of the intervention and data collection.

Five of the seven teens in this study were involved in a romantic relationship with the fathers of their babies. One participant described her relationship with the father of her baby as "currently dating," but noted that there was a no-contact order against her boyfriend because he was older than 18 and she was 16. One participant no longer had contact with the father of her baby, but was dating another young man. Four out of seven of these relationships were defined as lasting longer than one year.

In addition to perceived support from family and partners, perceived support from one's community is an important factor. In order to examine group members' level of perceived support and involvement from their communities, they answered questions regarding their activities related to employment and group memberships. Two participants had jobs outside the home at the time of this study. An additional three had recently left their jobs, due to the demands of their pregnancies, or their infants. Another participant worked as a child care provider to her younger brother, though this was an unpaid position, but was part of the arrangement she had made with her mother in lieu of the mother providing free housing. Two participations described being involved with some type of organization, one was a religious organization which met monthly and the other was a social service organization that provided case management.

Self-Efficacy Outcomes

Self-efficacy was considered an important factor to examine in this dissertation project because it represents the level of control that individuals feel in their lives. Self-efficacy data came from the Girl's Circle Self-Efficacy Scale, which is an adaptation of the Schwarzer

Self-Efficacy Scale (see Appendix G). When self-efficacy is low, individuals have more difficulty attaining goals, and using their personal resources to overcome obstacles. Recent research on levels of self-efficacy in teen mothers suggests that teens with higher levels of self-efficacy have more success in mothering tasks such as breastfeeding (Dennis, Heaman, Mossman, 2010). By evaluating participant's level of self-efficacy before the group intervention and again after completion of the intervention this researcher hoped to gain insights about the impact of MBG.

The initial plan for the use of quantitative data from the self-efficacy measure was a simple pre-intervention and post-intervention t-test. Through the use of a t-test, differences between before and after intervention scores could be analyzed for significance to provide information whether participation in MBG was helpful by increasing self-efficacy. However, it became clear after the conclusion of the intervention that this would not be the best statistical test to capture the impact of the intervention. The reason for this was that, of the five participants who sent in both the before and after intervention Girl's Circle Self-efficacy measures, participation in the intervention varied greatly. Specifically, there was one participant who attended one session, one who attended four sessions, two who attended five sessions and one who attended six sessions. Difference between the group members' pre- and postscores appeared to vary as well; participants who came to more MGB sessions seemed to have more positive differences in their post intervention measures. It was reasoned, then, that a more useful way of understanding the data would be to examine the relationship between degree of participation in MBG and differences in self-efficacy.

As such, a correlational analysis was preformed between the number of sessions attended and the difference between pre- and postself-efficacy scores. In order to perform this correlation, a new data set was created which measured the change in the participant's pre-intervention

self-efficacy score and their postintervention self-efficacy score. This new data set was labeled *change*. The Pearson product-moment correlation coefficient (*r*) was used to assess the relationship between number of group sessions attended and the change data set. The correlation shows a relationship of .86. This strong correlation suggests that there is a strong positive relationship between the higher the number of sessions attended and higher scores in self-efficacy following the intervention in this extremely small sample. While it cannot be stated that the intervention itself caused the rise in level of self-efficacy, the focus instead should be on the positive relationships between these factors. Put another way, this analysis has demonstrated that as attendance in the group increased, levels of self-efficacy increased as well.

Qualitative Results

As described previously, qualitative data in this dissertation were gathered through an open-answer questionnaire and the group facilitator's process notes. Open-ended questionnaires included brief answers to questions about each participant's experience in MBG and her needs as a teen mother. Process notes were brief notes written after each group meeting by the group facilitator which reflected the content and process of the session. The verbatim text of the open-ended questionnaire and the researcher process notes were collapsed into one group and considered the dataset. The dataset was analyzed through the previously detailed process; five core concepts were identified. The following section lists each core concept and provides verbatim text from the dataset for illustrative purposes.

The core concept, *Importance of Connection,* consists of the following themes: *connection through similarities*, *interest and acceptance of group members*, and *everyone has difficulties*. Connections were described as interpersonal relationships in which the participants recognized that other group members were experiencing similar feelings, events, and problems. In their answers to the open-ended questionnaire group members noted that feeling connected

through their shared experiences made them feel supported by their peers. Connection was often experienced when group members realized that they were all managing similar demands from their different social roles. For example, one participant's open-ended answer to what was helpful about group was, "It [group] really helped me realize that I wasn't going through it alone, that there were other people out there experiencing the same troubles and feelings and emotions that I was." Another member described the benefits of feeling connected to her peers. She wrote, "It really helped me when I was going through a rough time and there were people there to talk to who were going through the same thing." One group member explained how feeling connected during group made a lasting impression in her life outside of group as well, "It makes me more compassionate with how others feel and feel like everyone has feelings that are similar."

The core concept, *Mothering Creates New Stress***,** consists of the following themes: *difficulties with parental relationships, difficulties with romantic relationships,* and *pregnancy includes additional stress*. Relational stresses between the teen mothers in this sample and their partners was a common topic of group discussions. After one group the researcher reflected, "The girls spent a fair amount of time talking about how having their kids has changed their feelings towards their boyfriends. There appears to be a lot of disappointment about how the partners are stepping up to the parenting role." The most common partner problems as shown in the researcher's process notes involved disagreements about how to parent. Relational stress was also common as the group members attempted to individuate from their families of origin into their new families often while still living at home. Process notes included references to arguments between new mothers and new grandparents. The tension in these relationships seemed to be exacerbated by the degree of practical support the new mothers received from their parents and in-laws through child care, housing, and baby supplies.

The core concept, *Sharing My Story,* consisted of the following themes: *the importance of talking to group members, the permission to express my emotions,* and *the importance of being supported*. Group participants wrote about how MBG gave them a place to discuss their frustrations. Having a space where young mothers could speak about their difficulties as a mother and as a teen was described as, "helpful." For example, when asked what the most important needs of a new mother were, a group member answered, "To talk to others about problems and open up about feelings you have whether it be good or bad, its good to talk about your issues and not hold them in." In addition to the benefits of sharing their own emotions, group members also benefited from hearing one another's concerns. Hearing that their fellow group members were struggling gave others acceptance of their feelings and new perspectives on how to deal with these issues.

The core concept, *Becoming a Mom***,** consists of the following themes: *acknowledgment that "I'm the mom", feeling invalidated,* and *determination to take good care of myself and my baby*. This core concept describes the teen mother's transition to motherhood. This idea was present in their desire for a sense of confidence and acknowledgement as a mother and in their dedication to providing good care to their infants. Researcher process notes show that a common theme of the group discussions was how to be a good mother. For example, "The girls talked a lot tonight about what isn't acceptable for a mother. They all had examples from people in their lives who did things wrong as a parent and there was a strong sense of consensus that they were not going to make these same mistakes." However, the participants also described a lack of empowerment in their role as mother. This was a problem that occurred both in their families and in their communities. For example, when asked about her most important needs as a young mother, one participant wrote, "To be supported and acknowledged as a mom, not like someone that doesn't know anything."

The core concept, *Importance of Community Resources,* consists of the following themes: *the value of MGB, seeking similar group experiences,* and *access to information.* In response to a question about what participants wanted from their community responses, they indicated an interest in information about pregnancy, information about community resources, and information about other groups similar to MBG. For example, when asked about her most important needs as a young mother one participant wrote, "The *right* information." She elaborated on this in her response to the next question regarding what other resources she would like available from her community, "More educational classes that tell you all the stuff you really need to know and hear, not just the ones that scare you." Additionally, some responses talked about the need for more access to other community programs that provide different kinds of aid, such as clothing for infants and mothers.

Responses from the questionnaires also demonstrated that the participants had an interest in spending more time in group settings similar to MBG with fellow mothering peers. For example, when asked what changes could be made to the group to make it better in the future one participant wrote, "Make it longer, the time goes by way too fast." Other responses provided suggestions that the group facilitator lengthen the amount of time the group lasted, include more mothers so as to have larger a larger group, or hold the group more frequently.

Chapter 6: Discussion

In this chapter, I examine the similarities between my small sample and the larger population of pregnant and mothering teenagers in the United States, discuss the impact of MBG, and explore how a consideration of the experiences of teen mothers can enrich interventions for this population. Unexpected findings which emerged during MBG are also discussed. The lessons gleaned from conducting and studying this intervention are then synthesized into an integrated action plan for care providers seeking to provide helpful services to the teen mothers in their communities.

Pregnant and Mothering Teens as a Population

Demographic data from this particular research population was compared with the literature on pregnant and mothering teenagers. This demographic information helps to provide an examination of the characteristics that often accompany teen motherhood and are related to the developmental stage of adolescence. Additionally, the presence of resources and support networks are explored in order to understand teen mothers' perceived social support.

The average age of pregnant or mothering teenagers in this group was 18 and this is similar to the finding from NCPTUP that teenagers between the ages of 18 and 19 have the highest rates of pregnancy among teen mothers (NCPTUP, 2010). This age, at the end of the teenage years, is when an adolescent transitions into emerging adulthood. It is a time when teenagers develop goals for their adulthood and take steps to begin to realize these ambitions. Most teen pregnancies occur without planning (NCPTUP, 2010). As a result, motherhood often interrupts a teenager's plan for the future. While their peers are applying to college, or spending time figuring out what careers they want to pursue, teen mothers are busied with the demands of pregnancy and infant care.

Unexpected motherhood often forces teenage mothers to step out of the developmental stage of emerging adulthood. Rather than taking college classes to see where their interests lie, the teenage mother is more likely to take any available job to start making money. She may similarly feel pressure to remain in a problematic relationship for economic reasons. This focus on finding a job likely speaks to the urgency which teen mothers feel regarding the necessity of finding a source of economic stability for their families. The young mothers in MBG had an average educational attainment of completion of eleventh grade. Two participants decided to obtain their GED's so that they could find full-time employment to support their children. Another mother was able to enroll in night classes so that she could be home with her son during the day while she finished high school. The average educational attainment and the experiences of these mothers is consistent with previous research that shows that teenaged mothers have many roadblocks to completing their education (SmithBattle, 2006). However, participants from MBG also demonstrated the flexibility and determination which aided them in finding solutions to these educational roadblocks.

Securing daycare for their children is essential in continuing one's education. Mollborn (2010) suggests that living with one parent from her family of origin may help teen mothers get past the childcare roadblock, as grandparents may provide supervision for the infant. A study by Sullivan et al. (2010) emphasizes the importance of teen mothers continuing their education. This group of researchers analyzed the impact of several maternal factors to assess the environment of young children. They determined that, while young maternal age has a negative impact on the environment of young children, this effect was no longer significant when teen mothers continue their education. This suggests that keeping teen mothers engaged in school has protective results for her and her child.

Demographic data from this dissertation also provided information regarding the level of involvement participants have outside of the home. The majority of these new mothers did not belong to any other groups or organizations aside from MBG during the time of this intervention. However, several of the participants stated that they had previously been involved in groups such as sports, clubs, or community groups, but had stopped these activities during their pregnancies. Without community involvement the main source of support for these young women was through family, partners, and friends. When these relationships are not present or are negative in nature the teen mother is left without consistent social support. Membership in various groups during adolescence is typically used to help the teen define their emerging identity. Similar to the trajectory of school achievement, memberships are often abandoned in order to focus on the task of mothering. The teen mother, then, is developing her identity primarily in relation to her role as a mother. Immersion in this role may leave the teen mother feeling as though other elements of her personality have been lost and increase her experience of isolation. Watt (2007) writes that teen mothers must balance their developmental tasks of adolescence and the competing development of a maternal identity. When this is done without the support of a community, friends, or family there task is much more difficult.

Self-Efficacy

The perception of being in control of one's fate is important for teenagers as they transition to adulthood and for new mothers as they take on the demands of parenting. Research on self-efficacy shows a high degree of self-efficacy correlates positively with goal attainment, the ability to stand up for one's values in relationships, and tendency to be in better physical health (Beets, et al., 2007; McKee et al., 2006; Salazar et al., 2004; Sharma, Hoelscher, Kelder, and Hergenroeder, 2009). Self-efficacy, however, has been shown to be lower in pregnant and mothering teens compared to their non-parenting peers (Young, Martin, Young, & Ting, 2001).

It is likely that one reason for lower levels of self-efficacy in teen mothers is their lack of confidence in their new role as mother. Without the belief that one is able to control the direction of their lives, it is more difficult to feel empowered to make decisions which will benefit one's self and lead to goal attainment. There is a negative cycle inherent in a sense of low self-efficacy in which one has lower expectations of their success and thus puts forth less effort to reach their goals. Their lower effort, then, leads to poorer outcomes and confirmation that they do not have sufficient power to make changes.

In order to feel efficacious, though, one must have a sense of the personal goals that they are working towards. This becomes more difficult for teen mothers, who are often reassessing their futures to incorporate the needs of their children. The teen mother is faced with the question of how she can balance her personal goals with the goals that she is developing for her infant. Goal development is likely an area where additional support can be useful. The teen mother may be in the middle of her adolescence and busy exploring her own interests and competencies or she may be an emerging adult who is looking for a way to utilize their strengths in the world. In either case, the teen mother must both explore her personal goals and secure financial security as swiftly as possible. Support and resources for how to accomplish this would be quite valuable.

Birkeland (2004) completed a dissertation on the topic of adolescent mothers and depression and determined that a low degree of maternal self-efficacy was a significant factor in predicting maternal depression. Encouraging teen mothers to develop a sense of self that integrates her various roles is one way that this population can be supported. Through self-development, teen mothers examine their values and ultimately use these values to craft personal goals for themselves and their families. Support in the areas of self-exploration and goal setting are two important elements of increasing self-efficacy in teen mothers.

The Experiences of Pregnant and Mothering Teenagers

This section further examines the identified core concepts to gain a better understanding about the difficulties faced by pregnant and mothering teens and the expressed needs of this research sample. Pertinent problems illuminated by the qualitative data of this study include social isolation, increased relational stress, and difficulty developing confidence in the mothering role. Similarly, population needs identified in this research include desire for appropriate and helpful information and an interest in more access to peer support. These issues are first contextualized with recent research findings and then elaborated upon using the MBG dataset with the use of pseudonyms.

Social isolation. The results of this dissertation support the findings of other research which purport that social isolation is an unfortunate part of teenage mothers' lives. It is a factor which puts them at greater risk for the problems associated with teen pregnancy and all other mental health problems. Holgate, Evans, and Yuen (2006) describe how, during Great Britain's examination of the phenomenon of teen pregnancy, their researchers adopted the term "social isolation" as a way of understanding the experience of this population. The findings of this research suggest that this is an apt phrase for the rural teenaged mothers in this dissertation project as well. The participants often lived in communities where, due to long distances and lack of sidewalks, it was not possible to walk as a means of transportation. Lack of a driver's license or access to a vehicle left them isolated from communities. Beyond this, there was also a general lack of space in which these young women could meet and connect. Those participants who were no longer in school had even more limited access to their peers.

The new mothers in this study spent large amounts of time in their homes with little contact to friends or peers. For example, one prospective teenage mother who was very interested in participating in the group was not able to because she lacked a driver's license and

could not secure a ride. Since graduating from high school, she had been spending every day inside the trailer she shared with her daughter and boyfriend which was situated on a dirt road that was not paved sufficiently during the winter months. While she longed to get out and do things, she was also fearful of taking her young baby out in the cold for the long walk into town.

Along with practical isolation caused by the location of their rural homes, there appears to be a degree of psychological isolation for pregnant or mothering teens as well. A psychological disconnect between the roles of mother and adolescent causes conflict for the teenaged mother as she attempts to meet the demands of each role. Friends often cannot understand the new stresses that these young mothers' face after the infants are born. As a result, their premotherhood friendships frequently deteriorate. One MBG participant, "Leah," shared with the group that she no longer had any connections with any of her friends from before her daughter was born. The loss of these friendships, then, exacerbates the new mothers' sense of isolation. The transition to motherhood generally causes women of all ages to feel a sense of insecurity in their new caring role (Mercer, 2004; Winnicott, 1986). Teenage mothers must manage these insecurities as they become estranged from their peer groups who had previously offered support and aided them in identity formation and while they are likely experiencing some degree of social prejudice related her status as a "teen mom." While teenage mothers tend to rely on family members for practical support with their infants they are largely forced to manage the emotional elements of this new role alone.

The social isolation encountered by pregnant and mothering teens generally makes it difficult for these young women to find cohorts of other new mothers with whom they could develop friendships and receive support. Leah spoke at length during one group session about going out the previous night with a co-worker who helped her complete her taxes. She explained that she had not been out with a peer in so long that simply going to a mundane task like filing

her taxes felt exciting. In rural regions, the barriers to these types of support networks are significantly greater due to limitations on transportation and access to the community. MBG provided a space for a small group of teenaged mothers living in rural settings to connect with one another as they transitioned to motherhood. The space was especially valued by the participants for the way it provided access to their peers who were also mothering. Participants bonded through discussing their shared experiences.

Disclosing personal difficulties was one way that group participants formed connections with each other and diminished their experiences of social isolation. When a peer openly described the challenges she was facing as a mother her fellow group members provided support by sharing similar stories of their own setbacks. For example, when one group member, "Sarah" spoke about her anxiety related to returning to school after her baby was born, a more experienced mothering peer was able to share what her struggles in the transition back to school included. Here, the newer mother was able to become more prepared for her own challenges and the more experienced mother was able to feel valued as a mothering resource. An important aspect of the connections that participants in MBG made came from sharing these vulnerable feelings about their difficulties transitioning into mothers.

Feeling incompetent is recognized as a common experience among new mothers (Rubin, 1967). However, this experience conflicts with prominent social expectations in the United States that women have natural mothering skills. Women, regardless of age, who struggle in the transition to motherhood, are at risk for feeling a lack of connection to other mothers who they perceive as better mothers or more natural because they assume that other mothers do not struggle in the same ways that they have. Feelings of shame and inadequacy are compounded for teen mothers who are further characterized by American discourse as especially ineffective.

When the participants of MGB disclosed their personal struggles as women and as

mothers a new and unique dialogue was created that was free from societal bias. This dialogue provided an accurate description of their personal challenges while also setting a new group norm that struggling as a new parent is normal. For example, when pregnant group members explained their fears about becoming a mother other pregnant participants and participants who were already mothering were able to echo this sentiment, thus normalizing these fears. During one of the first groups, "Becky" became tearful as she explained to the group her feelings that, "I don't know how to be a mom." Group members rallied alongside Becky demonstrating with their openness and support that feelings like this were acceptable as a mom. Once a disclosure of a fear or personal inadequacy was made by one group members, others shared similar stories about times when they too had felt this way. In response to Becky's statement, Leah, the teenager with the oldest child shared that she still had feelings like this even after a year of parenting. After empathizing with Becky's feelings, the other group member began offering advice and resources.

Personal disclosures like these seemed to activate the participants' problem-solving minds. Together they used their own experiences to reach group consensuses about a variety of topics, for example: how to determine what behavior to tolerate from their partner, how to manage pumping breast milk in a less than encouraging work or school environment, and how to comfort a gassy infant. The sharing that took place in MBG helped to normalize the struggles faced by teenage mothers and through this type of sharing relationships between group members were fostered. With the support of these new relationships, group participants could then take a problem-solving mind towards the issues discussed in group.

Increased relational stress. The relational lives of pregnant and mothering teenagers include friendships, relationships with family members (including their new child), and romantic relationships. Friendships that were strong prior to a pregnancy often suffer as the demands of pregnancy and motherhood shift the new mother's focus and values away from her peer group.

Relationships with family members and romantic relationships, then, tend to be teen mothers' primary source of support. These relationships are often not thought of as ideal from the perspective of the teen mother, rather, they should be considered as the most consistent sources of support that she has available.

These primary relationships experience increased relational stress during the pregnancy and in the postpartum period. Teenage mothers often find their feelings towards their partners to be more complex as they attempt to coparent. Similarly, relationships with immediate family members also become more intricate as the pregnant or mothering teenager struggles to find a balance in her simultaneous roles of daughter and mothers.

Adolescence is a developmental phase known especially for the importance of peer relationships. Research indicates that, when compared to their childless peers, pregnant and mothering teenagers have been shown to have higher levels of romanticized thoughts about their relationships (Medora & von der Helen, 1997). Medora and von der Helen explain that romanticism is considered to be the feeling of romantic love for a partner, or the act of fantasizing about this type of love with a partner.

Differences in levels of romanticism seem to indicate that pregnant and mothering teenagers were more interested in intimate romantic relationships than their peers. Interestingly, Medora and von der Helen (1997) found that those pregnant and mothering teens who were no longer sexually active had significantly higher rates of romanticism than their peers who were still sexually active (Medora & von der Helen, 1997). The writers concluded from this that teens who were no longer in sexual relationships tended to idealize the impact of a romantic relationship while those still engaged in one had more realistic ideas of sex and romance. Thompson (1995) also writes about the different ways which teen mothers view romantic love. She notes that often the young mothers she interviewed had the ideas of relationships, sex, and

true love mixed into one concept. If they had sex in their relationships then this meant that they were in love. By this logic, choosing to have their boyfriend's baby was a step closer to intimate love. However, the romantic notions that lead many teenage girls to sexual relationships are not typically what keep teenage partners together after their baby is born.

On the contrary, idealized conceptions about intimate relationships likely give teenagers a limited and superficial sense of how relationships work. Most couples find themselves arguing about new topics when they learn that they are going to have a baby. Baldwin and Richardson (1986), two childbirth experts, write that during pregnancy the normal fights in relationships become more intense due to the heightened emotions of pregnancy. Hohmann-Marriott (2009) stated in her research on the impact of pregnancy on non-married couples that there has been insufficient research into the impact of the relationship between partners on the health of the pregnancy and of their newborn. This is especially true for nonmarried teen couples. Hohmann-Marriott examined the impact of relationship stress on the health of the pregnancy and the newborn by reviewing details of the Early Childhood Longitudinal Study-Birth Cohort, which gathered specific information about parents, their relationships, and their birth outcomes. Hohmann-Marriott wrote that there is an increased risk for poor prenatal care when one or both parents did not intend to conceive. She concluded that engaging with both parents throughout the pregnancy is an important step that care providers can take to increase the changes of a healthy pregnancy.

Another study by Figueiredo et al. (2009) examined the intersections of pregnancy and relationships by interviewing 43 couples in order to assess the impact of pregnancy on relationships. These couples filled out the Relationship Questionnaire as well as a depression and anxiety scale to assess for concurrent mental health difficulties. Not surprisingly, researchers found that participants who had been happy to find that they were pregnant demonstrated higher

relationship satisfaction. Participants who were living together also demonstrated higher scores on the Relationship Questionnaire. These are two important factors to note for teen populations as the pregnancy is often initially a source of stress in the relationship and the parents commonly live separately during at least some of the pregnancy. Figueiredo et al. also found that irritability and negativity increased in the relationship as the pregnancy progressed. Figueiredo et al. did not specifically examine the impact of pregnancy on teen relationships. However, factors that they identified to be associated with increased relational stress in couples are often present in teen relationships.

The experiences of participants in MBG who were still involved with their children's fathers mirrors the findings of current literature related to increased relational stress. Teenage partners found themselves dealing with various new problems during the pregnancy and the postpartum period. None of the participants described their pregnancies as planned. On the contrary, many of the young women who participated had been moving towards completing different personal goals (most commonly educational attainment) before they discovered that they were pregnant. Sharing the news of the pregnancy with their partners, and later with their families, was described with several different emotions including fear, joy, ambivalence, and anxiety. All participants shared stories of how the pregnancy or their newborn had caused challenges in their relationships. Two of the relationships ended after the news of the pregnancy surfaced. For the remaining five participants, though, their partners intended to stay with them and to have the baby together. One mother whose partner had intended to stay with her after the birth of their daughter had separated from this partner approximately three months after the baby was born.

The sense of romance in their relationships was prematurely overrun by the intense and unwavering demands of preparing for, and caring for a new baby. Participants often felt a sense

of unfairness that they were not able to get space from the pregnancy, or the newborn the way that they partners could. The unmet need for space from the demands of their pregnancy, and later of their babies led these mothers to feel resentment and anger towards their partners. New mothers also worried about the degree of involvement the new fathers had with their babies. New fathers' hesitancy to interact with their babies left these mothers wondering about their partners' commitment to the family and their ability to be a good father. "Tracy" came in feeling depressed in the weeks after her son was born because she felt that she had to force her boyfriend to hold their newborn. Fellow group members identified with her and shared stories about how their own partners or infant's fathers transitioned into the fathering role.

An additional stress that these teen parents encountered was managing the needs of their own family in the context of the larger family system. At times, this included reconciling differences between their own parenting styles and those of their partners. Another example from "Becky" is illustrative of this point. She had been planning on moving to the new state where she had been accepted into college weeks before she discovered she was pregnant. After deciding that beginning college away from her family while pregnant would be too stressful she remained home in the fall and enrolled in a community college. Her boyfriend "Billy" and she had always had a close and low-conflict relationship. After their daughter, "Hannah," was born the young family all moved in together into Becky's parent home. This presented problems both because Billy had a conflicted relationship with Becky's parents and because his style of parenting contrasted greatly to what Becky had experienced as a child. She recounted during one group how he had been reacting harshly to Hannah while the baby cried during the night. For Becky, this lead to arguments with Billy about how to handle their daughter's needs, and with her own parents who wanted to intervene with Billy themselves. For them, they felt responsible for not only their teenage daughter, but also for their infant granddaughter. In their case, the

financial aid of intergenerational living was counterbalanced with Becky being forced into a peace-keeper role both in her relationship with her boyfriend and her parents.

Becky's experience highlights some of the causes of increased relational stress between teen parents. She and her boyfriend had different experiences as young children, which then informed their own parenting styles. This may not have been an aspect of their relationship that they would have had to manage if they were not co-parenting. The pregnancy also forced the young couple to come to terms with Billy's relationship with Becky's parents, an issue that would have likely seemed less pressing if they had not become parents. Neither Becky nor Billy had been expecting to become pregnant, but based on their personal values chose to have their daughter, and remain together. This caused new dilemmas in their relationship which had previously been quite conflict free. Through her involvement with MGB, Becky was able to engage with a cohort of other pregnant and mothering teens and hear about their experiences quelling the relational stress that pregnancy caused. Sharing her personal experiences with relationship problems allowed her to hear similar stories from her peers which normalized relational conflict. Sharing in this way also gave her a sense of what other girls in similar positions were willing to accept from a partner. For example, some of her peers had very strong reactions to hearing about Billy yelling at the baby. The group reached a basic consensus that this was something that Billy needed to work on in the future and that Becky should not tolerate in the future.

Becky was also able to use me as a resource for an opinion of a trusted adult who was outside of her family system. Validating her difficult position within her family was my first priority and next I attempted to help organize her priorities around her own personal needs and the needs of her daughter. My goal in supporting the participants in this way was for them to learn to advocate for these needs within their families and their communities. It was important to

keep a balance between validating the group member but not demonizing the other family members who often had conflicting points of view. Exceptions to these values came when family members were clearly causing emotional damage to participants or when the decisions of the participants compromised her safety or the safety of her child. For example, one participant's partner was incarcerated due the illegality of their relationship as she was 16 and he was over 20. While there was a no-contact order between these parents-to-be, the group member still considered his involvement in the pregnancy to be an important source of support. Her mother did not want any kind of relationship between her daughter and this partner. It was a delicate balance to validate to this participant and her perceived importance of this relationship, while also supporting this teenager's mother's parental rights and reinforce the message that statutory rape laws exist to protect children and teenagers.

In terms of increased relational stress with the family there is an important shift in roles which takes places when a teen daughter becomes a mother. If her parents continue to support her through her pregnancy the family must resolve this new role with her existing one of daughter. The roles of mother/daughter are often exacerbated by the degree to which teenage mothers are forced to rely on their families at a time when they would otherwise be becoming more independent. Specifically, the economic demands of pregnancy and mothering often force teen mothers to rely on their families of origin for housing, financial support, and babysitting. While the support new teen mothers receive from their families of origin is vitally important to the welfare of the new families, it does not come without complication. It is likely that relationships between parents and their pregnant or mothering teenagers are subject to increased tension because of the "dual developmentalism" inherent in teenage parenting.

In the developmental stages of adolescence and emerging adulthood there is time for the teen to try out the responsibilities of adulthood by living on their own for the first time, or taking

on their first full-time job. However, when the adolescent or emerging adult's time is occupied by transitioning to parenthood as well, there is little room for exploration or more traditionally autonomous functioning. "Leah", who lived independently with her one-year-old daughter, "Rory", expressed frequent frustrations between herself and her mother "Donna" who would watch Rory while Leah worked full-time. One fight involved Donna becoming angry when Leah wanted to spend time with friends after work. Leah was frustrated that her mother did not see how hard she worked and realize that spending time with peers without Rory was important to her. Donna felt that Leah was asking too much for this extended babysitting time and failing to appreciate the additional demands that Rory had brought to their family system.

Along with managing the changes brought about by the teen becoming a parent and the parent becoming a grandparent, the extended family is also still managing the stress of the teenager becoming an adult. The participants of MBG were generally focused on the adolescent task of individuation. For them, individuation included taking on the role of mother, finding a job, and making plans for living in their own home. The families of these teenagers, though, often still viewed their daughters as children. The conflicts regarding the role of the teen mother in her extended family caused significant stress to the participants. Participants told stories in group about how these relational tensions were enacted. One participant had to ask her mother to stop waking in the night to feed her newborn. "Sue," who accompanied her daughter, "Grace," and Grace's newborn son, "Felix," to the first group admitted she had been stepping often in care taking for Felix. Grace was grateful for her mother's help, but also noted that she needed to learn to take care of him herself because she was his mother. In a follow-up letter from Grace after the completion of the group, she informed me that she and Felix had moved down south to be with other family members due to the high stress level of living with her mother.

The established power dynamic between a teenager and their parent in American society generally allows the parent/s to have the rights to make decisions for their child until age 18. When a teenage daughter becomes a parent herself her own need to develop parental control of her infant must contend with this established parent-child dynamic. When the new grandparents are able to view their teenage children as new parents with natural needs for autonomy both as adolescents and as new parents there is less likelihood for family tension. However, when the parents of teenager parents are rigid and operate from authoritarian values of control there appears to increased relationship tension resulting in less perceived support for new teenage mothers. This is a complicated issue, as the new grandparent still has legal responsibilities over their teenage daughter until eighteen. The teenage parent, though, holds the legal responsibility of their own child. If the parent of a teenage mother is concerned for their daughters' ability to keep herself and her own child safe, it is the new grandparents' responsibility to provide safety and facilitate growth. The difficulty here lies in providing this safety in a way that empowers the teenage mother to gradually step into the mothering role.

Empowerment in the mothering role. Empowerment, or the sense of autonomy, control, and mastery, is easiest when one's culture recognizes the value of a specific role or identity. The relationship between the new mother and her support network had a significant effect on her confidence in the mothering role. The teen mothers' own attachment figures play an important role in helping her transition into an empowered mother.

SmithBattle (2006) writes that prejudice against teenage mothers is a factor which has a negative impact their ability to accomplish their personal goals. This belief is also supported by Shanok and Miller who explain the important implications that study's designs have on the results,

> Though the vast majority of data are correlational, the assumption has been that teen parenting has *caused* the above outcomes. A few pioneering studies have called into question the methodological error of assuming that teens who became mothers would have had the same life trajectories as teens who did not, had they delayed pregnancy (Geronimus & Korenman, 1993; Hotz, McElroy, & Sanders, 1997). When more comparable control groups were used, such as sisters of teen moms and teens who had
>
> miscarriages, the economic and career gaps between women who give birth as teenagers and those who give birth later are significantly narrower.(p. 252)

There was not an objective measure used with the participants of this dissertation which specifically identified their socioeconomic statuses, however, they did provide information about if and how their parents were employed. Six of the seven participants listed their parents' jobs as some form of working class position. An additional member reported that her mother was unemployed. The societal bias which influences research on teen pregnancy also affects teen mothers in their day to day lives. Stereotyped teen mothers are portrayed as reckless parents who depend on government assistance and give little consideration to having more children. Inherent in these stereotypes is a lack of understanding of the traditionally limited options encountered by poor girls.

The stories shared by participants of MBG clearly communicate the personal impact of American societal bias against teen mothers. One participant's experience with the hospital exemplified this issue. Tracy had experienced several instances throughout her pregnancy with her son, "Jake," when she felt that her nursing staff and doctors caring her for were not taking her concerns seriously. Often her complaints of physical discomfort were explained as simple side effects of the pregnancy and in group sessions she wondered if her age was influencing how

they viewed her.

When Jake was born towards the end of group, he and Tracy faced several complications. After an emergency cesarean section, Jake had to be transferred to a hospital two hours away when they learned that he had inhaled meconium. When Tracy was finally able to be discharged from the hospital and see Jake again she learned that the hospital staff had given her boyfriend and mother-in-law the special privilege of being in Jake's newborn pictures. These photos were part of a program the hospital ran and were typically pictures of the newborns and their parents. Tracy had been aware of this program and had envisioned Jake' pictures as including him, herself, and her boyfriend. Being replaced with her mother-in-law in the photos was a clear message to her that neither her extended family nor the hospital staff viewed her as the mother. The assumption that teenage mothers are not equipped to care for their children delays their empowerment as women and as mothers.

Some MBG participants noted that the medical staff that provided their prenatal care were dismissive of their complaints. One participant felt so angry with a nurse who told her the pain she was experiencing was not related to labor that she refused to be cared for by this woman again. A difficult dilemma arises here. As the teenage patients feel invalidated and have less patience with staff, the staff may view the teenager as overreacting and consequently have less compassion towards them. This cycle leaves the care providers frustrated, and the teenagers feeling judged and untended. Skepticism from care providers regarding teenage patients' knowledge of their bodies may be internalized by teen mothers as a sense of insecurity in their maternal intuition.

Teenage mothers' experience of being recognized and respected as mothers by their local community and their families has a significant effect on their ability to gain confidence and empowerment as mothers. Confidence in one's ability to parent is a key element of what Mercer

(2004) calls the final stage of maternal role attainment. In order to reach this level of comfort in the mothering role, one must have access to some relationship in which they are valued as a mother. For the participants of this study MBG was a place where they could be recognized by their peers as young women who were also mothers. They were able to share their knowledge, their experiences, and their mistakes in order to help other pregnant and mothering teens. I was also able to act as a mentor in the role of the group facilitator and provide a different prospective, information and resources, and positive regard. While these young women still had to face prejudice in their everyday lives, they were able to craft a shared narrative about their own experiences of marginalization, and to agree as a group that they had something important to offer themselves, their families, and their communities.

The voiced needs of pregnant and mothering teens. Current literature regarding the expressed needs of pregnancy and mothering teens is significantly limited. There is an abundance of research which provides outside perspectives offering insights to what this population needs; however, a lack of research focused on the actual reports from teen mothers. One such finding was Judith Herman's (2006) ethnographic examination of second pregnancies during adolescence, and the second was a dissertation completed by Juliann Mangino (2009) which explored teen's mothers descriptions of their experiences in the educational setting. It is therefore a primary goal of this dissertation to offer the voices and insights of the teenagers in this study regarding their own most pressing perceived needs.

As a group, the expressed needs of MBG participants reflect a desire for information and more opportunities to be in group settings with mothering peers. The teens in this sample described needing a variety of kinds of information. On one level, they were looking for connections to community resources which could provide them with material needs such as baby clothes or car seats. Participants also expressed interest in information regarding local resources

which could help them secure Medicaid coverage for their families and finding assistance in pursuing child support. MBG participants described the completion of high school, finding appropriate day cares, and securing affordable housing as areas in which they need more resources. The other form of information that participants expressed a need for was education about pregnancy and childbirth. The participants of MBG were interested in learning about what they could do to have healthier pregnancies, and be healthier mothers.

There was specific expressed interest in the topic of self-care. During group sessions I offered the framework of the mind-body connection as a way in which participants could understand their overall health. This focus encouraged participants to take an active role in their health by finding simple ways to reduce their experience of stress. Often times, there were many things happening in the participants' lives that they had little control over. Simple and brief self-care activities such as diaphragmatic breathing, developing and reviewing personal affirmations, and scheduling time to engage in pleasurable activities allowed busy teenagers to make small but important changes in their daily life.

Every group ended with some kind of closing activity. This activity was often a mindfulness skill that we practiced as a group. Participants voiced much enthusiasm for this time in group when they could essentially distance themselves from their worrying minds and long lists of upcoming tasks and simply be in the moment. Practicing these skills during group also prepared the participants to bring the skills into their daily life. By focusing on the importance of caring for themselves the participants felt independent and able to positively affect their health. Because the lives of pregnant and mothering teens are filled with external demands, it is especially important to focus on simple self-care exercises which are not time-consuming and can be integrated into daily routines.

Another specific need that the participants of MBG described was their desire for more

opportunities to find peers in their communities who were also parenting. One group member noted at one of the last group sessions that there was, "Nowhere to see other young moms." She further explained that many other situations when she had interacted with other teen moms the environments were less supportive than the group setting. The value placed on their group experiences is likely related to the sense of social isolation faced by these teenagers. MBG participants, like most adolescent girls, had been defining their identity based on their social relationships. In the process of their pregnancies and first year of mothering, many of these teens had lost important relationships in their lives. The friendships which remained were difficult because peers who were not mothering understood little of the teen mothers' every day balancing act. Leah stated that the only peers that she did feel connection with were her co-workers who were maintaining a job while going to school. She felt that they, at least, had some similar experience feelings overwhelmed by responsibilities. By having the chance to meet other teenagers who are also mothering or preparing to mother, the teens in MBG had the chance to develop relationships where they could be seen as mothers and as teenagers.

Reflections on MBG

The final goal for qualitative data was to give participants a chance to reflect on MBG and provide suggestions for the future. Allowing participants to reflect on their experience and offer ways to make the group better was considered to be important in providing participants with a sense of closure from the group process and to give them the power to have a positive impact on the future of the program in an important way. The overall response to MBG was very positive. Group members suggested that the group be held twice a week, last for longer periods, have more participants, and continue longer than eight weeks. Seeing their own struggles reflected in their peers showed participants that they are not alone. This information allowed these teens to have more compassion with themselves. The group facilitator worked to

both validate the depth of their struggles while also normalizing them as part of the transition to motherhood.

Integrating knowledge about mothering with one's own sense of self is an important part of the transition to motherhood (Mercer, 2004). The group environment gave participants a chance to view how other teenagers had adapted into the mothering role. The pregnant and mothering teens in this sample communicated a need for more support regarding their transition to motherhood in their desire to be acknowledged as a mother and their interest in finding information to help them parent. These messages will be taken into consideration as the development of MBG continues.

Researcher's Reflections of MBG

Qualitative data from the participants of MBG demonstrated some of the common problems of teenage motherhood. The complexity of their lives provides valuable feedback in terms of program development for this population. MBG was determined to be a helpful and worthwhile service for pregnant and mothering teenagers in the rural area where it took place. The participants valued time to bond and support one another as they transitioned from teenagers to mothers. It is my intent that the feedback from these participants be integrated into the future of MBG through increased focus on maternal role attainment and I advocate for the group to be a continuous service in the settings where it is offered.

I propose expanding MBG into two separate group experiences. The first group would be similar to the current curriculum, but with increased focus on the process of maternal role attainment. This material would fit in nicely with the schedule for the third group session, which focuses on developing a concept of motherhood. In order to increase the elements of maternal role attainment, as described by Mercer (2004), this group session would elaborate upon an activity in which participants will speak about who they view as "mothering role models." If

participants have difficulty finding a role model among the mothers in their own life, they would be encouraged to use characters from movies and literature. This activity would also include a discussion where the characteristics of these ideal mothers will be examined. Through this activity the participants would be encouraged to consider what important characteristics of a mother are, and how they can personify these characteristics as a mother. With more attention to the process of becoming a mother in MBG, these teens will experience more support, and empowerment through their transition.

The second section of MBG would be a continued weekly group session which is free of scheduled activities. Participants who have completed the first eight sessions of the group will be *ambassadors of knowledge* who can educate other mothers who choose to come to the group but were not able or interested in attending the first eight sessions. Ideally, this group would run continuously with new mothers coming in as older mothers phase out. This phase of the intervention would maintain the relational frame, and allow the group participants to use the group sessions to discuss any topics relevant to the group. This is considered important because stress levels can increase dramatically after the participants' infants are born. Additionally, having the group open to any teen mothers regardless of the age of their children will allow a larger sample of teen mothers to receive support. Because attrition is always a problem for programs which serve adolescent mothers, this will also increase the number of participants in the group.

In light of the high degree of inter-dependence between teenage mothers' young families and their families of origin, it would be practical for MBG to extent its purpose towards involvement of these larger family systems. One manner of reaching this goal might be to hold multiple family groups. These might be a separate group which operates alongside the group for mothers only which invites fathers of the babies, new grandparents, and any other extended

family member who is providing support to the teen mother. The focus of this group would be to offer support to these families as they transition in order to accommodate the new infant and the new mother. The increased relational stress which begins with the new of a teen pregnancy could be explored and families could learn from one another how to best foster healthy attachments between the family and the new parents and the new parents and their baby.

Unexpected Findings

Just as new mothers learn as they go when caring for their newborns, the process of program development and action research was full of in-the-moment learning. This section explores the unexpected findings from MBG. This includes the role of family members, participant attrition, and the role of the group facilitator. This information is then used to make suggestions for future interventions with this population.

The role of family members in the group process. The first surprising aspect of MBG involved its participants. Teens who were already parenting were told that they were welcome to bring their children with them to the group sessions. However, the practicalities of traveling with a newborn and securing transportation for a group of mothers, some of whom did not have cars or driver's licenses, required the help of their family members. The presence of these involved family members underscores the significant impact which current literature attributes to family support for teen mothers. For example, Stevenson, Mati, and Teti (1999) conducted clinical interviews and gave questionnaires to teenage mothers about their social support and self-esteem. They concluded that teen mothers who perceived higher support from their parents had higher self-esteem. Benson, (2004) a social worker who has written about teenage pregnancy, states that the goal of the social worker in family systems with a pregnant teenage daughter is first to promote healthy communication between the pregnant teenager and her

parents. The emotional support of parents and other family members is an important factor which affects the lives of pregnant and mothering teens.

The family members involved in MBG came in and sat with the participants as group began and occasionally opted to stay for the group sessions. MBG had mothers, nieces, and sisters attend group at different times. These unexpected participants initially presented a potential problem in the confidentiality of the group. However, it became readily apparent that these family members provided valuable help as they bounced fussy babies, mixed formula for the mothers, and allowed the teenage participants to focus instead on the group process.

The solution to the dilemma of confidentiality with family members emerged from a group discussion. The facilitator and participants had a conversation about how they felt about family members' presence in the group. The group decided that family members were helpful, but acknowledged that there may be times when they would not feel comfortable speaking freely in front of them. The group agreed that at the beginning of each session there would be time for participants to decide separately if they wanted to welcome family members to the group session. The family members that were welcomed were informed of the confidentiality policy that the group participants had agreed upon. They were told that, if they wanted to participate, they had to consent to these conditions.

The involvement of family members, though not expected, proved to be a positive factor. This happened in a number of ways. The participant's mothers brought a new perspective to the group discussion. For example, Leah brought her mother, Donna, to a group session which focused on sexual education. At the beginning of the conversation, I had provided some information about reproduction, sexuality, and the impact of social messages about these two areas. As I tried to engage in a group discussion, there was a lack of engagement from participants. Eventually, Donna broke this silence by saying, "You know, what they never tell

young girls is that sex actually feels good!" The other participants all agreed with her sentiment and it lead to a new line of discussion about the mixed messages that adolescents receive about sex. This mother's ability to speak openly about sex gave the participants a chance to have an honest and productive discussion about the benefits and costs of sexual behavior.

The voices of the participant's mothers, in particular, were valuable in showing how the stress of becoming a mother is universal. These new grandmothers spoke of their own insecurity as new mothers. One grandmother discussed being a teenaged mother herself, and how her own goals had to wait while she cared for her children. Other mothers who gave birth in their 20s also shared their own fears related to personal competency in the role of mother. Hearing from these older women gave the participants the chance for their feelings to be validated, to see an example of how other mothers adapted into the role, and to understand that anxiety is a common experience for new mothers, regardless of their age.

Finally, the experience of having family members participate in MBG created an additional bond among the group members. They were given the chance to meet one another's family, and see their family dynamics. Later in the group, when one of the group members discussed a fight with her mother, the other participants understood the situation in a deeper way because they had witnessed the relationship themselves. While having family members attend meeting was not planned for, it was helpful as practical way of getting the participants to group, and adding important elements of motherhood to group sessions.

Attrition. Another unexpected finding involved attrition. Attrition occurred at all steps of the process from group recruitment to research evaluation. Attrition is an issue often discussed in literature regarding service delivery for teenage mothers. Anderson, Smiley, Flick, and Lewis' (2000) report findings that lack of transportation, lack of information about the

importance of serivces, and lack of health insurance acted as roadblocks to service delivery for this population. These factors had a negative impact on the accessibility of MBG as well.

The research design of MBG had planned on utilizing the integrated health care frame already present in the OBGYN unit of the hospital where the intervention took place, to make it easier for the teenaged population to attend group sessions. This was minimally successful. During the recruitment phase of this project, screening meetings with prospective participants were scheduled around pre-existing medical appointments that they had at the hospital. When the prospective participant missed her medical appointment, she also missed the initial meeting with me. Other times, the potential participant went to her medical appointment but forgot to attend the screening meeting. During the intervention phase, I created a list of all group members and sent it to the hospital's administrative assistants. It was hoped that the administrative assistants would schedule the group participants' medical appointments directly after or before the group meeting to minimize transportation issues.

While the primary administrative assistants were aware which patients were participating in the group, scheduling proved to be difficult. Not all providers were available every day of the week and some were only available in morning hours. MBG met from 5:00 p.m. to 6:30 p.m. so as to allow participants to get to school or work. Most medical staff worked until five in the afternoon which reduced the chance for appointments to be scheduled after group. Additionally, the primary administrative assistants who were aware of MBG were not always at the desk to do scheduling. When other administrative assistants were working at the desk, they were not aware to schedule the participant's appointments alongside the group sessions. Participants were also being scheduled for visits by other departments of the hospital, most often pediatrics, for their infants' appointments. These departments of the hospital were not made aware of the scheduling arrangement. In general, this strategy did not cut down transportation problems as desired.

Integrated healthcare was found to be a promising model as it allowed for better communication of the participants' mental health needs to their other care providers, but is simply not as convenient as in-school or in-home programs.

Group members also dropped out as the group continued. One reason was surely the demand of securing transportation to the hospital each week. One prospective participant was very interested in being part of MBG, but did not have a car, or a driver's license. A social worker who was assisting this teenager through a separate community program explained that it would be impossible for her to provide this transportation on a weekly basis because the teenager's home was so far from any of her other clients. This young mother's situation demonstrates how even teenagers who are actively engaged with community supports are not always able to utilize all of the services that they need. Work schedules kept other participants from continuing to attend group. These participants often explained that, while they continued to have interest in participation, they had to prioritize making money to support their children. Other participants had to stop coming because of health/pregnancy medical issues, including required bed rest. Implicit in these underlying factors of attrition are the complex and demanding needs that teenage mothers must balance, while caring for themselves and their children.

Three group members gave birth during MBG. Surprisingly, two of these participants came back to the MBG sessions directly after having their babies, and another only missed one session due to the fact that her infant had to be transferred to another hospital for more intensive care. As these mothers progressed further into the postpartum period it was more difficult for them to attend group sessions. One example that succinctly demonstrates the chaos of the postpartum period happened at the last group meeting. A participant who had attended group sessions faithfully throughout the intervention did not come. This was all the more surprising

because I had called her the previous day to remind her about group. When I called her the next day to check in, the participant explained that she had been talking about the last group all day, and mentioned it to several different friends. Then, after getting her newborn fed and changed, doing laundry, and eating dinner she realized that it was 8:00p.m., nearly three hours past the meeting time. This group member's decisions to first attend to the needs of her newborn demonstrates both her own natural maternal tendency and the difficulty at prioritizing one's own need for self-care in the first months of motherhood.

All of these issues of attrition might be helped by holding a group in a school during school hours or by providing transportation. Other interventions designed for school settings are able to avoid attrition more successfully. One example of such an intervention is "The Caring Equation." This is described by Robbers (2008) as a school-based program designed to educate teenage parents about child development, provide support and resources for education and vocational training for teenage parents, and provide interagency resources. Robbers evaluated the impact of this program on paternal involvement, as well as its impact on both parent's attitudes towards their children. Results indicate a high level of continued involvement throughout the program which appears to have a positive impact on teenage parents' attitudes and behaviors related to parenting.

An unexpected finding similar to attrition was the frequency with which this population moved to different homes after completion of MBG. These frequent moves made it more difficult to obtain post-intervention questionnaires and surveys. Five of the seven participants moved to a new home either during the intervention or in the following months. This made it difficult to obtain both the before intervention measures as well as the post intervention measures. These housing transitions often involved the participants moving out of their parents' home, which is characteristic of the emerging adult population. In the future it would be ideal to

have participants provide a phone number of a family member who would be able to aid the researcher in tracking the teen's home address.

Role of the facilitator. The role of the group facilitator in this intervention had surprising importance that was not recognized prior to MBG. I had envisioned my primary responsibility as the facilitator to develop and maintain empathic and authentic relationships with each group member, as well as foster these types of relationships among group members. Furthermore, I expected to act as an educator on issues related to psychological wellness, pregnancy, and mothering. Along with these roles, though, I also became a mentor for the participants of MBG. While I did not expect to become such a salient aspect of the intervention in this way, the mentoring role expanded the relationship between myself and participants, and as a result, the power of the group experience.

Karcher (2005) found that a dependable mentor figure has a positive impact on the mentee's self-esteem, social skills, and behavioral competence. This type of relationship is especially important for new mothers as well as for emerging adults (Arnett, 2011; Mercer, 2004). Mercer suggested that the presence of a mothering role model who can act as a mentor is helpful in giving new mothers examples of their new role. Spencer and Liang (2009) conducted interviews with mentors and their female adolescent mentees. They stated that the following factors appeared to be central to the success of the mentoring relationship: close emotional bond, engaging in enjoyable activities, reliability on the part of the mentor, and sharing skills/information.

I had the opportunity to take on a mentoring role in a special way because I was in the third trimester of my own pregnancy during the group sessions. Because my pregnancy was at this stage, it was physically obvious to group participants. The choice to disclose this personal information was, therefore, decided just by the timing of the group. It was not clear prior to

MBG what this would mean for the relationship between participants and me. Quite early on in the screening process the presence of a pregnant group facilitator proved to be a positive factor. Participants showed an openness to engage in a therapeutic relationship with me which quickened development of therapeutic rapport, a process that typically takes longer time to establish. The experience of empathy for me was heightened in many ways as I was feeling the strain, joy, and anticipation involved in my pregnancy.

This experience also meant that I had to work harder to ensure that my own experience of pregnancy was not biasing her from being open to how pregnancy felt to the participants. The most positive way that this factor affected the process of the group involved me stepping into the learning space along with the participants. Participants who had older infants had valuable information from their mothering experience that I, pregnant with my first child, did not. The desire for more information about parenting was, then, an authentic personal characteristic which participants appeared to appreciate.

Spencer and Liang (2009) state that one aspect of helpful mentoring relationships is that both the mentor and mentee have freedom to teach one another new skills. The effect of participants sharing their mothering knowledge with me produced a reversal of the power dynamics typically found in therapeutic relationships and resulted in empowerment in line with my initial design for the group. The role of facilitator-as-mentor as well as the other unexpected findings from the MBG experience contain useful information for program development.

Clinical Implications

The results of this dissertation project indicated that MBG was supportive of self-efficacy. Also, the project demonstrated that a therapeutic group intervention was helpful. The findings from this dissertation project will now be synthesized into suggestions for further intervention and research with populations of pregnant and mothering teenagers.

Implications regarding the intervention. The utilization problems that this intervention faced are a good example of the problems that care providers encounter when serving teenage parents and, thus, hold helpful lessons for future delivery of services. The tasks of reaching out to this population, providing accessible services, and maintaining their participation in the face of various other responsibilities, are daunting tasks. For this reason, it is suggested that care providers do one of two things. First, holding the MBG meetings within schools appears to be a good alternative to placing the burden of travel on perspective teenager participants. Second, working with other community organizations which may already provide case management services would give pregnant and mothering teenagers more support in the pragmatic issues related to transportation as well as a different level of support. Utilization problems encountered by the population of pregnant and mothering teens are a result of their busy lives and the lack of power that they have as teenagers. The more service providers can do to make interventions readily available to teens during pregnancy and in the postpartum period, the better will be the utilization.

While MBG did struggle with ensuring that pregnant and mothering teens had easy access to the intervention, this program did have several elements which are considered important for future program development. The clinical aspects of this intervention were intended to help pregnant and mothering teenagers to feel in control of their own lives. The first step in accomplishing this was connecting participants to tools such as psychoeducation, and information about community resources. Specifically, the topics of reproductive health, self-care, and managing relationships were found to be especially useful for participants. MBG also aided participants by connecting them with the services of the Pregnancy Wellness Program, which they could utilize after the group ended. While most hospitals unfortunately do not have such comprehensive mental health care for pregnant and postpartum women, many communities

have individuals who work to coordinate supportive services. It would be useful for future MBG facilitators to have individuals from other community resources attend a group meeting and give a brief presentation about what services are available and how to obtain them.

The next step of developing empowerment through self-efficacy in MBG involved giving participants some practice with new tools they were learning, through problem-solving discussions and skill-building activities. Skill-building activities were found to be useful in offering the participants practical ways to integrate important information into their lives. For example, after one group meeting that involved psychoeducation related to reproduction the participants were given small calendars and challenged to calculate the most fertile days of the month. These types of skill-building activities are described by Allen et al. (2007) as important elements of psychoeducation with pregnant teenagers. The group environment was one of support and encouragement so that these new mothers and mothers-to-be could develop confidence in their own mastery of various new skills.

MBG also demonstrated the importance of having social support in the process of maternal role attainment. Teen mothers experience less social support than older mothers in this transition. One apparent reason that this occurs is difficulty on the part of family and friends in integrating the teenager's new role of mother with her prior roles (daughter, friend, or girlfriend). Other teenage friends are not aware of the demands of mothering, and the friendship suffers, or the family's previous dynamics are complicated by the teenager's simultaneous need for both dependence on the family unit, and independence in establishing her own family. As a result of these situations, teen mothers feel more isolated and have more trouble moving through the developmental path of motherhood with ease and comfort. Mercer (2004) states that new mothers who have strong social supports available show more confidence in the role of mother. Mothers who feel confident are less likely to experience anxiety and depression, issues that also

affect the relationship between mother and infant. Essentially, when a new mother feels more supported by her environment she is better able to turn her attention towards the developing bond between herself and her newborn, and take better care of herself.

Through MBG, participants were given the opportunity to form relationships with mothering peers and with an older female mentor figure. In this setting they were able to be fully appreciated for the intersection of all of their identities: mother, daughter, partner, friend, and teenager. The development of a community with other individuals who hold similar cultural identities and the experience of being accepted by this community is considered to be an essential step in various racial and sexuality-based identity models (Caitlin Andrew, personal communication, June 1, 2012). Community development counteracts the oppression inherent in living in any one minority group. The participants of MBG were able to step outside of the narrow definitions of teenage mother offered by American society and craft their own which appreciates their lived experiences and wisdom as mothers. Development of such subcultures can provide accurate mirrors for pregnant and mothering teens that they can feel empowered in their many roles.

Another clinical perspective gleaned from MBG involves the ways that relationships between the teen mother and her family of origin can be integrated into an intervention. The unique relationship between teenage mother and her family can be both a negative and a positive factor in her life. Teen mothers generally had not expected to be relying on their families. However, the support of the extended family and any other available family context gives the teen mother better chances of avoiding the social problems which are typically associated with teen motherhood. Practical steps which intentionally enroll and welcome the family members as supports in transportation and babysitting would likely have a positive impact on service utilization. Conceptually, it would help the teen mother to garner healthy relational support at

home by focusing on how the family could help to recognize the teen as a new mother and support her on this path and support her parents/caregivers in their role transitions. Along this same line, future interventions which consider the needs of teen fathers would be extremely beneficial to these young family systems.

An important clinical aspect of MBG was its relational approach. As research suggests, the teenage mother is relational in nature (Gilligan & Brown, 1993). Her greatest struggles involve a sense of disconnection from her peers, balancing existing relationships with the demands of mothering, and developing a loving bond with her child despite the many stresses in her life. The MBG curriculum and its findings encourage a strong advocacy for the availability of relationally-informed group environments for pregnant and mothering teenagers. The simple act of being with one another in a space which fostered relationships gave group members feelings of connection and support.

Implications for future research. The challenges and successes of this dissertation project have important implications for further research with the population of pregnant and mothering teens. Because of this small sample size it is very difficult to generalize these findings to larger populations. Further research on the impact of MBG on self-efficacy is suggested in order to draw conclusions about the helpfulness of MBG. Qualitative exploration into personal characteristics commonly found in empowerment research such as perceived social support, self-esteem, and locus of control would also be good indicators of whether or not MBG builds resiliency.

In terms of the use of qualitative data, some simple methodological changes would be helpful for future research. The data gathered through the open-ended questionnaire in this dissertation project was intended to explore the needs of MBG participants as well as their perceived helpfulness of the intervention. The use of an open-ended questionnaire, though,

seems to have circumscribed the depth that participants gave in a dramatic way. Their reflections on the group intervention were, indeed, helpful in assessing this program. However, participants generally described what they felt was helpful in a few sentences. A more detailed questioning through a series of personal interviews would likely generate rich dialogue.

Continued research into the lives of pregnant and mothering teenagers will better illuminate the complex problems that they are facing in society. Work in the action research frame would allow services to be uniquely informed about the needs of these young women. The better that the psychological community understands these needs, the more useful services for this population will be. As well, a deeper understanding of what works for this population makes psychologists excellent advocates for public policies which can vastly alter the lives of teen mothers and their children in the United States.

Implications for Public Policy. The availability of a cohort with similar developmental goals and a sense of support and security is an experience which could benefit many pregnant or mothering teenagers. Sadly, this is out of reach for most teenage mothers. Public policy is an important avenue to consider when exploring the availability of appropriate services for pregnant and mothering teenagers. The impact that national, state, and regional politics have on the lives of pregnant and parenting teens is immense. Policies can determine whether or not they have access to comprehensive reproductive education, birth control, safe abortions, healthcare during and after pregnancy, welfare and/or a living wage to support their children, and safe day care options so that they can work or finish school.

Much of the focus on teen pregnancy in the United States is on prevention. Unfortunately, the most common prevention policies do not include the essential triad of comprehensive sexual education, easy access to a variety of birth control methods, and safe abortions that would give teenage girls the most control over their reproductive lives. If the

focus on public policy in the United States shifted to assessing the needs of teenaged mothers, and meeting these needs with resources, the negative impact of teenage motherhood could diminish substantially. Research on pregnant and mothering teenagers holds a hopeful and important message regarding the kinds of resources that are most effective. When teenage mothers are given the resources that they need, they are more often able to achieve personal goals and raise healthy children. The programs which show these positive impacts typically involve case management, increased social supports, and educational advocacy (Allen et al., 2007; Robbers, 2008; Seitz, Apfel & Rosenbaum, 1991; Seitz & Apfel, 1994). Public programs that currently support the needs of teenage mothers vary greatly from state to state and from town to town. To ensure that all teenage mothers have equal opportunities increased advocacy is needed for this population on a national level. A focus of such an advocacy campaign should include the difficulties faced by these young women and their children, and research findings that demonstrate how they are able to overcome these hardships with the appropriate interventions.

Conclusion

Pregnancy is the optimum time for a teenage parent to be guided along a safe track towards health, stability, and future opportunities. This is a period of time when these young women require high levels of involvement from care providers as they have a variety of needs ranging from prenatal care to case management and mental health services. It is also a time of significant life changes and growing stress. When teenage mothers can be connected to services during pregnancy there is also good evidence to suggest that they will have better chances of avoiding or minimizing postpartum depression, which can have severe effects on both mother and child. The literature suggests that supportive interventions during pregnancy can also increase educational attainment in teenage mothers and prevent second pregnancies during

adolescence. Pregnancy is the time when services should be established, relationships with care providers should be formed, and teenage mothers should be empowered to take an active stance as they interface with various social systems. When the newest generation of teenage mothers have access to these kinds of resources they will have immense power to change the American discourse about what teenage motherhood means and includes by being healthier individuals who raise healthier children.

During the transition to motherhood, teenagers are under significant stress. The results of this dissertation project suggest that by merely allowing these young women to develop relationships, gain a sense of empowerment, and have access to resources, they are able to feel more in control of their lives. Teenage mothers want to be good mothers; they need social support from their families and communities in order facilitate successful maternal role attainment.

A metaphor regarding the internal path towards health is fitting here. One day a man was walking down a dirt road and saw a horse with a saddle. The horse had no rider and there was not a farm for many miles. The man got on the horse and an hour or so later arrived at the horse farm. The farmer came out delighted, but also surprised, "How did you know he came from this farm?" he asked. The rider replied, "I had no idea of the way. I just assumed the horse did." Through authentic relationships which imbue confidence and empowerment, care providers can similarly help teenage mothers direct the course of their lives. The mothers participating in MBG needed an encouraging environment to discover their own paths. As one group member simply and eloquently noted when asked to describe what was most helpful about this intervention, "I think just talking and sharing our feelings is enough." Teen motherhood is a difficult journey. It is my hope of that this project is a small step towards the larger integration of the experience of teenage mothers into the services that assist her. By utilizing the wisdom of

the current generation of pregnant and mothering teenagers, service providers can contribute a valuable guide to the next generation.

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Appendix A

Flier for Recruitment

A New Group for Teen Parents is Starting

Support and education for teens on the road to motherhood.

The group:

- **Begins soon!**
- **Meets once a week for an hour and fifteen minutes**

You'll get the chance to:

- **Get a chance to meet other young mothers**
- **Learn about your pregnancies**
- **Support one another**
- **Work on understanding relationships**
- **Explore motherhood together**
- **Dinner will be provided**

Part of the Pregnancy Wellness Program out of Cheshire Medical Center

Collaboration with Girl's Circle

Appendix B

Script for Recruitment

Hello _____. My name is Megan Turchetti, I work with the Pregnancy Wellness Program at Cheshire Medical Center. I am putting together an educational and support group for pregnant teens. I was given your name by _____ *(provider),* do you have a few minutes to talk with me? ***(If yes proceed, if no- ask if there is a better time to call).***

I will be running a group later this summer for girls ages 14-18 who are pregnant or who have recently given birth. The point of the group is so that you can explore issues like coping with stress, learning to be a mom, balancing relationships and self esteem.

I will be running this group as part of a research project for my doctoral degree from Antioch New England University. Along with running the group I will be asking participants to fill out some surveys before and after the group. If you would like to be part of the group and not do the surveys that is fine.

You can also stop coming to the group at any time. Before beginning the group I will need to get consent, or permission, from you ***(if they are above eighteen)*** [from *your guardian]* ***(if they are under eighteen)].*** I will do this by sending home a packet for you *(and your guardian)* to read through. If it sounds like something you would like to participate in you can send it back. When I get the packets back I will call you to schedule a screening. We will be doing screenings to make sure that this type of group would be a good fit for you. After the screening you will be told whether you will participate in the group or if you will be put on a waitlist. We will figure out who gets to be in the group on a first come first serve basis. When the group starts we will meet once a week for eight weeks. Each meeting will be about an hour and fifteen minutes long. I will provide dinner for members at each group. Do you have any questions?

Do you think you would like me to send you a consent packet so you *(and your guardian)* can read more about this?

[If so…] That's great. Let me make sure that I have your current mailing address. I will call you back to schedule a screening as soon as I receive you packet.

[If not…] Thank you for taking the time to hear about all of this. Please know that the Pregnancy Wellness Program is available for support any time during your pregnancy as well as afterwards. Take care.

Appendix C Informed

Consent and Assent

CONSENT, ASSENT and PARENTAL PERMISSION TO PARTICIPATE IN RESEARCH

Cheshire Medical Center and Dartmouth-Hitchcock Keene

Towards a Relational/Psychoeducational Group for Pregnant Teens

Introduction: You are being asked to participate in a research study. Your participation is voluntary. "You" in this study may refer to your adolescent who is being asked to participate in the study.

You are being asked to participate in this study because you are pregnant and under the age of twenty, and you have been offered an educational and support group available for women like you.

Your decision whether or not to participate will have no effect on the quality of your medical care. Please ask questions if there is anything you do not understand.

What is the purpose of this study?

The purpose of the study is to learn about the needs of pregnant teens. You have been offered an educational and support group for women like you. This is a new group which has not been available to patients before. To see if this group has been helpful, we are asking you to complete two surveys before the group and two surveys when it is over. Our hope is to create a support and educational group for teens that will help them during their pregnancies.

Are there any benefits from participating in this study?

You may or may not benefit should you decide to participate in this study. We hope to gather information that may help others in similar positions in the future.

You will able to be part of the group without being part of the research.

What does this study involve?

Your participation in this study will last for 8 weeks provided you participate for the entire group. You will be asked to come to the hospital once a week during this time period.

Before participating in the group, you will be asked to complete a brief survey that asks for facts about you such as your age, grade in school and also some facts about your home life such as parents' marital status and number of siblings. A second survey will also ask you about how in control of your life you feel. After the group is over you will be asked to fill out the section of the survey which discusses control once more. You will also be given the chance to answer no more than five open-ended questions about your experience in the group and your needs as a young mother/ mother to be.
The group will cover materials regarding reproductive health, pregnancy, birth, coping with stress, managing relationships, and transitioning to motherhood. The type of education provided to you in these groups will be carefully designed to be age-appropriate for teenage girls. I, Megan Turchetti, will seek to answer all appropriate questions regarding these topics and create a comfortable environment where such questions can be asked.

How is this different from what will happen if you do not participate in this research?
The therapy offered in this research project is available to you without being part of this study.
If you choose not to participate in the research you are still welcome to participate in the group.

What are the risks involved with being enrolled in this study?
There is minimal risk involved with participation in this study. If at any point in time you wish to be referred to a therapists to discuss the issues brought up by this group or for other reasons, I will be able to refer you to Dr. Amanda Houle, a licensed psychologist and behavioral consultant who is in charge of the Pregnancy Wellness Program. Additionally, If at any point in time I determine it may be in your best interests to be referred to Dr. Amanda Houle, I will discuss it with you and make the referral.

Extreme emotional distress is not good for a pregnant woman or her unborn baby. If you feel that being part of this group would be extremely stressful to you, you should decline to participate.

Other important items you should know:
• Your decision whether or not to be in this study, or a decision to withdraw, will not involve any penalty or loss of benefits to which you are entitled.

●You will not receive any compensation if the results of this research are used towards the development of a commercially available product.

• **New Information:** To the best of our ability, any significant new findings during this research study will be made known to you. You can then decide if you want to continue in this study.

• **Withdrawal from the study:**
You may choose to stop your participation in this study at any time Your decision to stop your participation will have no effect on the quality of medical care that you receive at the hospital.

• **Number of participants:** We expect between 6-8 participants to enroll in this study here.

How will your privacy be protected?
The information collected as data for this study includes the copies of your completed surveys and any written information you provide in answering questions. Data collected for this study will be maintained for seven years.

Efforts will be made to protect the identities of the participants and the confidentiality of the research data used in this study, such as:

> Only the primary researcher and assistant researcher will collect questionnaires from patients. These will be kept by Behavioral Health Clinician, Dr. Amanda Houle, who maintains the questionnaire data in a secured file in her clinical office located within the Hubbard Center for Women's Health. For those who chose to participate, she will remove their names and replace them with a random number code. She will make these de-identified questionnaires available to the co-investigator, Megan Turchetti. The researchers will not have access to any list of patient names linked to these codes or numbers.
>
> Information from these questionnaires will be entered into a password protected computer within the Hubbard Center for Women's Health. This information will be transferred to a password protected compact disk. Once the study is complete, any remaining information on the computer will be deleted and the compact disk will be maintained in a secured locked file cabinet in Dr. Amanda Houle's office, only accessible to the investigators.

The information collected for this study will be used only for the purposes of conducting this study.

Who may use or see your health information?

By signing this form, you are allowing the research team to use your health information and disclose it to others involved in the research. The research team includes the researcher directing this study plus the people working on this study at DHMC and elsewhere. You are also permitting any health care provider holding your health information needed for this study to give copies of it to the research team.

Your permission to use your health information for this study will not end until the study activities by the research team are completed.

In the course of this study, information that identifies you may be disclosed to organizations that may not have a legal duty to protect it. These organizations may disclose it for other purposes.

Research data may be shared with officials of Dartmouth College, DHMC, and others involved in the oversight of this study as permitted by law. There is no guarantee that research data cannot be obtained by a court order or other legal process.

What if you decide not to give permission to use and share your personal health information?

If you do not allow use of your health information for this study, you may not participate in this study.

If you choose to stop taking part in this study, you may cancel permission for the use of your health information. You should let the researcher know in writing that you are canceling your permission. Information collected for the study before your permission is cancelled will continue to be used in the research.

Whom should you call with questions about this study?

Questions about this study may be directed to your doctor or to the researcher in charge of this study: Dr. Amanda Houle at the Hubbard Center for Women's Health at (603) 354-5400 during normal business hours.

If you have questions, concerns, or suggestions about human research at Dartmouth, you may call the Office of the Committee for the Protection of Human Subjects at Dartmouth College (603) 646-3053 during normal business hours.

Will you be paid to participate in this study?

No

CONSENT -

I have read the above information about the study "Towards a Relational/Educational Group for Pregnant Teens" and have been given an opportunity to ask questions. I agree to participate in this study and I have been given a copy of this signed consent document for my own records.

For participants 18 or 19 years of age:

_____

_____

Signature of participant Date PRINTED NAME

_____

_____

Researcher or Designee Signature and Date PRINTED NAME

For participants 17 years of age or younger:

_____

_____

Assent of minor (participant 17 years of age or younger) Date PRINTED NAME

_____

_____

Legally Authorized Representative (Parent/legal guardian) Date PRINTED NAME

I have explained to this minor what participating in this study will involve and have answered any questions that he or she has asked.

_____

Researcher or Designee Signature and Date PRINTED NAME

Appendix D

Participant Screening Questionnaire

Name: _____
Age:_____
Gestational Pregnancy/ Age of Children:_____
History of Pregnancies:_____
Complications Related to Current Pregnancy:_____
Mini-Mental Status:_____
_____
_____
Depressive Symptoms:_____
_____
_____
Anxiety Symptoms:_____
_____
Other Presenting Symptoms?:_____
Trauma History:_____
Mental Health History:
_____
_____
Current Social
Supports:_____
_____
_____
History of Working in
Groups:_____
Currently Working or in
School?:_____
FOB:_____Age:_____ Job/School?:_____
Presently Living

with:_____

Appendix E

Abridged Weekly Schedule for MBG Intervention

Week One: Getting Started
Agenda Items
-Introductions to the group (15 minutes): what is the purpose of this group and what do we hope to use it for. (Wants and Don't Wants H.O)
-Introductions to each other (20 minutes): Who are we and what should we know about each other. (Interviewing Each Other Activity)
-Designing our space together (20 minutes): Discussion on confidentiality, and how to help each other be comfortable. Create a group ritual for beginning and ending. Writing our group rules.
-Begin the crash course (15 minutes) get as far as possible with the crash courses
-End with a check out (5 minutes)

Week Two: Our preconceptions about conception
Agenda Items:
-Check in (5-10 minutes)
-Finish crash course if needed. (10 minutes)
-What does it mean to be a teen mom? Mural activity with collage. (35 minutes)
-Where do we get these ideas? (Pies of influence) (15 minutes)
-Check out (5-10 minutes)

Week Three: Our babies, ourselves
Agenda Items:
-Check in (5-10 minutes)
- Discussion of self-esteem, self-image and self-care (15 minutes)
-Making lists of self-care activities (10 minutes)
-Letters to ourselves after the birth and to the baby: The mother I want to become, the type of child I want to raise. (40 minutes)
-Check out- (5 minutes)

Week Four: Getting our Emotions to work for us
Agenda Items:
-Check in (5-10) minutes
-Discussion of emotions, emotions during pregnancy (20 minutes)
- Getting to know our emotions worksheet (15 minutes)
-Explain cycle of thoughts, emotions, behaviors and practice dissecting situations with difficult emotions (20 minutes)
-Check out (5-10 minutes)

Week Five: Harnessing our Strength
Agenda Items:
-Check in (5-10)
-Discussion of personal strengths and how it can be difficult to honor them (10 minutes)
-Personal strength H.O activity of creating a holding container for our strength (35 minutes)

-Explanation of personal affirmations- what they are and then writing down a self affirming thought and sharing it with the group (10 minutes)
-Check out- (5-10 minutes)

Week 6: Relationships Round One
Agenda Items:
-Check in (5-10) minutes
-Why relationships are difficult, period and why they are even harder at this time in your life. (20 minutes)
-What we want in a partner (15 minutes)
-Role plays (20 minutes)
-Check out (5-10 minutes)

Week Seven: Relationships Round Two
Agenda Items:
-Check in (5-10) minutes
-Pitfalls of relationships, "teach I statements and reflective listening" (20 minutes)
- Pregnancy and relationships (15 minutes)
-Role plays continued (20 minutes)
-Check out (5-10 minutes)

Week Eight: Birth Readiness and Fears
Agenda Items:
-Check in (5-10)
-Talk about birth (20 minutes)
-Hear from our birth expert (25 minutes)
-Have Ruth come in and talk about resources and how to get them question and answer (20 minutes)
-Completing surveys (15-20 minutes)
-Check out-(5)

Appendix F

Demographic Data Questionnaire

Demographic Information

Name:	
Date of Birth:	
Grade (if no longer in school put highest grade achieved) ***please circle*****:**	***8th Grade 9th Grade 10th Grade*** ***11th Grade 12th Grade College*** ***Other_____***
Race (please circle):	***Caucasian (White) African-American*** ***Latino Asian Biracial***
Please list all of the people who live in your home and how they are related to you.	***For example:*** ***Susan (Mom)*** ***Bill (Step Dad)*** ***Mike (Brother)***
Are you currently in a relationship?(please circle)	***No Yes- (less than 6 Months)*** ***Yes-(6-12 months) Yes (more than 1 year)***
How many children do you have?	
Please list any clubs or organizations	

you belong to.	
What are your parent's jobs?	***Mom:*** ***Dad:*** _____ _____ ***OR*** ***Don't Know*** ***Don't Know***
Do you currently have a job?	***Yes:*** _____ ***No***

Appendix G

Girl's Circle Self-Efficacy Outcome

Outcomes p. 3

Please tell us if the following feelings or experiences are not true, hardly true, moderately true, or exactly true:

	Schwarzer Self-Efficacy Scale[1]	Not true (1)	Hardly true (2)	Moderately true (3)	Exactly true (4)
C1	I can always manage to solve difficult problems if I try hard enough.	NT	HT	MT	ET
C2	If someone disagrees with me, I can find a way to work out the problem.	NT	HT	MT	ET
C3	It is easy for me to stick to my plans and accomplish my goals.	NT	HT	MT	ET
C4	When an unexpected thing happens, I am confident that I can deal with it successfully.	NT	HT	MT	ET
C5	I can find ways to handle new situations.	NT	HT	MT	ET
C6	I can solve most of my problems if I put in the necessary effort.	NT	HT	MT	ET
C7	When something stressful happens, I can stay calm and figure out how to deal with it.	NT	HT	MT	ET
C8	When I have a problem, I can usually find several solutions.	NT	HT	MT	ET
C9	If I am in trouble, I can usually think of a solution.	NT	HT	MT	ET
C10	I can usually handle whatever comes my way.	NT	HT	MT	ET

[1] Schwarzer, R., & Scholz, U. (2000). Cross-Cultural Assessment of Coping Resources: The General Perceived Self-Efficacy Scale Paper presented at the First Asian Congress of Health Psychology: Health Psychology and Culture, Tokyo, Japan.

Used with permission of One Circle Foundation (personal communication, May 5, 2009)

Appendix H

Qualitative Questions

Open-Ended Questions
Please use your own words to answer the following questions. Any feedback at all will be very helpful.

1. **What did you find helpful about this group?**

_____
_____
_____
_____

2. **What would you change about this group to make it more helpful?**

_____
_____
_____
_____

3. **What do you think are a young mother's most important needs?**

_____
_____
_____
_____

4. **What would you like to have available for extra support from your community?**

_____
_____
_____
_____

5. **How did your experience in this group effect the way you relate to others, if at all?**

_____
_____
_____
_____

Appendix I Researcher

Field Notes

Session One: Five teens attended the first session. We engaged in introductions and worked to create group norms by creating group rules. I offered that they should think of a name and one participant suggested we use "Mothering: A Beginner's Group." All but two participants are still pregnant. During the introduction activity many participants described finding out the news of their pregnancy as a shock and sharing this news as a stressful issue. The participants all seem to be excited to meet one another and to be engaged in the group.

Session Two: Five teens attended, one from last week missed and a new teen came for the first time tonight. We covered topics of reproductive health, sexual education, and the messages from the media regarding teen motherhood and adolescent sexuality. One mother of a participant attended her opinions seemed to help other share their feelings on the subject. We will need to discuss family participation next week.

Session Three: Four teens attended. Topics included focusing on what kind of mother you want to be. One participant was accompanied by her newborn son and mother who cared for the infant outside of the group room. Participant seemed to have mixed feelings about her mother taking on so many caretaking tasks for the baby. We discussed how to manage confidentiality with family members and decided that we would plan on checking in without family members and reaching a group consensus about whether or not they would be invited in. If they do want to participate they will have to agree to maintain confidentiality. Participants demonstrated a range of how much thought and consideration they seem to have given the changes that will occur when the

babies come. Participants who are already mothering emphasized the drastic impact of these changes.

Session Four: Three group members attended. Topics included discussing the impact of emotions on overall wellness. One group member was having a difficult week as she had recently broken up with the young man who she had been dating when she got pregnant. Other group members were very intense about wanting to encourage her to have high standards for him. One group member discussed how her emotions have changed since she became pregnant and how much relational conflicts set her off recently. She gave an example of her mother-in-law making rude comments to her and not allowing her to take baby clothes to her own home because she wanted the participant and her boyfriend to move back into her home.

Session Five: Four group members attended. Topics included ways to harness personal strength in times of difficulty. One group member attended with her newborn daughter and sister, who cared for the infant during group. Group discussion included expectations for the fathers of the babies and awareness of the impact of one's own childhood on their parenting style.

Session Six: Two group members attended. Topics included the introduction to relationships. A new group member attended with her son who was approximately ten months old. The two discussed their relationships throughout the group. They talked about not ever going out to see friends, and not ever seeing any of the friends that they used to have before they gave birth.

Session Seven: One group member attended. Both this participant and the facilitator had given birth the previous week and both newborns were present. The session involved discussing the experience of the participant's birth which involved complications and focusing on how she was managing the immediate transition. Her experience of labor and delivery included feeling quite left out of things because her son was transferred to another hospital where her boyfriend and mother-in-law cared for him primarily. This was especially difficult because she has a conflictual relationship with the boyfriend's mother.

Session Eight: Two group members attended. Focus became how the participants were balancing being moms, how their romantic relationships were going, and how their extended families were handling the fact that they were mothers. The older mother of the pair sympathized greatly with the new mother who was having a hard time with her boyfriend's mother. The two discussed the difficulty of being seen as "less than a mother." The session ended with the two making plans to keep their weekly check-ins with one another going after group was over.