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# Resiliency and Adolescent Motherhood in the Context of Residential Foster Care

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## **Abstract**

The purpose of the current study was to explore how adolescent mothers experienced pregnancy and parenthood within the context of residential foster care. Adolescent mothers in foster care are a vulnerable population although little research has explored their experiences, particularly from a resiliency framework. The present study begins to fill this gap by conducting focus group interviews with 39 adolescent mothers living in residential foster care. Using thematic analytic methodology, we uncovered themes that highlighted not only the mothers' struggles, but also their capacities for resilience. Specifically, the mothers experienced societal stigma, parenting judgment, and challenging relationships with their child(ren)'s father as common struggles. However, the mothers described how the social support they received and the relationships they formed with the other adolescent mothers living in residential foster care allowed them to develop resiliency including through specific lifestyle changes that helped them to prepare for motherhood.

**Keywords** Adolescent parents · Foster youth · Strengths based perspective · Thematic analysis

The United States consistently ranks as having the highest adolescent pregnancy and parenting rate among all western nations (Sedgh, Finer, Bankole, Eilers, & Singh, 2015). In 2017, approximately 194,000 children were born to adolescent mothers (Hamilton, Martin, Osterman, Driscoll, & Rossen, 2018). Although it has been less frequently documented, adolescents in the foster care system are especially vulnerable to becoming pregnant and having a child (Dworsky, 2015; King, Putnam-Hornstein, Cederbaum, & Nee-dell, 2014; Putnam-Hornstein, Cederbaum, King, & Nee-dell, 2013). To address parenting services for foster youth, some residential foster care facilities are designed to meet the unique needs of adolescent mothers. Supportive housing aids adolescents' transition into motherhood by providing opportunities, such as the ability to save income, for these parents who might otherwise be unable to raise a child (Radey, Schelbe, McWey, Holtrop, & Canto, 2016). These supports are important given that these mothers are also exposed to a number of vulnerabilities including lowered educational attainment (Mollborn, 2010), decreased mental health connected to experiences of trauma (Gibson, Cal-lands, Magriples, Divney, & Kershaw, 2015), and dating violence (Herrmann, 2013). Yet, there is little information about adolescent mothers who reside in these facilities. The present study specifically explores how pregnant and parenting adolescent mothers in residential foster care developed resiliencies within the struggles of young parenthood.

## **Literature Review**

### **Resiliency Theory**

Resilience theory proposes that individuals are imbued with the ability to adapt to traumatic life events (Windle, 2011). Although resilience does not negate the detrimental effects of such events, it aids in improving the quality of life for those who have experienced them. Some researchers critique this theory for its lack of a concrete conceptualization (Luthar, Chicchetti, & Becker, 2000; Masten, 2016); however, in the current paper, we define resilience as “the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma” (Windle, 2011, p. 1). Resilience is a process, not simply an outcome, for those who have experienced negative life events (Hendrick & Young, 2013). As both a process and an outcome, resilience

develops as individuals' intrinsic characteristics act in conjunction with their direct environment, such as the people and social structures (Lerner et al., 2012). Resiliency is developed and maintained through forming healthy attachments and positive perceptions of oneself. Relational stability, routine, and family, community, and cultural rituals can foster these attachments. Resiliency can also occur through work to increase self-efficacy, motivation, and the ability to make meaning of life events (Masten, 2016). It can also occur through facing life changes as they occur and developing the capacity to set and meet life goals (Madewell & Ponce- Garcia, 2016), such as that of new parenthood and successful child-rearing.

Adolescence is a key time period in fostering resiliency as trauma is often not a singular event and traumatic circumstances can accumulate over the lifespan; however, development that occurs during this developmental period might help to buffer negative outcomes (Chen & Foshee, 2014). As this time is marked by transitions, identity formation, and the capacity for positive change and growth, it is especially important to focus on resiliency (Burt & Paysnick, 2012). Focusing on resiliency during adolescence is also important due to the salience of building strong relational ties during this period which can help mitigate the effects of trauma (Chen & Foshee, 2014; Purvis, Cross, & Pennings, 2009). This might occur through strong, healthy ties to adults (Purvis et al., 2009) or by creating new friendships with peers (Madewell & Ponce-Garcia, 2016).

Although a life course perspective of resilience theory focuses on contextual factors, some researchers are critical of its homogenous application to populations with differing standards of successful resilience (Luthar et al., 2000). This calls for a greater focus on isolating what resilience means within specific populations, such as adolescent mothers in residential foster care (Burt & Paysnick, 2012). Given the importance of context, studies of vulnerable populations should recognize the myriad factors that require attendance in order to foster resilience (Kulkarni, Kennedy, & Lewis, 2010; Shea, Bryant, & Wendt, 2015). In the present study, we will attend to how resilience manifests both in and among this population by building from the current body of research that has documented the capacity for resilience among adolescent mothers in foster care (e.g., Aparicio, Gioia, & Pecukonis, 2018; Haight, Finet, Bamba, & Helton, 2009; Radey et al., 2016).

## **Vulnerabilities in Foster Care and Adolescent Motherhood**

Previous research has indicated that many adolescents in foster care have been exposed to myriad hardships, including family violence, substance abuse, homelessness, and poverty (Aparicio, Pecukonis, & O'Neal, 2015; Goodkind, Schelbe, & Shook, 2011). They also face many difficulties, such as decreased education, unemployment, and involvement in the legal system once they transition out of the foster system (Goodkind et al., 2011). Witnessing and experiencing family violence indicates a history of trauma and is often the basis for youth placement in the system (Aparicio et al., 2015; Goodkind et al., 2011). Once in the system, they often struggle to have their voices heard and needs met (Forenza, 2016a). Additionally, research suggests that although foster youth are able to conceptualize many attributes of healthy dating relationships, their lived experiences of intimate partnering are often less than ideal (Forenza, Bermea, & Rogers, 2018). Specifically, they often struggle with communication, dating violence, and unhealthy sexual practices (Forenza et al., 2018; Scott, Moore, Hawkins, Malm, & Beltz, 2012; Winter, Brandon-Friedman, & Ely, 2016).

Foster youth are especially vulnerable to becoming pregnant (Dworsky & Courtney, 2010; Manlove, Welti, McCoy-Roth, Berger, & Malm, 2011), with approximately one-third of all girls in foster care giving birth at least once by the time they are 19 years old (Manlove et al., 2011). Further, one study found that 12% of adolescent parents in foster care had their first birth before the age of 15 years, 14% before 16, and almost a quarter (22%) by the age of 17 (Dworsky, 2015). Adolescent parents in foster care are also at risk of experiencing a repeat pregnancy, with approximately one-third having their first child before turning 18 years old also having a second child during adolescence (Putnam-Hornstein et al., 2013). These high rates of pregnancy among foster youth be due to their early onset of sexual activity (Manlove et al., 2011; Winter et al., 2016), increased rate of sexual assault (49%; Manlove et al., 2011), and lived experiences, such as extreme poverty or parental substance abuse, which have been associated with transactional sex (Winter et al., 2016). Pregnancy and parenthood potentially compound previous experiences of trauma. Adolescent mothers are likely to experience childhood victimization, such as witnessing violence or being physically or sexually abused by a parent or caregiver, depression,

and violent relationships (Herrmann, 2013; Kennedy, Bybee, & Greeson, 2015). Adolescent mothers also often face isolating societal stigma, such as perceptions that they will be unsuccessful in life, are promiscuous, or are harassed by both adults and peers, complicating their transition into parenthood (Bermea, Toews, & Wood, 2018; Vinson & Stevens, 2014). In addition to stigma, mothers might experience isolation from their peers as they begin to spend more time engaging in parenting activities (Pryce & Samuels, 2010).

Specific to adolescent mothers in foster care, some studies have demonstrated how their experiences with their own parents, such as abuse, abandonment, and/or substance use, only served as examples of parenting behaviors to avoid (Aparicio et al., 2018; Radey et al., 2016). Moreover, in their study of adolescent parents in the foster system, Schelbe and Geiger (2017) found that a history of parental absence and neglect was connected with adolescent parents struggling to identify normative developmental behaviors for their child, such as difficulties in sitting still, and may inadvertently implement unhealthy parenting behaviors, such as putting young children on diets. Unhelpful caseworkers might also pressure some youth out of the system entirely at the age of 18 instead of at the maximum age of 21 (Goodkind et al., 2011), and many foster youth have described feeling unprepared to leave care (Liabo, McKenna, Ingold, & Roberts, 2017). Subsequently, structural constraints, such as being forced to drop out of school to raise their children and losing scholarship funding to attain a college education through extracurricular activities, and pervasive low income make it difficult for these youth to find adequate employment, which might cause them to lose their child to the system (Pryce & Samuels, 2010), creating a cyclical pattern. As such, they require more helpful supports that facilitate one's capacity for resilience.

## **Strengths**

### **Personal Strengths**

Despite negative experiences and struggles, some research has documented adolescent parenthood in general as a time of personal growth and resilience (Aparicio et al., 2015, 2018; Goodkind et al., 2011; Pryce & Samuels, 2010). For example, mothers who experience stigma might connect with others who have similar

backgrounds (Haight et al., 2009). Some mothers express pride at their ability to overcome challenges and engage in the difficult work of raising a child (Schelbe & Geiger, 2017; Shea et al., 2015). Specifically, they have discussed how a transition into motherhood has helped them develop their own parental identities (Brubaker & Wright, 2006), create a positive view for their children's futures (Aparicio et al., 2018), and develop a sense of purpose while nurturing filial bonds (Pryce & Samuels, 2010).

Previous researchers have found that mothers who navigate parenthood while in the foster care system also experience personal growth (Brubaker & Wright, 2006; Haight et al., 2009; Schelbe & Geiger, 2017). Despite describing feelings of anxiety at the prospect of motherhood, many adolescent mothers in foster care express excitement and pride during pregnancy (Aparicio et al., 2018). Counter to the numerous difficulties these youth encounter over the course of their lives, many adolescent mothers in foster care value parenthood as an opportunity to create a better life and disrupt cycles of tumultuous family life (Schelbe & Geiger, 2017). Indeed, some mothers in foster care view parenthood as a means of creating a family apart from the foster care system and, subsequently, become advocates for others with similar experiences (Aparicio et al., 2018).

### **Structural Strengths**

Although less commonly reported, being in the foster system might provide support for adolescent mothers. In discussing foster youth in general, Forenza (2016a) documented how youth in foster care can participate in organizations designed to meet their explicit needs, such as foster youth advisory boards. As such, they are able to draw on the similar experiences unique to youth in foster care from their peers (Forenza, 2016a, b). Indeed, foster youth have described these peers as family, and the social support they received from both peers and adult advocates as a critical resource (Forenza, 2016b). Adults, such as caseworkers, might further offer parenting guidance specific to youth with children as a form of support to help mitigate the strains of new parenthood (Schelbe & Geiger, 2017). Mothers can also receive mentoring and counseling to aid in building resiliency amidst stigma against young parents (Shea et al., 2015), as well as to help them cope with the violence that has potentially accumulated

across their life (Kulkarni et al., 2010). Formal support for mothers in foster care is important in their capacity for resilience (Aparicio et al., 2015).

As the extant literature outlines both vulnerabilities as well as strengths for adolescent mothers in the foster care system, the present study seeks to recognize how both manifest within this population through the use of a resilience framework.

Specifically, we conducted our analysis based on the following research questions: (1) What are the social contexts for pregnant and parenting mothers in residential foster care? (2) How do adolescent mothers in residential foster care exhibit resiliency?

## **Methodology**

### **Sample**

The present study was conducted as part of a relationship education program for pregnant and parenting adolescents funded by a grant from the U.S. Department of Health and Human Services and approved by the university's Institutional Review Board. We collaborated with local residential foster care facilities serving adolescent mothers to implement a relationship education program designed specifically for pregnant and parenting youth. The program served any pregnant or parenting youth up to the age of 21, the maximum age youth could live in foster care in the focal state. Members of the grant team, licensed professional counselors who had previously facilitated the program, implemented weekly sessions with mothers who wanted to participate in the program. Each session focused on different aspects of building and maintaining healthy relationships. The program was implemented in four separate residences specifically for adolescent mothers. All mothers enrolled in the program were eligible to participate in the focus group but were not mandated to attend given their many prior obligations, such as schoolwork or extracurricular activities.

A total of 39 adolescent mothers participated in one of four focus groups conducted in the summer of 2015 as part of the formative evaluation. Focus groups were especially useful when conducting collaborative research such as within each home because they provide insights into the specific processes occurring as part of this research, such as parenting (Merriam & Tisdell, 2016). One focus group was held at each location, with an average of 10 mothers (range 5–16 mothers) per group. Two of



the campuses were located in separate urban cities ( $n = 16$ ;  $n = 5$ ), one was located in a suburban town ( $n = 10$ ), and one was held in a rural location ( $n = 8$ ). All focus groups took place in a private meeting room on the mothers' residential campus and lasted an average of 39 min (range 30–45 min).

Almost half of the mothers identified as Hispanic ( $n = 18$ ), followed by Black/African American ( $n = 11$ ), White ( $n = 9$ ), and Asian ( $n = 1$ ). The average age of the mothers at the time of the interview was 17.2 years (range 15–21 years). However, two mothers declined to report their age. The majority of participants had already given birth at the time of the focus groups ( $n = 28$ ), and less than a third of the participants were pregnant when the focus groups took place ( $n = 12$ ). Most of the participants had one child ( $n = 25$ ), a few had two children ( $n = 3$ ), and just over a fourth were pregnant with their first child ( $n = 11$ ).

## **Context**

The state where the facilities were located had extended care, meaning youth were able to stay in care until the age of 21. Residential facilities are mandated by the state to meet specific requirements, including that staff must have training for working with foster youth and explicit plans must be in place for emergencies based on youth's behavior, such as escalations of conflict into violence. Each youth must have individualized treatment records, recommendations, and are able to maintain contact with friends and family when legally permitted on a case-by-case basis.

The majority of mothers in our study had been placed directly from child protective services into the homes because of histories of family physical and sexual abuse and neglect. Each residence had different policies regarding the mothers' exits from the facility, such as when they aged out of care, were able to move into independent living, were placed in a different foster home, or were reunified with their birth family. All mothers attended local schools, as opposed to on-campus education, and were able to leave on pass if the administration had pre-approved it. All mothers entered the residence because they were pregnant or already mothers and had not become pregnant with their first child while there.

## **Data Collection**

A female with a background in interviewing and field experience with adolescent parents conducted the focus groups while a female note-taker, who had experience in focus group data collection, assisted. The moderator followed a semi-structured interview protocol developed in conjunction with program facilitators and residential staff in order to ensure that topics around experiences surrounding early pregnancy and parenting and involvement in foster care were addressed. This form of protocol development is common in collaborative research because staff have expertise on the population in question (Merriam & Tisdell, 2016). Therefore, the authors of the protocol were better able to sensitively address the participants' histories of, and the potential for, trauma within these subject matters (Aparicio et al., 2015; Winter et al., 2016). Discussions highlighting adolescents' resources and resiliencies were referenced through questions such as "What is it like to be in this program with other parents your age?" and "Who supports you?" Through these questions, mothers were able to discuss personal experiences outside of the relationship program.

The research team assured confidentiality to all participants by providing information about the use of pseudonyms and redacted identifiers. Mothers' provided a name, either a nickname or self-selected pseudonym, they chose during the focus groups. The interviewer personally transcribed the interviews and redacted all names and identifiers and assigned a participant number before subsequent analysis. Regardless of the name they chose, researchers also assigned pseudonyms to mothers in the present study. All individual participants included in the study gave informed consent, and the residence provided guardian consent to those under the age of 18, who then provided their own assent. Each of the participants received a gift card to thank them for their time and input.

## **Thematic Analysis**

We conducted an inductive thematic analysis by using the steps outlined by Braun and Clark (2006). Initially, two coders individually immersed themselves in the data through careful reading and re-reading of each transcript, then open coded each of the focus groups and made notes of salient patterns and themes. One coder had no

experience with the program under evaluation; the other was part of the internal evaluation team and had conducted and transcribed the focus groups and referenced notes and memos taken during data collection. While remaining open to major thematic patterns in the data, patterns of parenthood and relationships were particularly salient (Braun & Clark, 2006).

Following the identification of broad concepts present within the focus groups, coders then coded for discussions that represented the mothers' specific experiences (Braun & Clark, 2006). After this step, they reviewed the codes they identified in this process then refined and collapsed them into families of themes (e.g., Struggles, Resilience) and themes (e.g., Relationship with the Child's Father; Braun & Clark, 2006). Per Krueger and Casey's (2014) recommendations for best practices when analyzing focus groups, the coders considered the specificity of the discussions related to these themes as well the mothers' emotionality (e.g., frustration, excitement) along with the frequency of examples. The coders also referenced field notes taken during data collection addressing nonverbal communications, including agreement/disagreement with speakers, nonverbal expressions, and emotionality, to ensure accuracy of coders' interpretations during in-depth coding.

### **Trustworthiness**

During all stages of analysis, coders followed Creswell's (2014) suggestions on implementing trustworthiness, including credibility, transferability, dependability, and confirmability. Extensive memoing was referenced at each step in the process to help ensure credibility during both data collection and analysis (Creswell, 2014). Three of the four authors had experience working with pregnant and parenting adolescents, further establishing credibility in interpreting the data. Specifically, two of the authors spent time at data collection sites and understood the rules and campus culture. A third author also had experience working with housing organizations for foster youth (Creswell, 2014). To help establish transferability, we provided rich descriptions through our discussion, use of in vivo quotes, and information about the residences. This gives other researchers the opportunity to determine whether our findings are applicable to other settings, such as other foster homes (Creswell, 2014). Third, we established dependability through a

comprehensive audit trail maintained and referenced throughout analysis. The audit trail consisted of notes taken during meetings between the coders both in-person and electronically, such as through phone and video conferencing or e-mail and in each codebook iteration. It also consisted of real-time notes taken during the focus group and debriefing notes made post-focus group (Creswell, 2014). Lastly, confirmability was established through analyst triangulation between members of the coding team as they met regularly, both in person and electronically, to ensure that the below outlined themes and subthemes reflected the mothers' lived experiences (Creswell, 2014).

## **Findings**

Two distinct families of themes emerged, the first pertaining to our research question concerning the contexts in which adolescent mothers were transitioning to parenting and the second pertaining to our second research aim of uncovering these adolescents' resiliencies in the process. *Struggles*, the first family of themes, illustrated the difficult contexts in which participants were making this important transition. For instance, the mothers described stigmatization for being parents at a young age, adult judgment on their ability to parent because they were adolescents, and relationship struggles with the father of their child leading to uncertainty about the role they wanted him to play in their children's life. *Resilience*, the second family of themes, further explored how social supports—both outside of and within the residential foster care facility—positively influenced mothers' ability to cope and grow from their experiences, particularly those within the former theme. For example, the mothers offered examples of social support from individuals who were not adolescent parents, such as biological family members, support from the other mothers within the residence, and exhibited changes in their lives that illustrated their commitment to parenthood.

## **Struggles**

In the first family of themes, the mothers described their struggles of being adolescent parents in residential foster care. The first theme under *Struggles* was *Motherhood Stigma*, as it relates to being an adolescent mother. The second was the *Parenting Judgment* that adults made of participants' perceived capacity to parent. The

final theme was the *Relationship with the Child's Father* as the mothers struggled to determine the prospective role of their child's birth father.

### **Motherhood Stigma**

Participants in two focus groups discussed the ways in which others outside of the residence contemptuously viewed them because of their identity as an adolescent mother. Some described ways in which judgment towards their motherhood status occurred from strangers in their everyday lives. In one group the mothers recalled:

Emily: We've all been judged.

Roni: People judge us every day...

Raquel: Especially, when we go out with the stroller.

Sidney: People just stare at us.

Mothers in another focus group offered specific ways in which loved ones had turned their backs on them once they found out they were pregnant. Daniela shared that her mother did not speak to her for 3 weeks after disclosing her pregnancy. Hannah's grandmother had similarly disowned her, and she described how adults, such as her friends' parents, made it difficult for her to gain support from her peers who might otherwise have been a resource.

One of my friends, one of my best friends, we've known each other since we were like two, three years old, I got on the computer one day and I realized she'd blocked me [on social media] ... [My friend's dad said], "My daughter can't talk to you anymore because you're pregnant."

Hannah's statement indicated how pregnant and parenting adolescents encountered societal stigma due to their motherhood status, placing some of their longstanding social relationships and support in jeopardy.

### **Parenting Judgment**

Related to stigma, participants in all focus groups described how adults' opinions about them extended into judgments made about their parenting abilities due to their age. Zoe explained, "You try to talk to any adult that has a child, and they're gonna look at you like you don't know anything about kids 'cause you're younger."

Brooklyn added, “I don’t like them telling me what to do with my child... they play that.”

As a result, the mothers were not receptive to unsolicited parenting advice from adults. During a discussion of how others would tell them how to parent, Brooklyn expressed, “They can kiss my-” However, it should be noted that several participants expressed gratitude for the parenting training they received at the facility. “In the real world, if you don’t have an apartment, it’s you and them four walls helping you out,” said Ava, in support of resources at the residence.

#### Relationship with the Child’s Father

One factor that made the transition to motherhood difficult was their relationship with the father of their child. Participants in all focus groups were largely uncertain about the prospective roles of their child’s birth father. When the focus group moderator asked participants to discuss co-parenting in one group, the mothers provided a variety of responses:

Roni: I am [planning to co-parent].

Taylor: Depends on the situation.

Makayla: Once I have the baby, I will. If I feel like it.

The ambiguity expressed in this conversation further extended into formal systems as some participants, both across and within focus groups, contemplated child support orders. To illustrate, Hannah discussed her own experiences with the group:

“Everybody’s like, ‘you should put him on child support just in case he leaves you’ [and] I’m just like, ‘I don’t know what to do!’” To this end, participants in one focus group referred to fellow residents, all of whom were expectant mothers, as surrogate “baby daddies.” Although the term “baby daddy” is a common colloquial phrase referring to children’s fathers, it distanced participants from an implied romantic relationship. It appeared their hesitancy or unsureness of involving the father in helping to raise their child was due to the nature of their relationship. For example, when asked about communicating with their partners, the fathers of their children would, as Juanita put it, “get straight ‘hood.” This indicates how the quality of the parental relationship might have affected their reluctance to involve the father.

Participants discussed actively constructing more positive relationships with their

children's father and shared how they thought their relationships might change after they gave birth. Specifically, Jada noted that her relationship with her baby's father had improved since moving into residential care: "It's easier to *not* get mad at him now that I'm not living with him," she began. "Like, we have a good relationship. We're close to each other, but I don't want to see [him] every day," she concluded. Participants in a second group anticipated the ways in which they would negotiate relationships among themselves, their baby's father, and their children. Chiefly, participants in this focus group wanted their children to be privy to healthy, loving, and respectful relationships in order to offer their children the healthy role models they often did not have growing up. Mia described how this manifested in her family: "When I'm with... my boyfriend and my child, I don't want my child to be seeing us arguing or in a negative way. I want him to see us, like, hugging and stuff. And showing love." Elaborating on this point, Camilla recalled lessons learned from watching her parents interact:

If a baby sees different [than love between parents], then they're gonna grow up to think that's okay. 'Cause I thought it was okay... "my mom's getting yelled at. She's getting called a b-word"... I always told myself as I got older, "I'm not gonna let nobody talk to me [the way my dad talks to my mom] ... But when my boyfriend came into the picture, I realized what love did to me. And I did allow him to call me the b-word and then he said it again and that's whenever I was like, "okay, I'm putting my foot down."

Here, Camilla implied that although individuals might learn negative behaviors from their families of origin, they can also strive to become stronger as they break cycles of abuse for their children. These mothers sought to make this change for the sake of their children. Discussions such as these indicate the mothers' potential for resilience, despite their struggles.

## **Resilience**

The second family of themes to emerge was how the mothers displayed resilience moving forward from their struggles. The first theme, *Social Support*, described the external networks of individuals who were not adolescent parents, such as teachers or biological family members, the mothers perceived to be available. The

second theme was *Relationships between Adolescent Mothers*, referring to the shared experiences of motherhood derived from the intra- and inter- personal dynamics of living in specialized residential foster care. Finally, and most importantly, these themes allowed the mothers to prepare for the third theme, *Lifestyle Change*, the task of motherhood in residential foster care.

### **Social Support**

During the focus groups, mothers reflected on external networks of social support outside of the other mothers. Support often manifested from adults in the home and across all focus groups, participants indicated not needing or wanting anything from trained, human service professionals like social workers or counselors. In one group, the primary reason for not needing or wanting anything from external formal supports was because “We have everything [here].” Chloe elaborated, “We have it made here [at this residential facility].” “Yeah, we really do,” began Taylor, “It’s like, how much more can you ask for?” Their discussion reflected the importance of the support the residential staff provided.

The trend of feeling supported by their network of residential staff extended from other residents and staff to non-professionals as well. All participants who spoke offered illustrations of robust networks of social support, where individuals helped participants to be resilient. These forms of support included biological families and friends from their schools or before they were in care. One participant discussed her grandmother as a consistent support throughout her pregnancy. Hannah offered, “I have a lot of support. Like, all my friends support me, some of my old teachers, my boyfriend and his family, and my [biological] dad, when I talk to him.” These supports aided in creating networks on which the mothers could rely, especially in contrast to other negative relationships and stigma they experienced.

### **Relationships Between Adolescent Mothers**

Most participants reflected positively on their time in residential foster care. Some offered anecdotes of community and camaraderie to illustrate their point. Makayla recalled:



The people that are there are wonderful. Like I'm sick yesterday, and they wrote me a letter, a get-well card that everybody signed and everything like that. I woke up and was like, "what's this?" You know, looked at it, whatever. And so, just little things like that.

Most importantly, the mothers who viewed their residential communities positively also indicated an inherent bond with other residents, which bolstered their support network. "We relate. We're all in the same situation. We all came here to, you know... have a healthy baby and get ourselves together and start the life for our child," shared Makayla.

In a different focus group, Zoe further contextualized the subtheme of inherent bonds among residents:

Where I'm at, [being] a teen mom is like the *worst* thing possible to happen. So, when I came here, I automatically knew there'd be a lot of female drama because it's all females and all children. But it's definitely been a lot better to understand. I can be with people that [are dealing] with the same thing that I'm dealing with.

As indicated here, a primary bond among residents included the unique experience of having a child and the steadfast commitment to creating a healthy life for that child. Two mothers in the same focus group noted that following through on these commitments presented feelings of accomplishment. "Some people don't have awards, but [through this program] they can know they accomplished something," offered Makayla. "I think everyone here—and this is a huge step to take—to come all the way out here and, like, [leave] everything and everybody just to be a better parent. I think that's a big step," said Taylor. The goal of becoming a good or better parent often motivated a shift in their current lifestyle.

### **Lifestyle Change**

In anticipation and as a result of motherhood, participants in all focus groups expected and/or had already made life- style changes for their babies. These included a loss of autonomy, decreased time with peers, and a shift in priorities. Although many of these actions might have been difficult for the mothers, they illustrated the sacrifices they actively made, both through internal decisions, such as an increased understanding of what it meant to be a parent, and external behavioral changes, such

as modeling healthy behaviors, in order to be positive and involved parents. As Chloe noted:

[You have to] understand that your life is not gonna be the same. You're not gonna get to do whatever you want to, whenever you want to. You can't talk the way that you used to. You can't, you know... say things that you would normally say around your kids because, you know, they pick up on that no matter how old they are.

Makayla noted how this understanding motivated mothers to change behaviors regarding their children. "Mothers are gonna get frustrated. You know, you're gonna get very, very frustrated so they [staff at the residence] teach you how to try to deal with that. And, you know, if it's trying to discipline your child, you know it's a healthy way to do that." Teyana similarly shared how she felt she'd matured as a parent, offering, "I think they [children] get a lot of how they act and stuff from you. Like, if you're childish your kid's not gonna take you seriously." Hailey also contextualized the need to change behaviors when she explained the importance of her child in her life, offering that, "I told a lot of my friends... 'Now, if you see me out, like going out at any place, you're gonna see me with my daughter.' That's my responsibility. She's gonna go wherever I go." She went on to disclose that, throughout the course of her pregnancy, she had, in fact, lost friends. However, the mothers often felt as though they were more responsible than their peers who did not have to make sacrifices for their children. When Roni shared how "I feel like some of them [non-parenting peers] just pawn [their responsibilities] off on their parents." Sydney agreed, "Oh, yeah." Furthermore, much of the time they lost with their peers, they spent with their child, which the mothers described as enjoyable. Chloe shared, "I just go to my room and I try to, like, play with him. But he's only a couple weeks old and I know he can't do much, but I want him to know that I love him." Jada recalled feeling negatively when she was unable to spend time with her child, "I feel like when I don't have that time with my daughter I feel guilty." Participants emphasized that their child influenced them to be more mature and that they took priority over peers and social relationships, indicating a sense of pride and their commitment to motherhood.

## **Discussion**

Mothers in the present study discussed a variety of experiences within their residential foster care facilities. The present study examined the resilience of these mothers, such as their ability to nurture relationships with their children's father (Aparicio et al., 2015), foster bonds with their peers, and gain resources from adults in their community (Forenza, 2016a; Thompson, Greeson, & Brun- sink, 2016). Although our findings speak to the mothers' struggles, they also highlight resiliencies. These findings illuminate a population of young mothers who are, despite being vulnerable to a number of difficulties and in need for increased services, understudied.

For pregnant and parenting adolescents, the process of developing a maternal identity is an important task (Brubaker & Wright, 2006; Haight et al., 2009; Shea et al., 2015). The mothers in our study expressed strong ties to their mothering identities, including involvement and relationship changes with their partners. Similar to a study by Shea et al. (2015), love as well as pride for their child and/ or expectant child facilitated these changes. Additionally, consistent with a body of literature discussing the loss of autonomy that comes with motherhood during adolescence (Brubaker & Wright, 2006; Pryce & Samuels, 2010), the mothers in our study also described seeing less of their friends and, when they did, it was with their children pre- sent. However, consistent with our resiliency framework, the development of a mothering identity offered the chance to develop positive identities (Brubaker & Wright, 2006; Schelbe & Geiger, 2017). Previous research has described this transition to motherhood as an "opportunity...to create a new identity in light of motherhood" (Shea et al., 2015, p. 848).

The mothers' positive self-perceptions of anticipating motherhood did not always translate to others. The stigma associated with adolescent motherhood can hinder help- seeking and continues to be a barrier to youth receiving the effective services they need (Goodkind et al., 2011). Aside from parenting judgment, the mothers in our study were vague in their descriptions of what exactly defined stigma for them. However, previous studies have documented others' perceptions of promiscuity (Brubaker & Wright, 2006), an inability to gain an education (Bermea et al., 2018), and the belief that they would be "welfare queens" (Haight et al., 2009) as sources of stigma.

The mothers discussed being able to battle the stigma through resources such as peers and supportive adults. Indeed, the mothers in our study emphasized personal

supports both within and outside of the residence. This contradicts a long-established literature that correlates life in foster care with lacking relational permanence (Cunningham & Diversi, 2012; Goodkind et al., 2011). However, a study on adolescent mothers, although not in foster care, linked social support and a rich social network with positive outcomes (Brubaker & Wright, 2006), indicating the importance of these bonds. For example, the mothers redefined themselves as valued members of a social group as opposed to outsiders (“We’re all in the same situation”). The mothers’ exposure to pregnant and parenting peers in the same internal space (i.e., the residence) helped mitigate the negative effects of external judgments. The connections the mothers made between themselves in the residence are especially important to parenting given participants’ largely ambiguous responses regarding the prospects of the birth father’s involvement in the child’s life. These particular mothers viewed other girls at the residence who provided support for the mother and her child as the “baby daddy,” a phrase now used flexibly to denote friends who played a more meaningful role than the child’s biological father. Although largely used in a joking manner, it is illustrative of the ambiguity around birth father involvement as well as the value of the mothers’ connections within the residence. This parallels research by Haight et al. (2009) who found that mothers want to connect with and mentor other adolescent mothers in foster care. As many mothers in foster care struggle in co-parenting support, often through shared childcare duties (Schelbe & Geiger, 2017), residential “baby daddies” can be a positive resource that adolescent parents who are not in residential care lack.

The mothers in this study expressed that they would not need or want services from trained human service professionals. Some, but not all, felt this was because the care and services they were already receiving within the residence met their needs. Similarly, Haight et al. (2009) noted that although adolescent mothers in foster care struggle with many external social services (e.g., caseworkers), they find solace and support from their foster parents, typically their foster mothers. Many, albeit not all, of the mothers discussed the benefits of available internal services. In providing adolescent mothers in foster care with these resources, it becomes possible to aid in transitioning them out of care while nurturing their resiliency.

## **Limitations and Implications**

Although our findings contribute to an understanding of resilience for adolescent mothers in foster care, they have some limitations. One is the evaluative purpose of the questions; as such, recommendations are based on interpretative analysis and not derived from direct questions asked of the mothers themselves. However, one author of the focus group protocol was a social worker interested in their social supports and wrote questions for this purpose. Second, our study voiced the narratives of the mothers and did not take into account the policies that regulate the broader foster care system. Despite these limitations, multiple implications make this study a strong contribution to knowledge on adolescent mothers in residential foster care.

## **Practice**

We propose that it is critical for residential foster care facilities to actively cultivate resilience among youth including young mothers. Although biological family members might be a source of support and can offer one such resiliency- building modality, this is not always the case and might not always be feasible (Rutman & Hubberstey, 2016). Other potential external social resources, as voiced in our study and cited in other work, include teachers, community mentors (e.g., church members), and friends (Morton 2016; Rutman & Hubberstey, 2016). Increasing the number and quality of these ties can prevent feelings of isolation, particularly if separated from one source of support, such as biological parents or the child's father. Larger external support networks are able to provide different types of needs that might not be available within the residence (Blakeslee, 2012).

Practitioners should also work to develop social resources within the residences. Findings highlight the importance of facilities where mothers with similar experiences can connect (Haight et al., 2009). For example, practitioners can provide space and mentoring to foster mothers' close relationships with one another by encouraging babysitters or writing get well cards. Fostering an overt culture that recognizes mothers as supports for one another might be a promising trauma-informed practice approach. Mothers who have aged out of the system might also be able to provide role modeling, mentoring, and friendship to youth in care; it is also possible for older mothers who have

spent more time in care to mentor younger mothers. Similarly, mothers with children might provide mentorship to first-time expectant mothers (Thompson et al., 2016).

The mothers described how care within the residences tended to be more helpful than from those external to the facility, such as their social workers. This might be partially due to heavy caseloads, which do not allow for more individualized time spent with each youth (Liabo et al., 2017). However, foster youth in general who spend more quality time with case workers tend to have better outcomes regarding their sense of self-efficacy (Scannapieco, Smith, & Blakeney-Strong, 2016). Parallel to trauma-informed care approaches, the availability of consistent and reliable caregivers can help youth who have experienced trauma to improve feelings of safety and security (Purvis et al., 2009). As all staff might not have received clinical social work training, they should receive specific training through programs and workshops that allow them to work with and model healthy communication and relationships for these mothers. In order to maintain a consistent staff, it is important to create a work environment that reduces job turnover through frequent and constructive communication between supervisors and supervisees, sufficient staff to reduce case-loads, and providing spaces for practitioners to recognize and discuss their own struggles in practice (Kim & Lee, 2009). Residences might also measure outcomes related to resilience in order to develop a more thorough understanding of not only the mothers in their own facilities but help to develop more culturally responsive measures of success within this population (Madewell & Ponce-Garcia, 2016).

## **Policy**

In terms of policy, funds should be allocated for services catered specifically for this population. For instance, programs and groups, such as foster youth advisory boards often improve self-efficacy for foster youth transitioning out of care (Forenza, 2016b). Although this research centers around general foster youth, as opposed to those who are adolescent mothers in residential care, residences might implement specific groups to meet the unique needs of pregnant and parenting foster youth. Given others' findings and the resounding desire for support from these mothers, we propose policies that incentivize or require residences to foster unity between mothers or with

other residences, such as advisory boards within the homes.

The mothers reported struggles with the fathers of their children, such as communication difficulties (“they get straight ‘hood”) or dating violence (“[he] call[ed] me the b-word”) that resulted in a strain on their co-parenting relationship. Foster youth in general often struggle in their dating relationships before taking into account adolescent parental relationships (Forenza et al., 2018), which parent- hood can exacerbate (Schelbe & Geiger, 2017). Despite the increased need to facilitate healthy relationships among this specific population, few relationship services are specifically designed for pregnant and parenting foster youth (Scott et al., 2012). Providing funds for relationship education development and implementation aimed at increasing healthy communication skills and preventing dating violence for parents in residential care is of the utmost importance. Taking together these recommendations regarding both practice and policy, it is possible to improve the lives and well- being of adolescent mothers in foster care.

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