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Rebecca Colvin
(Berkshire Children and Families,
Child Care of the Berkshires, and
The Helen Berube Teen Parent
Program) The dilemmas and
challenges of teenage motherhood:
Exploring the barriers in the
discovery of self

ABSTRACT

The purpose of this study was to examine the barriers that may prevent adolescent mothers from accessing social support. For the purpose of this study, the barriers examined were depression and self-esteem. The sample consisted of 50 adolescent mothers who were participants in several social service agencies located in western Massachusetts. The participants completed the Rosenberg Self Esteem scale, the Brief Symptom inventory scale, and a brief form used to gather basic demographic information. Case workers indicated what kinds of social support services the adolescents were engaged in at their programs. Adolescent mothers who were involved in one formal support were more likely to be involved in other formal supports. Hypotheses for this study were not supported; neither depression nor self-esteem were related to accession of social support in this study.

These findings have a direct connection to clinical practice and treatment planning with adolescent mothers. If we assume based on the findings from this study that lack of depression and high self esteem are related to having social supports than it is important for clinicians who work with adolescent mothers and their families to be aware

of the ameliorating factor social supports provide to adolescent mothers and their children.

Clinicians need to be aware of an adolescent mothers social support network because studies indicate that social support decreases depression and increases self esteem for adolescent mothers.

THE DILEMMAS AND CHALLENGES OF TEENAGE MOTHERHOOD:
EXPLORING THE BARRIERS IN THE DISCOVERY OF THE SELF

A project based upon an independent investigation located in Berkshire Children and Families, Child Care of the Berkshires, The Helen Berube Teen Parent Program, submitted in partial fulfillment of the requirements for the degree of Master of Social Work

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2007

ACKNOWLEDGEMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank all my friends and family for their ongoing support; listening endlessly to problems and stressors related to my thesis; and for asking me over and over again “I thought you finished that paper”.

I wish to thank Dr. Marsha Kline Pruett, Ph.D., M.S.L. for her patience and support throughout the thesis process. I thank her for challenging me and allowing me to grow at my own pace in this process.

I thank Susan Guerrero for her endless hours of reading and editing my thesis; her ongoing support and positive encouragement which supported my growth in this long process.

I thank Marjorie Postal for her understanding and support with statistics.

I would like to thank all the young women who participated in this study; you are both inspiring and amazing. I also would like to thank Berkshire Children and Families, Child Care of the Berkshires, the Woman, Infant, and Children Program, and the Helen Berube Teen Parent Program for allowing me the opportunity to learn from the participants within your agencies.

Finally, I would like to thank Paul, my partner and my best friend for his endless support, his encouragement, and his sense of humor. You were and are my rock at Smith and in life. I thank you for telling me to “tie a knot and hang on” when I was at my lowest. Lastly, I thank you for sacrificing 27 months of your life so I could continue my education and accomplish my goals.

This thesis is dedicated in memory of Stephen Kelly

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CHAPTER I

INTRODUCTION

This study focuses on the relationship between depression and self-esteem and accessing social supports for adolescent mothers. The study explores two questions: does depression act as a barrier in accessing social support for adolescent mothers? Does poor self-esteem act as a barrier in accessing social support for adolescent mothers? It is important to understand how adolescent mothers can access support because according to Sommer and colleagues (1993), adolescent mothers have been found to be more depressed, to experience more stress in the parenting role, and to be less positive about being a parent compared with women who become mothers in their early twenties.

The purpose of this study is to expand the current literature that exists on depression and self-esteem of adolescent mothers. Social support has been identified as an important factor during the transition to parenthood for adolescent mothers. In a study of adolescents one month after delivery, Dormire, Strauss, & Clarke (1989) found that participants with increased social support had increased their parenting skills. Parenting responsibilities ultimately place adolescent mothers in a more dependent position; they must rely on support from family, friends, and community resources. If depression and self-esteem are barriers to accessing the necessary social supports for adolescent mothers, current research might help us understand how that occurs and how to address it. By expanding the current literature, clinicians and social workers may be able to treat adolescent mothers more effectively.

There is plenty of literature that exists on adolescent mothers, social support, depression and self-esteem. There is research that discusses mental health and barriers to social support for adolescent mothers. The research on this subject is limited to the positive and negative outcomes of social support with adolescent mothers and their children and how different forms of support benefit or create conflict for adolescent mothers and their children. The following literature review focuses on research regarding adolescent mothers, depression, self-esteem, and social support.

CHAPTER II

LITERATURE REVIEW

Adolescent pregnancy is a common phenomenon that affects our society on many levels. Adolescent mothers and their children are at an increased risk for poverty, child abuse and neglect, mental health issues, and poor health outcomes. These risks are decreased when adolescent mothers and their children have the social support necessary to overcome obstacles and challenges faced on a daily basis. According to The National Organization on Adolescent Pregnancy, Parenting and Prevention, Inc.(www.noapp.org) there are 500,000 infants born to adolescent parents every year in the United States. Every 56 seconds an adolescent gives birth and the estimated cost of adolescent pregnancy yearly is 7 billion dollars. Adolescent pregnancy is costly due to the risks faced by adolescent parents and more than 3 million children. Carothers, Borkowski, Burke, Lefever, & Whitman (2005) assert that,

“Early childbearing affects adolescent mothers as well as their children. In addition to the obstacles adolescent mothers encounter- such as identity formation, struggle for autonomy, and puberty- adolescent mothers are often overwhelmed by their parenting responsibilities. Adolescent mothers must balance the responsibilities of parenthood with the need to continue their education, maintain financial security, and meet their infants’ emotional and physical needs. (p. 263)”

Depression

Incidence and Prevalence

Empirical explanations have been used to explain relationships between depression, social support, and self-esteem in relation to adolescent mothers. This review

begins with studies that discuss the prevalence and incidence of depression with adolescent mothers, and goes on to discuss stressors that contribute to their depression, self-esteem in relation to parenting, positive and negative aspects of social support, the developmental process of adolescence, and the effects of maternal depression on infants and children.

Given the stresses faced by these adolescent mothers as described above, it is not surprising that depression is a concern. Depression is defined by the Diagnostic and Statistical Manual of Mental Disorders (2002) as an individual who feels a profound and constant sense of hopelessness, despair, guilt, worthlessness, and helplessness. In adolescents, this mood may present as irritable. According to the Diagnostic and Statistical Manual of Mental Disorders (2002) women are at a significantly greater risk than men to develop Major Depressive Episodes. Another form of depression to consider is not as severe as a major depressive episode but is considered a mood disorder. Dysthymic disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders (2002) as a depressed mood lasting longer than two years. Adolescents who present with Dysthymia are noted to have low self-esteem and poor social skills.

When researching depression in adolescent mothers it is important to explore postpartum depression. Postpartum depression is a complex mix of physical, emotional, and behavioral changes that occur after giving birth that are attributed to the chemical, social, and psychological changes associated with having a baby. According to the Diagnostic and Statistical Manual of Mental Disorders (2002) about 50%-75% of new mothers experience the "baby blues". After delivery 59% of adolescent mothers of 1-3 year olds met criteria for adult depression (Colletta & Lee, 1983).

Several studies have measured the prevalence of depressive symptoms in adolescent mothers (Schmidt, Wiemann, Rickert & Smith, 2006; Deal and Holt, 1998; Hudson, Elek, & Campbell-Grossman, 2000; Clemmens, 2002). These researches have concluded depressive symptoms among adolescent and first time mothers were prevalent. Statistics indicate that 50 % of adolescent mothers experience moderate to severe depressive (MSD) symptoms during the first year postpartum (Schmidt et al.,2006). Postpartum depression at times may lead to major depression. According to Colletta & Lee (1983) 59% of adolescent mothers of 1-3 year olds met criteria for adult depression. In conclusion, studies have indicated that depression is prevalent among adolescent mothers and depression may continue past the postpartum phase of motherhood.

While the studies mentioned above found adolescent mothers to have depressive symptoms, Troutman and Cutrona (1990) found that despite the relatively high prevalence of clinical depression among adolescent mothers in this study, no statistically significant differences between the childbearing and non-childbearing samples were found for rates of either major or minor depression. The study concludes that adolescents in general have high prevalence of clinical depression but found that adolescent mothers are not at an increased risk for depression (Troutman & Cutrona, 1990).

In trying to explain why adolescent mothers may be at risk for depression, one theory suggests that adolescent mothers experience multiple changes to their bodies, which increases their risk for depression. Adolescent pregnancy deviates from the normal course of development. Because of this, adolescent mothers face two monumental physiological processes simultaneously- their physical transformation of puberty and the changes of gestation (Trad, 1995). Because of the physiological changes associated with

adolescent pregnancy, adolescent mothers may be at a higher risk for postpartum depression.

Role of Stressors

There is much literature that explores possible contributions to depression, including psychosocial stressors. Several studies indicate that there is a positive relationship between psychosocial stressors and depression (Barnet, Joffe, Duggan, Wilson, & Repke, 1996; Prodromidis, Margarita, Abrams, & Sonya, 1994; Pianta & Egeland, 1994). One study indicated a bidirectional relationship, between psychosocial stressors and depression meaning depressive symptoms themselves play a role in the generation of stressful events and stressful life events may predict depression (Pianta & Egeland, 1994). Prodromidis et.al.(1994) indicated that depressed mothers consistently reported more problems in most areas of psychosocial functioning. Additionally, the best predictors of maternal depression were mental health status, family relations, and social skills.

Some studies found stress to increase after the birth of the child (Barnet et. al., 1996; Panzarine, 1984). Panzarine (1984) examined perceived stressors, coping strategies, and perceived social supports in a group of 43 adolescent mothers during puerperium. Findings for perceived stressors and coping indicate the mothers expressed concern about their interactions with the baby, the baby's health, and when alone- not being able to stop the baby from crying (Panzarine, 1984). In a study conducted by Barnet et al. (1996), the adolescents studied had high stress levels, which had increased from prenatal to postpartum period, and were positively associated with depressive

symptoms. In conclusion, studies indicate that stressors increase after the birth of the baby and increased depression is associated with high levels of stress.

Some studies found stress to be increased by lower levels of marital or relationship satisfaction (Gelfand, Teti, & Fox, 1992; Panzarine, Slater, & Sharps, 1995). According to Panzarine et.al. (1995) Twenty-six mothers had reported worry about their relationship with the father of the baby. They expressed relationship and communication concerns. Some mothers were sensitive to criticism about baby care and were upset that the father of baby was inconsiderate with the time constraints in caring for the baby. In another study conducted by Gelfand et. al. (1992) parenting stress was compared among depressed and non-depressed mothers of infants. They found that depressed mothers had lower levels of marital harmony and social support, greater numbers of everyday problems, and more intense parenting stress. Overall, these findings indicate that adolescent mothers face increased psychosocial stressors, which may contribute to high stress levels, which has been positively associated with depressive symptoms.

Impact of Depression on Infants and Children

When adolescent mothers suffer from depression their children are at risk for emotional, psychological, and physical developmental delays (Field et.al., 2000; Rhule, McMahon, Speiker, & Munson, 2006). Field et. al. (2000) concluded that infants of mothers with depressive symptoms showed developmental delays, if depressive symptoms persisted over the first six months of the infant's life. The infants presented with inferior Brazleton scores, flat affect, immature sleep patterns, and growth delays were seen at three months with head circumference and length. A study conducted by Martinez, Malphurs, Field, & Pickens (1996) concluded that depressed mothers showed

less facial features, game playing, physical activity, and vocalizations with their infants. A study conducted by Ruttenberg, Finello, & Cordeiro (1997) disagreed with previous results regarding depressed mothers and risks to infants. Results from their study found no difference between depressed mothers' and non-depressed mothers' interaction with their infants.

In an article review, Panzarine (1988) noted that adolescent mothers are less sensitive in their responses to the interaction cues of their children, and are more likely to use physical rather than verbal exchanges with their children. Panzarine notes that these deficits can have a negative impact on a child's development. She also noted that empirical evidence supports findings that adolescent mothers' interactions with their infants may set the stage for the infants' developmental delays in cognitive, language, and maybe social development. Similarly Gelfand et al. (1992) found that increased stress in depressed mothers with higher levels of parenting stress behaved less optimally, scoring lower on scales of sensitivity, warmth, animation, and engagement with their infants, and more often expressing anger versus the depressed mothers who reported less parental stress. They were judged independently to be more competent, warm, and sensitive when interacting with their infants.

Despite difficulties experienced by children of adolescent mothers some children show resilience in spite of their mothers' vulnerabilities. In a longitudinal study conducted by Rhule et.al. (2006) 100 children born to adolescent mothers were followed and the study examined the prediction of positive behavioral, social, and academic adjustment at grade three. Individualized testing and parent and teacher ratings were used to measure adjustment outcomes. Results demonstrated that children of adolescent

mothers showed considerable resilience, in that 89% of children were positively adjusted in at least one domain of functioning despite their at-risk status.

Social Supports

Given the increased psychosocial stressors and increased risk of depression faced by adolescent mothers and their children, it is vital that ameliorating factors are understood to support adolescent mothers and their children. One of the factors most researched is social support. This study adopts Cohen, Underwood, & Gottliebs' (2000) definition of social support. They describe two supportive functions that comprise social support. The first function is instrumental support, which is comprised of tangible support, practical support, behavioral assistance, and material aid. The second function is informational support, which is comprised of advice, guidance, appraisal support, cognitive guidance, and problem solving.

When should social supports begin?

When examining different forms of support it is important to examine when interventions and support should begin. According to a study conducted by Honig and Morin (2001), home visits prior to infant birth made a significant difference in preventing child abuse and neglect. Services beginning prior to an infant's birth for high-risk adolescent mothers proved to be a protective factor against abuse/neglect. The longitudinal follow-up of high-risk parents showed that participation in a two-year home visitation program significantly reduced rates of confirmed child abuse and neglect, confirmed abuse rates were compared with program dropouts (Honig & Morin, 2001). Several studies indicate that support perinatally will increase positive maternal outcomes

(Koniak-Griffin et al., 2002; Koniak-Griffin et al., 2003; Nguyen, Carson, Parris, & Place, 2003; Collins, Schetter, Lobel, and Scrimshaw, 1993; Honig & Morin, 2001).

Adolescent mothers and their children benefit from instrumental and informational social support. Perinatal support will increase positive maternal outcomes (Koniak-Griffin et al., 2002; Koniak-Griffin et al., 2003; Nguyen et al., 2003; Collins et al., 1993). Collins et al. (1993) concluded women who received more prenatal support experienced better progress in labor and delivered babies who appeared healthier five minutes after birth, as indicated by their Apgar rating. Koniak-Griffin et al. (2002) found that home visitation produced healthy outcomes for children of adolescent mothers; infant hospitalizations were substantially reduced and immunization rates increased while participating in an early intervention program of intense home visitation. Nguyen et al. (2003) also found positive birth outcomes of Hispanic adolescent mothers and their infants. Adolescents in the control group had a higher percentage of premature births versus the intervention group who delivered at full term. Apgar scores were similar for both groups and no birth defects were reported for either group. In each of these studies when social support was present, adolescent mothers and children are at a decreased risk to their health and well-being.

Instrumental Support

Ongoing instrumental support is essential to the development and safety of children of adolescent mothers. Adolescent mothers have limited understanding of child development, high stress levels, low availability of social support and mediocre parenting attitudes and behaviors (Culp, Culp, Blankemeyer, & Passmark, 1998). Culp et al. (1998) concluded after six months of intervention the mothers significantly improved their

knowledge of infant development, empathic responsiveness. Stevens-Simon, Nelligan, & Kelly (2001) concluded the opposite in that intensive home visitation did not alter child maltreatment or maternal life course development. When mothers have the informational support necessary to parent their parenting skills improved.

In a study conducted by Stern and Alvarez (1992) which compared pregnant adolescents, parenting adolescents, and non-pregnant adolescents on knowledge of child development and attitudes toward caretaking a sample of 39 adolescent mothers, 45 pregnant adolescent, and 45 adolescent girls participated in this study. The pregnant, parenting, and non-pregnant adolescent groups examined in the study were found to differ in their knowledge of child development. Adolescent parents are known to have less child development information, but when compared to non-pregnant adolescents, they were more realistic in their developmental milestone expectations. Pregnant and parenting adolescents were within norms for most of the milestones whereas non-pregnant adolescents underestimate the capabilities of infants (Stern & Alvarez, 1992). Results indicate that compared with non-pregnant adolescents adolescent mothers have some child development knowledge but overall studies have concluded that adolescent mothers have limited child development knowledge, which puts children at risk (Culp et.al., 1998; Stern & Alvarez, 1992).

Studies conducted by Flynn (1999) and Mann, Pearl, and Behle (2004) indicate a positive affect on parental knowledge and child health when adolescent mothers are participating and receiving ongoing instrumental support identified as groups or home visitation. In a short-term study conducted by Mann et.al. (2004) sample consisted of 42 pregnant and parenting adolescents ages 13-20 and adults who began parenting as

adolescents. Mann et.al. (2004) measured changes in knowledge and attitude following participation in the classes. The PAAT items, which assess parental knowledge, were grouped into five subscales- creativity, frustration, control, play, and teaching-learning. Second form of measurement was the AAPI, which assess participants' attitudes. It consists of four subscales: parental expectations for the child, parental empathy for child's needs, parental value of physical punishment, and parent child role reversal. Gains in knowledge were modest (Mann et.al., 2004). Comparison of pre and posttest scores using paired sample t-tests indicated statistically significant improvement in six of the nine areas of knowledge and attitudes; creativity, frustration, control, play, teaching and learning and parental expectations for the child and parental value of physical punishment (Mann et.al., 2004).

Flynn (1999) conducted a one-group pretest posttest intervention study that sought to analyze the efficacy of a program designed to improve infant outcomes through the enhancement of health practices and parenting skills. This sample consisted of 137 low income, pregnant and parenting adolescent mothers from an urban area who were screened positive for risk of child maltreatment. Findings indicate favorable outcomes among program participants. Neonatal and postnatal mortality were zero. The percentage of low birth weight infants within the sample was markedly lower than that of local or national percentages among adolescents. The incidence of child abuse and neglect was much lower compared with adolescents nationwide. Age appropriate immunizations were above local and national urban averages. To sum up, findings indicate that adolescent mothers and their children are at a decreased risk when adolescent mothers are participating in ongoing instrumental support of interventions.

Instrumental support has been noted as an ameliorating factor with adolescent mothers and their children. Several studies indicate social support acts as an ameliorating factor to adolescent mothers, their children, and depressive symptoms (Bunting & McAuley, 2004a; Bunting & McAuley, 2004b; Camp, Holman, & Ridgway, 1993; Panzarine, 1986; Rhodes, Ebert, & Fischer, 1992; Thompson & Peebles, 1992). Thompson and Peebles (1992) concluded that frequent contact with a caseworker was associated with fewer depression symptoms. Panzarine (1986) concludes that social support contributed to a smooth transition to motherhood, sharing childcare with the family was an important component of support received, and social supports were essential to motherhood. Camp et.al. 1993 concluded social support did very little to alleviate the anxiety and stress associated with pregnancy, but once the infant was born social support was associated with lowered stress levels. According to Bunting & McAuley (2004) grandmothers are a primary source of support and they appear to have a positive influence on parenting behavior. The relationship between mother and daughter can be either supportive or conflictual. Bunting & McAuley (2004) notes that conflict in interpersonal relationships may increase with time with older teenagers wanting to assert their independence.

Emotional Support

Several studies identified emotional support with positive outcomes (Panzarine, 1986; Waller, Brown, & Whittle, 1999; Gee & Rhodes 2003; Richardson, Barbour, & Bubenzer, 1995). According to Waller et. al. (1999) social support through mentorship promoted encouragement, which has been associated with positive birth outcomes, continuing education, and reducing stress levels. Other findings indicate that peer

relations are an important source of emotional support (Richardson et.al., 2005).

Richardson et.al. (2005) concluded that perceived support from peers surpassed that of family/relative. Panzarine (1986) conducted a qualitative study and 69% reported the father of the baby was a source of emotional support as well as 63% reported families as emotional support. A small qualitative study conducted by Stiles (2005) found that adolescent mothers defined emotional support as having someone to talk to and someone who would not judge them. Gee and Rhodes (2003) assert that male partners (including fathers) are one of the primary social resources for adolescent mothers, and the support that they provide during the postpartum adjustment period is often critical to the adolescents' well-being. Approximately half of adolescent mothers identify a male partner as someone who provides social support and this support is often rated as being as important as support provided by their mothers. Moreover, their support has been associated with adolescent mothers' greater overall life satisfaction, lower psychological distress, and higher levels of self-esteem (Gee & Rhodes). Furthermore, evidence suggests that father support may contribute to less angry and punitive parenting on the part of adolescent mothers.

Social support is considered an important mediator for depression with adolescent mothers and their children (Barnet et. al.,1996; Gelfand et. al.,1992; McKenry, Browne, Kotch, & Symons, 1990). Gelfand et al. (1992) and Colletta (1981) that depressed mothers had less social support. McKenry et al. (1990) concluded depression postpartum and at one year was present and the role of social support in the adjustment to parenthood was clarified. Colletta (1981) found that when young mothers were isolated from a supportive social environment their children were at risk of maternal rejection.

Social support has been researched as both positive and negative for adolescent mothers. Support in some studies has been a positive factor (Bunting & McAuley, 2004a; Bunting & McAuley, 2004b; Camp, Holman, & Ridgway, 1993; Panzarine, 1986; Rhodes, Ebert, & Fischer, 1992; Thompson & Peebles, 1992) and some studies found a negative effect (Cramer & McDonald, 1996; Dean, Lin, & Ensel, 1981). Support with family and peers has been noted to contribute to stress and depression in adolescent mothers but also has been identified as a protective factor. Barnett et.al., 1996 concluded adolescent mothers and the infants' father were identified as most common support provider during the third trimester but by four months post partum a significant portion of the adolescent mothers did not name their mothers or the infant fathers among their support networks. According to Cramer & McDonald (1996) kin support was not effective in alleviating the stress that accompanied pregnancy and motherhood and in some cases, it actually created stress and conflict. When relationships are difficult the conflict they produce may make it difficult to access support and to be satisfied with that support.

Many factors may contribute to the stress and conflict with social support. Adolescents with mild to moderate depressive symptoms were less satisfied with the support (Dean, Lin, & Ensel, 1981). Dean et.al. (1981), found that depression was associated with social support problems regarding interpersonal conflicts (communication problems), and dissatisfaction with the community. Cramer & McDonald (1996) concluded the underlying issue with dissatisfaction, stress, and conflict with support was related to the discrepancy between the young mother's expectations and her support

networks performance. Adolescent mothers have many needs and when those needs are not met, it appears that conflict, stress, and dissatisfaction with social support is present.

In a study conducted by Barnett et.al. (1996) support satisfaction increased from the prenatal to the postpartum period despite the actual decline in the number of support persons. Social support was negatively associated with depressive symptoms, especially in those adolescents who were highly stressed (Barnett et.al., 1996). Findings also indicated that social support did not provide a protective effect among low stressed adolescent mothers (Barnett et. al., 1996). Findings indicated that those who were low stressed may not be at the greatest risk for depressive symptoms. In a study conducted by Panzarine (1986) findings indicate the opposite in that the perceived support that was offered at times created more stress. The participants noted that the most important factor that made advice giving a supportive interaction was the fact that the participant could refuse the advice. Information had to be offered in a way that the adolescent mothers felt respected.

Adolescent mothers are also sensitive to support offered and how it is presented. Gee and Rhodes (2003) study examined the role of biological fathers in the lives of minority adolescent mothers over the first 3 years postpartum. Relationships with fathers were, in general, less supportive and less problematic at 3 years postpartum than during the prenatal period. Results indicated that father support was not associated with adolescent mothers' psychological adjustment (Gee & Rhodes, 2003). Father absence, however, was positively associated with both depressive symptoms and anxiety (Gee & Rhodes, 2003). Barnett et.al. (1996) found that adolescent mothers who received material support from their infants' fathers had significantly higher rates of depressive symptoms

and 75% of pregnant adolescents who reported receiving material support from infants' fathers also reported high levels of interpersonal conflict. This statistic could be due to the high level of need by the adolescent mothers' and the fathers inability to meet the high need, so the result is increased interpersonal conflict or a perceived need not being met by the infant's father (Gee & Rhodes, 2003). Support by fathers' has been noted to be both positive and negative and it is noted to either contribute to depression or a protective factor for depression, parenting, and emotional support.

In conclusion, research shows that social support is effective and considered a protective factor, but satisfaction with perceived social support seems to be a factor in adolescent mothers' accessing social support. Therefore, it is safe to assume that extensive social support is not always a protective factor and in some cases increases depressive symptoms and stress in adolescent mothers. Therefore, in doing research one should consider that depression may not be a barrier but adolescents may not want to access a social support because they are dissatisfied with the support they are receiving.

Self-Esteem

Adolescent Development

Adolescence is a time of development transformation. The developmental changes are monumental for adolescent mothers. They go through many changes that Trad (1995) refers to the five domains: physical change, cognitive functioning, affective regulation, interaction with peers, and interaction with family. With these changes it is difficult for adolescent mothers to develop a healthy sense of self. Identity formation is critical for young adults but it is complicated by the parenting role and demands placed on adolescent parents (Nurius, Casey, Lindhorst, & Macy, 2006). Young women in a

study conducted by Nurius et al. 2006 found adolescent mothers to have distinct identity profiles that have important implications for psychosocial functioning, interpersonal relationships, social support, and parenting. Nurius et.al. (2006) asserts “self concept valence and identity health matter for adolescent mothers since it explains risk and protective factors, which respectively enhance or diminish young women’s well being and capacity for positive interpersonal relationships (pg.113)”. It is important to note that identity health is imperative to psychosocial functioning and interpersonal relationships. Without healthy identity development, one could speculate that the adolescent mothers have a lower level of social support due to insufficient interpersonal skills of adolescent mothers.

Hulbert and McDonald (1997) used Erikson's stages of development to explain adolescent mothers’ development. Erickson’s eight stages represent a life span perspective from infancy to adulthood. Each stage represents a psychological conflict to be resolved in order for the individual to proceed successfully to the next and subsequent stages leading to healthy personality development. Adolescent mothers have to deal with the stage of generativity before they are ready. The generativity stage age range is 35-60 which focuses on children, community, and nurturing close relationships. This stage of development is about satisfying and supporting the next generation which goes against the stage of adolescence. Adolescence, which Erikson’s defines as age 11-18 focuses on identity development and peer relationships. The developmental tasks in this stage of development are physical maturation, emotional development, membership in peer group, and sexual relationships. Because of these developmental barriers it is easy to see how adolescent mothers have difficulty navigating these stages. They are struggling with

identity development and at the same time are catapulted into generativity which is satisfying and supporting the next generation these stages go against each other. Because of these difficulties they are not able to develop an autonomous sense of self (Hulbert & McDonald, 1997). This places their social and emotional development at risk or even halted. This places the children at risk because adolescent mothers are not developmentally capable of dealing with the demands of parenting. (Hulbert & McDonald, 1997). Adolescent mothers often face more than one life circumstance change simultaneously such as separation from their mothers, formation of other intimate relationships, and transition to pregnancy and then motherhood, which may affect their self-esteem (Hulbert & McDonald, 1997).

Self-Esteem and Parenting

Teti and Gelfand (1991) examined whether self efficacy beliefs mediate the effects on parenting behaviors such as depression, perceptions of infant temperamental difficulty, and social martial supports. The sample consisted of 86 mothers including 48 depressed mothers. The results from the study conclude that maternal self-efficacy is a central mediator of relations between mothers' competence with their infants and factors such as maternal perceptions of infant difficulty, maternal depression, and social martial supports (Teti & Gelfand, 1991) . In conclusion findings from this study would lead one to begin to assume that the role of self efficacy is central to a mother's ability to caretake her child. Self efficacy is imperative to a healthy parent child relationship.

Racial Differences in Self-Esteem

When looking at self esteem it is important to examine racial differences because in a study conducted by Smith, Johnson, and Findlay (1994) differences in self esteem were found between African Americans and European Americans. Findings indicate that African American pregnant adolescents compared to pregnant European American adolescents expressed greater confidence in their ability to deal effectively with stress and tension (Smith et.al, 1994). Findings reported fewer overt symptoms of cognitive or perceptual dysfunction with African American pregnant adolescents. African American pregnant adolescents were more likely to report positive alliances with parents and view the emotional atmosphere at home as favorable, warm, and supportive. African American pregnant adolescents also expressed greater capacity for developing and maintaining close relationships. In comparing pregnant African American and European pregnant African Americans scored higher on all self-esteem dimensions, including impulse control, mental health , social functioning, family functioning, vocational functioning, self-confidence, self-reliance, body image, sexuality, and ethical values. It is important to note that 50% of the European Americans were married and the assumption was made that the marriages were a result from the pregnancy, because all adolescent were still in school. None of the pregnant African American adolescents were married (Smith et.al., 1994)

Parenting Knowledge and Self-Esteem

Hulbert and MacDonald (1997) investigated the relationship between adolescent mothers' self-esteem and their knowledge of parenting skills. Findings indicate that mothers' knowledge of parenting skills relates to their self-esteem. When the baby was

three months old, the correlations between baseline self esteem and role reversal, empathy, and developmental expectations were each significant. As the mother's self-esteem decreased, she was more likely to believe that the child should gratify her needs. Findings with corporal punishment and self-esteem scores suggest that self-esteem becomes predictive of appropriate punishment knowledge at three months. As punishment becomes more of an issue, the mother was more likely to inappropriately punish. If this trend was to continue, the negative correlation between self-esteem and corporal punishment scores may continue to increase. Hulbert and MacDonald (1997) assert,

“the significant correlation between role reversal and maternal self esteem in adolescent mothers supports the theoretical perspective that self esteem, as an indicator of role identity, is predictive of parenting. According to Eriksons theory, role identify is the primary developmental task of adolescence. In order to achieve role identity, the adolescent needs to experiment with many roles and have the opportunity for positive social support during this experimentation. One of the possible risk factors of adolescent parenting is that the adolescent mother does not have the adequate time to resolve her role identity”(p.649).

Anderson and Lauderdale (1982) measured self-esteem of abusive parents in child abuse intervention programs in three states. They found that low self-esteem was a factor associated with abuse. Melnick and Hurley (1969) found that abusive mothers had low self esteem, lower ability to nurture, lowered ability to empathize, high frustration related to their dependence needs, and lowered satisfaction with their families. Parents in the study who abused their children had limited abilities to cope with life's stressors.

Anderson and Lauderdale assert,

“Parents in this study could be characterized as individuals who view themselves as being worthless, have poorly integrated personalities, and feel confusion and conflict in terms of their basic sense of self. A low level self esteem, coupled with the failure to parent adequately as evidenced by the abusive behavior, low employment and income status, and low educational level, points to the general failure of the client group to engage in successful social functioning”(pg.292)

With underdeveloped self-esteem, adolescent mothers are at an increased risk for psychosocial stressors. Nurius et.al. (2006) studied 236 adolescent mothers. They were placed into four groups; strong identity health, average identity health, impaired parenting, and vulnerable identity health. Findings indicate that women with strong identity health rated higher on every variable; higher on self esteem and all self concept variables and lower levels of the global index of mental health problems. There was a significant difference between the self-esteem in the strong identity health and the impaired parenting group. “People with stronger mental health, self esteem, and social support view themselves and their futures in highly, even exaggerate positive terms” (Nurius, p.115).

Conclusion

Adolescent mothers may face tremendous stress from the moment they make the decision to become a parent. Adolescent mothers face physiological and psychological changes that put them at an increase risk for depression (Trad, 1995). Depression has many effects on adolescent mothers and their children. Adolescent mothers have been found to have low self-esteem, which may contribute to decreased social networks and low social skills (Nurius et al., 2006). With all factors combined adolescent mothers and their children are at an increased risk for developmental, psychological, and emotional

delays. Social support may be available to create a protective factor for adolescent mothers and their children. This leads me to the research question I seek to explore; Do depression and poor self-esteem act as a barriers in accessing social supports for adolescent mothers?

CHAPTER III

METHODOLOGY

The purpose of this study is to examine the barriers that may prevent adolescent mothers from accessing social support. For the purpose of this study, the barriers examined are depression and self-esteem. The research question is: Do the adolescent mothers under study suffer from depression and low self-esteem, and if so, is that related to their accessing social supports available to them? Two hypotheses will be investigated in this quantitative study. The first hypothesis states adolescent mothers who identify as depressed will access less social support than less depressed mothers. The second hypothesis states that adolescent mothers with poor self-esteem will access less social support than those adolescent mothers with high self-esteem.

This is a cross-sectional study designed to examine the relationships between depression, self-esteem, and social support. The formal supports examined in this study are identified as instrumental support and informational support. Instrumental support is comprised of tangible support, practical support, behavioral assistance, and material aid. Informational support is comprised of advice, guidance, appraisal support, cognitive guidance, and problem solving. The specific social support variable considered in this study is home visitation, which is identified as informational support and instrumental support. Home visitation is defined as informational because it provides problem solving support, guidance, and advice with parenting issues as well as personal issues. Home

visitation is also defined as instrumental because home visitors provide practical support such as transportation to appointments for adolescent mothers. The second variable is school, which is identified as informational support. During school students receive cognitive guidance as well as advice and problem solving skills. The third support is job training, which is identified as informational support. Job training provides career-counseling, problem solving skills as well as cognitive guidance. The fourth variable is childcare. Childcare is identified as instrumental support. It allows adolescent mothers the support necessary to attend school or work. The fifth variable is groups, which are identified as informational and instrumental. They provide instrumental support by assisting adolescent mothers with problem solving skills, time to themselves as well as support from other mothers regarding parenting and personal issues. Groups are also informational support. They provide adolescent mothers with useful information about services in the community as well as information regarding parenting education. The sixth variable is the Department of Transitional Assistance and it is defined as instrumental support. The monies provided by the state agency assist adolescent mothers in supporting their families. The seventh variable examined is the Women, Infants, and Children program, which is also instrumental support in that it provides women, infants and children with supplemental nutrition. Supplemental nutrition would be defined as material aid to an adolescent mother. I am examining these supports because in the many years I have worked with adolescent mothers I have seen these social supports underutilized. Second, I hypothesize that depression as well as low self-esteem are theories for the underutilization of social support services for adolescent mothers.

Sample

The sample collected was a convenience sample. This non –probability-sampling technique was conducted by using agency staff to recruit participants. A sample of 50 adolescent mothers, between the ages of fourteen to twenty–one, agreed to participate in this study. The mean present age was 19.02 years old (SD=1.450). The mean age at delivery was 17.32 (SD= 1.477). Race and Ethnicity were identified as followed; 64 % (n = 32) of participants identified as Caucasian/ White, 14 % (n = 7) identified as Hispanic/ Latino, 12% (n = 6) identified as African American/ Black, and 10 % (n = 5) identified as Bi-Racial. Income level varied from \$0-20,000 with 68 % placed in the \$0-5,000 range. The living situation varied among the sample but 36% (n = 18) reported living alone followed by 24% (n = 12) living with father of the baby, and 18% (n = 9) living with parents. I recruited participants from Childcare of the Berkshires; Healthy Families and the Young Parent Childcare Project, the Helen Berube Teen Parent Program, Berkshire Children and Families; The Redfield House, Evenstart, Healthy Families, The Young Parents Support Outreach Program, and the Women infant and Children program. These numbers are summarized in Table 1.

The first agency, the Helen Berube Teen Parent Program, is an alternative education facility, which has served young mothers and their infants for nearly 24 years. Pregnant and parenting women under the age of 21 years enroll in the program in order to receive parent support while continuing their secondary education, or while obtaining their general education diploma. With eight education tutors, a specialized maternal and child health registered nurse, a case manager, a social worker, and an onsite accredited

nursery; the teen parent program offers a comprehensive range of educational, healthcare and social service options throughout an academic school year.

The second agency is Berkshire Children and Families, which is the umbrella agency for The Redfield House, Evenstart program, The Young Parents Support and Outreach Program, and The Healthy Families program. The Redfield House is a supportive living environment for young parents and their children, which offers parenting and life skills training and a wide range of parenting groups. The Evenstart program provides adult education, early childhood education, home visits, and parent child groups. The Young Parents Support Outreach Program is a home visiting program, funded by the Department of Social Services, which helps support and provide access to services and supports for young mothers age 14-23. Healthy Families is a home visitation program that serves pregnant and parenting adolescent mothers ages 14-21. Healthy Families offers parenting support, child development information, and ongoing parenting support through home visitation and parenting groups.

The third agency is Child Care of the Berkshires, which is the umbrella agency for Healthy Families as described above and The Young Parent Childcare Project, which is a program that assists adolescent mothers ages 14-20 with free childcare, case-management and life skills.

The fourth agency is Women, Infants, and Children (WIC), a special supplemental nutrition program for women, infants, and children. WIC serves to safeguard the health of low-income women, infants, & children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Ethics and Safeguards

A potential risk for being participants in this study may have been emotional distress brought upon by reflections and how they were feeling. Some adolescents may have experienced feelings of sadness or anxiety. Since many participants were active in mental health agencies already, they were encouraged to access the supports that were available to them. In case the agencies were not meeting their needs, a list of local, affordable referral sources was made available to them. A benefit for young parents to participate in this project may have been a offer of a well-needed opportunity to focus on what they need, and participation may have allowed them the time to reflect on their current situations and time to reflect on services they were not accessing. Participants were given pizza for their participation in the research project.

The informed consent was explained to the participants and informed consent was obtained, using parental consent and informed consent (Appendix A and B). In the state of Massachusetts, a parenting adolescent under the age of eighteen is allowed to give her own informed consent, because she can make medical decisions for her child. This is known as “logical reasoning”. The researcher got informed parental consent from the parents of the adolescents when the adolescent mother was under the age of 18 and lived with her parents. The researcher used the home visitors to get parental consents signed for Healthy Families participants. The adolescent mother under the age of eighteen who did not live with her parents and was not involved with the Department of Social Services signed her own informed consent. Mothers over the age of eighteen signed their own informed consent. Participants and parents were given a copy of the informed consents, which listed contact information for the researcher. All participants had the opportunity

to withdraw from the study on or before March 15, 2007. All participants who participated on or after March 15, 2007 were informed through the informed consent process they could withdraw on or before April 10, 2007.

The researcher will keep all data for three years, per federal regulations. After this time the materials will continue to be kept secured or destroyed. Each participant was given a number, which identified the corresponding data and questionnaires that were administered. Informed consents are being kept separate from completed instruments. No names were used on any documentation except for the program staff questionnaire. This allowed program staff to identify and rate the participants' involvement with social support. Confidentiality was held to a high standard but anonymity was not possible due to data being gathered in groups. The researcher was sensitive to confidentiality by spreading out all participants while they were completing questionnaires in order to maintain confidentiality and allow them privacy so other participants did not look at their responses. The only person who has handled the data is the researcher and the statistical analyst once identifying data was removed. Participation in this study was voluntary. Participants were informed that any question may be skipped at any time. If a participant withdrew, all of their information was destroyed immediately. One participant withdrew from the study and data was destroyed.

Data Collection

Instruments

Demographic data was collected in order to compare participants on numerous variables (Appendix C). The questions were as follows; (1) How old are you? (2) How

old at age of delivery? (3) What is your race and ethnicity? (4) What is your income level? (5) What is your current living situation?

Brief Symptom Inventory

The instrument used to measure depression was the Brief Symptoms Inventory scale (BSI) (Appendix D). The BSI is used to measure levels of psychopathology. The test may also be used with adolescents as young as 13 because separate norms for this age group have been developed. The BSI is a 53 item brief self-report form. The inventory assesses nine primary symptom dimensions, including somatization, obsessive-compulsive thoughts and behaviors, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, and paranoid ideation. Instructions direct respondents to report how much discomfort each item caused them during the past week, including during the current day. (American Psychological Association, 2000).

Reliability is based on a sample of 718 psychiatric outpatients,

“Cronbachs alpha coefficients ranged from 0.71 on the psychoticism dimension to 0.85 on the depression dimension. A sample of 60 non-patient individuals were tested twice across a two-week interval, and coefficients ranged from 0.68 for somatization to 0.91 for phobic anxiety. The Global Severity Index (GSI) has stability co-efficient of 0.90. (American Psychological Association, 2000).

In terms of validity The BSI identifies psychological distress across nine symptom domains. In a study of newly diagnosed cancer patients the BSI correctly identified 84% of the patients who were actually judged clinically distressed 1 year later as potentially problematic (American Psychological Association, 2000).

Rosenberg Self-esteem Scale

The Rosenberg Self Esteem Scale is a ten-item Likert scale with items answered on a four-point scale - from strongly agrees to strongly disagrees (Appendix E). The scale attempts to measure global self-esteem. It consists of 10 statements related to overall feelings of self-worth or self-acceptance. (Rosenberg,1989). Positively and negatively worded items are included in the scale to reduce the likelihood of response set. When five items are reverse-scored, higher scores indicate greater self-esteem. Silbert and Tippet (1965), in a study involving use of the RSE with adolescents, reported good test-retest reliability (.85) over a two-week interval. A Guttman scale reliability coefficient of .92 among adolescents was reported by Rosenberg (1965).

Variables

Participants answered three questions at the end of the demographic questionnaire, which are identified as variables. The variable questions are, (6) Current services offered and are participating in? (7) How helpful are services? (8) What supports don't you have that you would find helpful?

The program staff questionnaire was designed to measure social support accessed by the adolescent mothers (Appendix F). The program staff included social workers, case managers, and home visitors. The role of gathering data from program staff was to provide the most accurate information necessary to determine the consistency in accessing support. The program staff rated the participants individually on home visitation, school, job training, childcare, groups, Department of Transitional Assistance, and Women, Infant, and Children program.

Healthy Families Massachusetts is a program funded through the Children's Trust Fund. Healthy Families of Berkshire County and Northampton are two programs within the Healthy Families Massachusetts network. Healthy Families of Childcare of the Berkshires and Berkshire Children and Families use a web-based database, called the Participant Database System (PDS), for collecting all of its information as it relates to families and the services provided to the families. Data, which is input into the PDS, include the home visit encounter record. The record includes; observations made at home visit, activities conducted with family, items discussed, immunizations, goals and the family's progress on the goals, referrals made to other programs/services, medical issues (either for parent/child), results of developmental assessments completed with the child, and any secondary contacts with the families (phone calls, mailings, etc.). Home visitors are also required to complete 3,6,12,18,24,30, and 36-month status reports, which document demographic data as well as all supports accessed during that time.

The Helen Berube Teen Parent Program, The Redfield House, The Young Parents Support Outreach Program, Evenstart program, and The Young Parents Childcare Project all use case notes, which monitor social supports used. The Helen Berube Teen Parent Program monitors data through case notes and attendance records. School attendance, group attendance childcare, home visitation, DTA, and WIC are all documented in case files. The Redfield House utilizes case managers who have daily contact with all residents in the program and are able to monitor social supports utilized by residents. Social supports are monitored through case notes and treatment plans. The Young Parent Support Outreach Program has one case manager who meets with participants in their homes on a weekly basis. The case manager monitors social supports through case notes.

Case managers also provide transportation to and from appointments which help monitor social supports accessed. The Evenstart program has case managers who meet with students on a daily basis. Case managers monitor social support through case notes, individual education treatment plans, weekly contact with all participants, and contact with community agencies. The Young Parents Childcare project uses monthly reports to monitor all social supports. Monthly reports are used for yearly outcomes which measure childcare, attendance to job and or school, groups, DTA, WIC, and home visitation.

Procedures

At The Helen Berube Teen Parent Program, The Redfield House, The Evenstart program, and Healthy Families of Childcare of the Berkshires and Berkshire Children and Families, researcher-attended groups that participants were currently attending with prior approval from program staff. Researcher recruited participants by asking who was between the ages of 14 and 21, currently parenting, and interested in participating. The potential participants were assured that their participation or choice not to, would not in any way affect their relationship with their agency, or the services they were offered. Those who were eligible and interested attended a subsequent group that was held after a short break. In the second group the researcher went through the informed consent and allowed time for questions. The researcher then passed out the three forms of questionnaires, gave instructions, and allowed time for questions. Researcher was available during the group for any questions while participants were completing the questionnaires.

For participants who wanted to participate and needed parental consent the researcher made special accommodations to come back to the agency so the participants

were able to participate. The researcher used home visitors to get parental consent from participants who were receiving home visitation from Healthy Families as well as using a flyer (Appendix G) to recruit participants to groups. Parental consent became very difficult due to attendance and participants forgetting the parental consents. Researcher tried phone call reminders and self-addressed stamped envelopes for the parental consent all of which were unsuccessful.

Recruitment for The Young Parents Childcare Project and The Young Parents Support Outreach Program was limited due to overlap in services with adolescent mothers. I went to the office and I was able to meet with the participants during their visits to the office. Researcher recruited participants by asking who was between the ages of 14 and 21, currently parenting, and interested in participating. The potential participants were assured that their participation or choice not to, would not in any way affect their relationship with their agency, or the services they were offered. Those who were eligible and interested attended a subsequent group that was held after a short break. In the second group the researcher went through the informed consent and allowed time for questions. The researcher then passed out the three forms of questionnaires and gave instructions and allowed time for questions. The researcher was available during the group for any questions while participants were completing the questionnaires.

Data Analysis

All data are analyzed using SPSS. Descriptive data will be analyzed by t-tests. Correlational data will be analyzed using Pearson's Rs and Correlational methods will be used to analyze the data. Descriptive statistics will be used to analyze the data received from the demographic questionnaire

Table 1

Number of participants by agency

PROGRAMS	NUMBER OF PARTICIPANTS	PERCENTAGES
The Redfield House	17	34%
The Helen Berube Teen Parent Program	7	14%
Evenstart Program	4	8%
Healthy Families Berkshire County	8	16%
Young Parent Childcare Project	2	4%
The Young Parents Support	4	8%
Healthy Families Northampton	8	16%

CHAPTER IV

FINDINGS

The purpose of this study was to examine the barriers that may prevent adolescent mothers from accessing social support. For the purpose of this study, the barriers examined were depression and self-esteem. The major findings of this study are presented in this chapter. The researcher begins with a socio-demographic profile of the young women who participated in this study.

The age of the participants in this sample at the time of participation ranged from 16 to 21 years. The average age was 19, with a standard deviation of 1.45 years. The average age at the time of delivery was 17 years with a standard deviation of 1.48. The majority of participants (n=32, 64%) identified as Caucasian, 12 % (n = 6) of participants identified as African American, 14 % (n = 7) identified as Hispanic, and 10 % (n = 5) identified as Bi-racial.

Income levels varied among participants with 68 % (n = 34) reporting incomes of \$0-5,000, 18 % (n = 9) reporting incomes of \$5,000-10,000, 4 % (n = 2) reporting incomes of \$ 10,000-15,000, and the remaining 10 % (n = 5) reporting incomes of \$ 15,000-20,000. Living situations varied with the highest percentage 36% (n = 18) of participants living alone. Alone was defined as living with the participant's child and no other people. A quarter of the sample 24 % (n = 12) reported living with the fathers of their babies; 18 % (n = 9) reported living with their parents; 10 % (n = 5) reported living

in a Teen Living Program; 4 % (n = 2) reported living with a partner; 6 % (n = 3) reported living with relatives; and 2% (n = 1) reported living in a homeless shelter.

Participants were asked to identify all services they were participating in. A little more than half the sample, 52 % (n = 26) of participants reported using childcare, 66 % (n = 33) reported receiving assistance from the Department of Transitional Assistance (DTA), and no participants in the sample of 50 reported using job training. A little more than half, 52% (n = 26) of the sample reported attending school, 28 % (n = 14) of participants reported having a case manager, 52 % (n = 26) of participants reported having a home visitor, and 70 % (n = 35) of participants reported participation in the Women, Infant, and Child program (WIC).

Participants were asked to identify all groups in which they participated. The first group was a TLP therapy group, which is a mandatory group for the Teen Living Program. Only 10 % (n = 5) were involved in the group due to its limited availability. Participants were involved in a second group titled Parents as Teachers; 16 % (n = 8) of participants reported participating in the group. The participants also identified other groups of which they were members of: parenting groups, a creative writing group, a craft group, and a playgroup. These findings are summarized in Table 2.

When participants were asked how useful services and groups were on a scale of one to five with five being very helpful, 44 % (n = 22) reported groups and services as “very helpful,” 30 % (n = 15) reported groups and services as “helpful,” 20 % (n = 10) reported groups and services as “somewhat helpful,” 2 % (n = 1) reported groups and services as “not helpful,” and 4 % (n = 2) reported a groups and services as “not at all helpful.” These findings are summarized in Table 3.

Participants were asked an open ended question: What supports would be helpful that you currently do not have? The number one response (40 %,n = 20) was transportation. No respondents identified specific destinations for transportation. The second most reported response was help from father of the baby; 26 % (n = 13) desired this. Other supports the participants identified were stress management, child support, a Latina group, a dance group, housing, people to talk to, and more support from the Department of Transitional Assistance. These findings are summarized in Table 4.

The second part of this chapter presents the findings for participants' self-esteem, depression and social supports. The first hypothesis for this research states that adolescent mothers with poor self-esteem will access less social support than those adolescent mothers with higher self-esteem. The second hypothesis was that adolescent mothers who identify as depressed will access less social support than less depressed mothers.

Self Esteem

For the Rosenberg self esteem scale the possible score ranged from 0-40 with 40 being high self-esteem. For the sample of 50, the mean score was 31.60 with a SD of 3.2. The minimum score was 24.00 and the maximum score was 38.00.

A t-test analysis was performed to determine if there was a difference in the Rosenberg Self-esteem scale between those who reported using childcare, school, home visitation, case manager, the Women, Infant, and Children program, and the Department of Transitional Assistance and those who did not report using each type of service. No significant difference was found with the score on the Rosenberg Self Esteem Scale between those using services and those who were not. A t- test was not performed for job

training because no participant reported using job training. Thus, the first hypothesis was not supported. No significant differences were found between those who used any kind of support and those who did not on self-esteem. Results are summarized in Table 5.

Spearman's RHO tests were performed to examine the association between the program staff questionnaire and self-esteem. There were no significant correlations with self-esteem and home visitation, school, job training, childcare, groups, the Department of Transitional Assistance, and the Women, Infant, and Children program. This allows the conclusion that there was no relationship between accession of social support and self-esteem among these adolescent mothers. These findings are summarized in Table 7.

Using a .10 cutoff there is a positive correlation with 90% confidence between the participants' self-esteem and PSQ6 (participation in the Department of Transitional Assistance) ($r=.286$, $p=.08$). So, as self-esteem goes up, so does their participation to a minimal extent in accessing the Department of Transitional Assistance.

Depression

The Brief Symptom Inventory was used to measure depression. The minimum score for the BSI in the sample of 50 was .00 and the maximum score for the BSI was 3.83 with the highest possible score of 4.00. The mean score for the sample was .9040 with a SD of .973.

A t-test analysis was performed to determine if there was a difference in the Brief Symptom Inventory scale for depression between those who reported using childcare, school, home visitation, the Women, Infant, and Children program, the Department of Transitional Assistance, and a case manager and those who reported not using those services. No significant differences were found. A T test analysis was not performed for

job training because the sample did not self-report using the support. Thus, the second hypothesis was not supported. No significant differences were found between those who used any kind of support and those who did not on depression. These findings are summarized in Table 6.

Finally, a t-test was performed to determine if there was a difference in the Rosenberg Self-Esteem scale and the BSI depression scale, between those who were living with the father of the baby and those who were not. No significant difference was found on the score of the Rosenberg Self-Esteem Scale. A significant difference was found on the BSI depression scale ($t(43.47)=2.919, p=.006$, two-tailed). The group living with the fathers of their babies had lower mean depression scores (.4306) than those not living with the fathers of their babies (1.0535).

Spearman's RHO tests were performed to examine the association between the program staff questionnaire and depression. There were no significant correlations with depression and home visitation, school, job training, childcare, groups, DTA, and WIC. There were no relationships between accession of social support and depression for these adolescent mothers. These findings are summarized in Table 8

Spearman's RHO tests were performed to examine the associations between different types of supports. Participants who were enrolled in school were more likely to utilize childcare and participate in groups ($r=.727, r=.693, p<0.05$). Participants who were reported to be involved in job training also received services from DTA ($r=.575, p<0.05$). Participants involved with the Woman, Infants, and Children program were more likely to use home visitation, school, childcare, groups, and the Department of

Transitional Assistance($r = .480$, $r = .613$, $r = .458$, $r = .538$, $r = .361$ $p < 0.05$). These findings are summarized in Table 9.

Using .10 cutoff Spearman's RHO tests were performed and a negative correlation between depression and program staff report of participation in childcare ($r = -.293$, $p = .06$) and program staff report of participation in school ($r = -.263$, $p = .097$) was found, indicating more depression is associated with less participation in school and childcare according to staff reports.

Conclusion

This chapter presented the findings from 50 adolescent mothers who participated in a quantitative study. The major findings suggest that as participants' self-esteem increased, they tended to make more use of the Department of Transitional Assistance. Findings which examined associations between different forms of support yielded some results. Participants who were enrolled in school were more likely to use childcare and attend groups. Participants who were enrolled in home visitation also were more likely to attend groups. Participants who reported being involved with job training were more likely to use Department of Transitional Assistance. Those participants reported to be involved in the Women, Infant, and Children program were more likely to use home visitation, school, childcare, groups, and the Department of Transitional Assistance. The final findings suggest that depression is associated with less participation in school and childcare.

The next chapter will review major findings, discuss implications for practice, compare and contrast major findings with current literature, and offer recommendations for future research.

Table 2
Self report of participation and non-participation in groups

Groups	Participating in		Non Participation	
	Number (N=50)	Percent	Number (N=50)	Percent
TLP Therapy	5	10%	45	90%
Parents as Teachers	8	16%	42	84%
Parenting Group	8	16%	42	84%
Parents Helping Parents	6	12%	44	88%
MELD	11	22%	39	78%
Creative Writing	2	4%	48	96%
TLP group	2	4%	48	96%
Craft Group	1	2%	49	98%
Healthy Families Group	13	26%	37	74%
Play Groups	1	2%	49	98%
Cooking Group	1	2%	49	98%

Table 3
Self report of how useful services and groups were

	Number (n=50)	Percent
Not at all helpful	2	4%
2	1	2%
Some what helpful	10	20%
4	15	30%
Very helpful	22	44%

Table 4

Helpful supports that participants currently report not having access to:

<u>Supports</u>	<u>NUMBER</u> (n=50)	<u>PERCENTAGES</u>
Stress Management	1	2%
Transportation	20	40%
Help from father of baby	13	26%
Child Support	4	8%
Latina Groups	2	4%
Dance Group	2	4%
Housing	4	8%
People to talk with	6	12%
Department of Transitional Assistance	3	6%

Table 5
T-test results for depression for participation and non-participation in services

Depression

	Participation		Non participation		t	Sig.(2-tailed)
	Number	Mean	Number	Mean		
Childcare	26	1.03	24	.76	.97	.33
DTA	33	1.03	17	.64	1.35	.18
Job Training	0a		50	.90		
School	26	.85	24	.95	-.37	.70
Case manager	14	.90	36	.90	.01	.98
Home Visitor	26	1.10	24	.68	1.52	.13
WIC	35	.94	15	.80	.48	.63

Table 6
T-tests results for self esteem for participation and non participation in services

Self-esteem

	Participation		Non Participation		T	Sig. (2 tailed)
	Number	Mean	Number	Mean		
Childcare	26	31.53	24	31.66	-.14	.88
DTA	33	31.66	17	31.47	.20	.84
Job Training	0a		50	31.60		
School	26	32.23	24	30.91	1.46	.70
Case manager	14	31.64	36	31.58	.051	.95
Home Visitor	26	31.23	24	32.00	-.84	.40
WIC	35	31.45	15	31.93	-.47	.63

a= a. t-score cannot be computed because at least one of the groups is empty

Table 7 Correlations for Supports and Self-esteem from Program Staff Questionnaire

	Self-esteem	Home Visitation	School	Job Training	Childcare	Groups	DTA	WIC
Home Visitation								
Correlation Coefficient	.12	1.00	.28	.42	.25	.46*	.18	.48*
Sig. (2-Tailed)	.41		.07	.06	.11	.00	.27	.00
Number	48	48	40	20	39	47	38	45
School								
Correlation Coefficient	.16	.28	1.00	.02	.72*	.69	.08	.61*
Sig. (2-Tailed)	.31	.07		.93	.00	.00	.64	.00
Number	41	40	41	18	38	41	34	38
Job Training								
Correlation Coefficient	.37	.42	.02	1.00	.13	-.10	.57*	.09
Sig. (2-Tailed)	.10	.06	.93		.57	.66	.01	.68
Number	20	20	18	20	20	20	17	20
Childcare								
Correlation Coefficient	.19	.25	.72*	.13	1.00	.52*	-.09	.45*
Sig. (2-Tailed)	.22	.11	.00	.57		.00	.59	.00
Number	41	39	38	20	41	40	33	38
Groups								
Correlation Coefficient	.06	.46*	.69*	-.10	.52*	1.00	-.02	.53*
Sig. (2-Tailed)	.68	.00	.00	.66	.00		.88	.00
Number	48	47	41	20	40	48	48	45
DTA								
Correlation Coefficient	.28	.18	.08	.57*	-.09	-.02	1.00	.36*
Sig. (2-Tailed)	.07	.27	.64	.01	.59	.88		.026
Number	39	38	34	17	33	38	39	38
WIC								
Correlation Coefficient	.20	.48*	.61	.09	.45*	.53*	.36	1.00
Sig. (2-Tailed)	.16	.00	.00	.68	.00	.00	.02	
Number	47	45	38	20	38	45	38	47

* Correlation is significant at the 0.05 level (2-Tailed)

Table 8 Correlations for Supports and depression from Program Staff Questionnaire

	depression	Home Visitation	School	Job Training	Childcare	Groups	DTA	WIC
Home Visitation								
Correlation Coefficient	-.05	1.00	.28	.42	.25	.46*	.18	.48*
Sig. (2-Tailed)	.69		.07	.06	.11	.00	.27	.00
Number	48	48	40	20	39	47	38	45
School								
Correlation Coefficient	-.26	.28	1.00	.02	.72*	.69	.08	.61*
Sig. (2-Tailed)	.09	.07		.93	.00	.00	.64	.00
Number	41	40	41	18	38	41	34	38
Job Training								
Correlation Coefficient	-.16	.42	.02	1.00	.13	-.10	.57*	.09
Sig. (2-Tailed)	.49	.06	.93		.57	.66	.01	.68
Number	20	20	18	20	20	20	17	20
Childcare								
Correlation Coefficient	-.29	.25	.72*	.13	1.00	.52*	-.09	.45*
Sig. (2-Tailed)	.06	.11	.00	.57		.00	.59	.00
Number	41	39	38	20	41	40	33	38
Groups								
Correlation Coefficient	-.10	.46*	.69*	-.10	.52*	1.00	-.02	.53*
Sig. (2-Tailed)	.46	.00	.00	.66	.00		.88	.00
Number	48	47	41	20	40	48	48	45
DTA								
Correlation Coefficient	.04	.18	.08	.57*	-.09	-.02	1.00	.36*
Sig. (2-Tailed)	.78	.27	.64	.01	.59	.88		.02
Number	39	38	34	17	33	38	39	38
WIC								
Correlation Coefficient	-.06	.48*	.61	.09	.45*	.53*	.36	1.00
Sig. (2-Tailed)	.66	.00	.00	.68	.00	.00	.02	
Number	47	45	38	20	38	45	38	47

* Correlation is significant at the 0.05 level (2-Tailed)

Table 9 Correlations for Supports from Program Staff Questionnaire

	Home Visitation	School	Job Training	Childcare	Groups	DTA	WIC
Home Visitation							
Correlation Coefficient	1.00	.28	.42	.25	.46*	.18	.48*
Sig. (2-Tailed)		.07	.06	.11	.00	.27	.00
Number	48	40	20	39	47	38	45
School							
Correlation Coefficient	.28	1.00	.02	.72*	.69	.08	.61*
Sig. (2-Tailed)	.07		.93	.00	.00	.64	.00
Number	40	41	18	38	41	34	38
Job Training							
Correlation Coefficient	.42	.02	1.00	.13	-.10	.57*	.09
Sig. (2-Tailed)	.06	.93		.57	.66	.01	.68
Number	20	18	20	20	20	17	20
Childcare							
Correlation Coefficient	.25	.72*	.13	1.00	.52*	-.09	.45*
Sig. (2-Tailed)	.11	.00	.57		.00	.59	.00
Number	39	38	20	41	40	33	38
Groups							
Correlation Coefficient	.46*	.69*	-.10	.52*	1.00	-.02	.53*
Sig. (2-Tailed)	.00	.00	.66	.00		.88	.00
Number	47	41	20	40	48	48	45
DTA							
Correlation Coefficient	.18	.08	.57*	-.09	-.02	1.00	.36*
Sig. (2-Tailed)	.27	.64	.01	.59	.88		.02
Number	38	34	17	33	38	39	38
WIC							
Correlation Coefficient	.48*	.61*	.09	.45*	.53*	.36*	1.00
Sig. (2-Tailed)	.00	.00	.68	.00	.00	.02	
Number	45	38	20	38	45	38	47

* Correlation is significant at the 0.05 level

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to examine two barriers that may prevent adolescent mothers from accessing social support. For the purpose of this study, the barriers examined are depression and self-esteem. This chapter compares the study findings with the current literature and discusses the implications for future research and social work practice, as well as the limitations of the study. The first hypothesis was that adolescent mothers who identify as depressed will access less social support than less depressed mothers. The second hypothesis states that adolescent mothers with poor self-esteem will access less social support than those adolescent mothers with higher self-esteem; this study did not confirm this. Findings that were supported are as follows. Findings for depression found that adolescent mothers who were living with the fathers of their babies had a lower mean depression than those who were not. No other forms of social support assessed were related to depression among these mothers. Other findings from the research indicate that adolescent mothers who were involved in one form of formal support were more likely to be connected to other forms of formal support. But only one type of social support; the Department of Transitional Assistance was related to self-esteem.

Compare and Contrast Findings with Current Literature

Several studies have measured the prevalence of depressive symptoms in adolescent mothers (Clemmens, 2002; Deal and Holt, 1998; Hudson, Elek, & Campbell-Grossman, 2000; Schmidt, Wiemann, Rickert & Smith, 2006). These researches have concluded that depressive symptoms among adolescent and first time mothers were prevalent. While the studies mentioned above found adolescent mothers to have depressive symptoms, Troutman and Cutrona (1990) found that despite the relatively high prevalence of clinical depression among adolescent mothers in their study, no statistically significant differences were found for rates of either major or minor depression during pregnancy, six weeks postpartum, and at one year postpartum between the childbearing and non-childbearing samples. Although this study researched factors relating to depression and adolescence that were different from those in the current study, there is a parallel in that neither study found depression to be linked to outcomes of interest. Furthermore, the girls in this sample showed very low rates of depression in general.

Several studies indicate social support acts as an ameliorating factor for adolescent mothers and their children against depressive symptoms (Bunting & McAuley, 2004a; Bunting & McAuley, 2004b; Camp, Holman, & Ridgway, 1993; Panzarine, 1986; Rhodes, Ebert, & Fischer, 1992; Thompson & Peebles, 1992). In a study conducted by Gelfand et. al. (1992), parenting stress was compared among depressed and non-depressed mothers of infants. They found that depressed mothers had lower levels of marital harmony and social support. This is consistent with my findings. A significant difference was found on the Brief Symptom Inventory Scale between

adolescent mothers who were living with the fathers of their babies and those who were not. In this study those who were living with the fathers of their babies had a lower mean depression score than those who were not. That does not suggest marital harmony, or even that the parents were married, but that the mothers were working with the fathers of their babies to co-parent and/or create a home for the family.

Several studies (Barnet et. al.,1996; Gelfand et. al.,1992; McKenry, Browne, Kotch, & Symons, 1990;Gelfand et al.1992; and Colletta,1981) found that depressed mothers had less social support. These findings are inconsistent with this study. Findings in this study found that depressed mothers did not access less social support than non-depressed adolescent mothers. The sample (n=50) was not depressed overall, and they accessed childcare, the Department of Transitional Assistance, school, home visitation, the Women, Infant, and Children program, and support groups.

Adolescence is a time of development transformation. The developmental changes are monumental for adolescent mothers. They go through many changes in five domains according to Trad (1995): physical change, cognitive functioning, affective regulation, interaction with peers, and interaction with family. Identity formation is critical for young adults but it is complicated by the parenting role and demands placed on adolescent parents (Nurius, Casey, Lindhorst, & Macy, 2006). One study conducted by Nurius et. al. (2006) indicates that adolescent mothers need social support when developing their identity. Without this support adolescent mothers and their children are At risk for psychosocial stressors, depression, and low self-esteem. This leads me to the conclusion of my findings: One reason the adolescent mothers in this study may not be depressed and have moderate self-esteem is that unlike the literature this study cites, the

adolescent mothers are no longer in the transition to parenthood. They are beyond it, and with a network of support they may have had time to reconstitute, and may have navigated to young adulthood.

One finding from this study showed that participants with higher self-esteem were more likely to participate in the Department of Transitional Assistance; this state program is a financial assistance program designed to temporarily support families when they have a financial need. The researcher speculates that as adolescent mothers feel better about themselves they are better prepared socially to access services necessary to function independently. The financial assistance provided by this service may help adolescent mothers to feel better about themselves in that they are able to support and sustain their family. Nurius asserts, "People with stronger mental health, self esteem, and social support view themselves and their futures in highly, even exaggerated positive terms" (p.115). As self- esteem increases, adolescent mothers may be more likely to think highly of their future and self-worth, and access support.

The findings in this study indicate that the adolescent mother participants have moderate levels of self-esteem. When adolescent mothers have a large support network they are at a decreased risk for psychosocial stressors and depression. So as a result of findings from this study, I am left with the question: Do the adolescent mothers under study have higher self-esteem and lower depression because they have an intact network of support? The findings from this study do indicate that adolescent mothers involved in social supports have lower depression and moderate self-esteem.

Limitations of Research

One limitation that was likely to have contributed to the lack of findings is the lack of variability in the sample. The sample is quite clustered rather than evenly distributed. All the participants report moderate levels of self-esteem and low levels of depression. In addition the participants in this study were recruited from different programs that provide support to participants. Adolescent mothers who participate in such programs may be different than those who do not participate in such programs. Findings may have yielded different results from participants who were not actively involved in such supportive programs. Because this sample was voluntary, the participants who were willing to participate may have been a healthier sample.

A second limitation for this study is the relationship the researcher had with several agencies as well as the relationship with many of the participants. These relationships may have affected the participants' ability to respond openly to all parts of the questionnaires used in the study. The researcher was employed at one of the agencies and had daily contact with a large part of the sample on a daily basis. This relationship may have interfered with the girls' openness in completing the questionnaires. The participants may have not felt completely comfortable in the confidentiality process. Along the same lines I believe that a portion of the sample may have believed that data would have been shared with their program staff. The researcher did discuss the confidentiality of the study, but in a sample this large there may have been trepidation in being completely open in filling out the questionnaires. One thing that would alleviate this suspicion in future research is accessing participants from agencies where the researcher is not employed and has no relationship with program staff or participants.

A third limitation is the method of data collection. The researcher collected data in small groups, which again may have decreased the level of comfort for participants to openly respond to the measures used in the study. Anonymity was difficult in this study due to the group format, but the researcher made arrangements for the group to spread out in the space. Still the apprehension of someone else seeing their responses may have led to a minimization of responses on the questionnaire.

Implications for Social Work Practice

The findings of this study have implications for clinical social workers who work with adolescent mothers and their support network. Although the generalizability of these findings are limited due to the lack of variability in the sample, they still offer suggestions to guide practice when used together with other research.

Adolescent mothers in this study who were involved in the Women, Infant, and Children program were connected to many other social supports: home visitation, school, childcare, groups, and the Department of Transitional Assistance. These correlations may denote that social service agencies are assessing adolescent mothers' support network and from that assessment connecting them to the supports they need. Home visitation was highly correlated with the mothers attending groups. Thus, I conclude that home visitation programs are providing other forms of support to adolescent mothers. Home visitors are meeting in the homes of adolescent mothers and their children as well as directing them to groups which get adolescent mothers out of the house, connecting them to others, providing parenting support and parenting education. These are all factors that studies report are associated with lower depression and higher self-esteem.

In this study, the mothers' use of the Department of Transitional Assistance was highly correlated with the participants' accessing job training. This researcher believes that this is a direct consequence of the welfare-to-work movement in which people who receive the Department of Transitional Assistance are required after a two-year period to volunteer, work, or attend job training for twenty hours per week. In this study there was a correlation between the mothers' use of childcare and her attendance in school. Thus, I conclude that adolescent mothers who are attending school do have access to formal childcare. This form of support is essential to the psychological growth of adolescent mothers, as well as their self-esteem. In this study there was a correlation between the mothers' attendance to school and her participation in groups, which leads the researcher to conclude that the schools identified by the participants are offering groups that create a supportive network. These correlations imply that social services agencies are assessing social networks for adolescent mothers and connecting the participants to the necessary supports, which may be related to higher self esteem and lower depressive symptoms.

These findings have a direct connection to clinical practice and treatment planning with adolescent mothers. If we assume based on the findings from this study that lack of depression and high self-esteem are related to having social supports, then it is important for clinicians who work with adolescent mothers and their families to be aware of the ameliorating factor social supports provide to adolescent mothers and their children. In doing clinical work with adolescent mothers, clinicians need to be aware of adolescent mothers attachment to a support network. When a clinician assesses an adolescent mother and discovers she has no intact network of support, many questions can stem from that assessment. Why isn't she connected to supports? Does she have the

social skills necessary to access and maintain relationships with social supports? Is there an existing mental illness that is preventing her from accessing the social support? Is she dissatisfied with the support? If an adolescent mother is isolated with limited connection to a community, one would wonder about her ability to connect and maintain relationships. Assessing a support network is critical to clinical work that clinicians who work with adolescent mothers need to be aware of because studies indicate that adolescents with social support have lower depression and higher self-esteem on average.

Implications for Future Research

One could speculate that participants have self-esteem and no depression due to the social supports they are currently participating in. All participants of the study were involved in a social service agency that provided support to adolescent mothers. Because participants were involved in these programs one could conclude that less depressed girls were more likely to join programs. Future research could examine a group of adolescent mothers who were participating in social supports and compare their self-esteem and depression to a group of adolescent mothers who were not involved in social supports. This would provide research that would examine differences between two groups of adolescent mothers. The group who was not accessing the social support may be more high risk, and this would allow researchers to examine why they were not accessing social support. This type of research would help clinicians and other providers identify concerns and issues that adolescent mothers have in accessing support.

Correlations in this study provide a glimpse into how adolescent mothers are connected to social supports. Either the adolescent mothers themselves are finding a way to connect themselves to the social support or the social support programs are doing an

assessment of the support network adolescent mothers have and then connecting them to the necessary support. With this in mind, future research could examine how adolescent mothers are connected to social support and how agencies that serve adolescent mothers assess their social networks and the difficulties in doing so. Participants in this research study are connected to supports but the adolescent mothers who did not participate or show up to the groups may be at higher risk and the ones with whom we should be most concerned with. These are the adolescent mothers we need to reach and examine the barriers they are experiencing in accessing social support.

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Appendix A

Parent or Guardian Informed Consent

Hi, my name is Rebecca Colvin, and I am a student at Smith College School for Social Work. I am conducting a study, which will explore the barriers adolescent mothers encounter in finding and using social support. The barriers I will focus on will be sad and anxious feelings your daughter may have. The second part of the study will focus on supports that were available to your daughter, and how often she accessed them. This research will be conducted in an effort to gain insight into how a community can support adolescent mothers effectively. The study is being conducted to fulfill my school requirements for a master's degree. Data will be used for my master's thesis and for a possible future presentation or paper on this topic.

Participants will be females age fourteen to twenty one, first time mothers with children six and under, who are first time parents. I am looking to find 50 participants to complete questionnaires in order to fulfill my school requirements.

If you decide to give permission for your child to participate, and your daughter agrees, she will participate in the study and her participation includes answering questions regarding how she feels about herself, worries she may be having, or sadness she is feeling. Some questions may include for example how she would rate her mood. Once she has filled out her questionnaires I will speak with her program staff or home visitor to discuss her participation in utilizing social support. Her responses to questionnaires will not be shared with her program staff or home visitor. For example, I may ask to what extent she has been able to attend school. Her participation will take an average of twenty minutes to complete the two questionnaires.

Upon reflection your daughter may think about things that make her feel sad or anxious. If this does happen she may wish to talk to someone at her agency. I will also give her a list of professionals from outside the agency in case she'd rather talk with one of them

The benefits of being part of this research are that it will further research and help professionals understand possible barriers to accessing social support. As compensation for her time, she will receive pizza during the group.

Participation in this study is voluntary. She may choose not to skip any question. You both have the right to withdraw her participation from this study at any time: before, during, or after the meeting at which your daughter filled out questionnaires. You each may withdraw on or before **March 15, 2007**. Your choice to withdraw will not have any negative consequences for her involvement at the agency. Moreover, all information she has provided me up to that point will be destroyed immediately. Privacy will be protected by assigning a number to your questionnaire. Consistent with federal regulations, all original data will be stored under lock and key for three years. After that time, the information will continue to be kept stored or destroyed.

if you have any questions, please call me, Rebecca Colvin, at (413)281-7783 Monday thru Thursday, 8:30 AM- 5:00 PM.

You will be given a copy of this form to keep.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOU'RE CHILDS PARTICIPATION AND YOUR CHILDS RIGHTS AND THAT YOU AGREE TO YOUR CHILDS PARTICIPATION IN THIS STUDY.

Signature

Date

Rebecca Colvin, Researcher

Date

Resource Referrals:

- 24 Hour Crisis Hotline: 499-0412
- The Brien Center: Outpatient Services 499-0412
- Parental Stress Line: 1800-632-1628
- Counseling Center of the Berkshires: 499-4090

Appendix B

Informed Consent for Participation in Research Study

Hi, my name is Rebecca Colvin, and I am a student at Smith College School for Social Work. I am conducting a study which will explore the barriers adolescent mothers encounter in finding and using social support. The barriers I will focus on will be sad or anxious feelings you may have about yourself. The second part of the study will examine what supports you access and how often. This research will be conducted in an effort to gain insight into how your community can support you more effectively. The study is being conducted in order to fulfill my school requirements. Data will be used for my master's thesis and for a possible future presentation or publication on this topic.

Participants will be females age fourteen to twenty one, who are first time parents whose child is six or younger. I am looking to find 50 participants to complete questionnaires in order to fulfill my school requirements.

Your participation in the study will include answering questions regarding how you feel about yourself and worries or feelings of sadness you may have. Some questions may include for examples how you would rate your mood or whether you worry a lot or have trouble eating or sleeping. Once you have filled out your questionnaires I will speak with your program staff or home visitor to discuss what kinds of social support you have utilized while at the agency. For example, I may ask how often you have been able to attend school. You may skip any questions that are not comfortable to answer. Your responses from the questionnaires will not be shared with your program staff or home visitor. Your participation will take an average of twenty minutes to complete the two questionnaires.

Upon reflection you may think about things that make you feel sad or anxious. If this does happen you may wish to talk to someone at your agency. I will also give you a list of professionals from outside the agency in case you'd rather talk with one of them

The benefits of being part of this research are that it will further research and help professionals understand possible barriers to accessing social support. As compensation for your time, you will receive pizza during the group.

Participation in this study is voluntary. You may skip any question. You have the right to withdraw your participation from this study at any time: before, during, or after the meeting at which you will fill out questionnaires. You have the right to withdraw from the study on or before **March 15, 2007**. Your choice to withdraw will not have any negative consequences for your involvement at the agency. Moreover, all information you have provided me up to that point will be destroyed immediately. Privacy will be protected by assigning a number to your questionnaires and keeping the number confidential. Consistent with federal regulations, all original data will be stored under

lock and key for three years. After that time, the information will continue to be kept stored or destroyed.

If you have any questions, please call me, Rebecca Colvin, at (413)281-7783 or Monday thru Thursday, 8:30 AM- 5:00 PM at 629-1128.

You will be given a copy of this form to keep.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Signature

Date

Rebecca Colvin, Researcher

Date

Resource Referrals:

- 24 Hour Crisis Hotline: 499-0412
- The Brien Center: Outpatient Services 499-0412
- Parental Stress Line: 1800-632-1628
- Counseling Center of the Berkshires: 499-4090

Appendix D

Brief Symptom Inventory (BSI)

Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptions that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE LAST 3 MONTHS, INCLUDING TODAY. Circle the number you have selected in the column to the right of the problem. Do not skip any items. If you change your mind, block out your first number completely and circle your new choice in the same row. If you have any questions, please ask the clinician.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

HOW MUCH WERE YOU DISTRESSED BY:

		Not at all	A little bit	Mod	Quite a bit	Extreme
1. Nervousness or shakiness inside	0	1	2	3	4	
2. Faintness or dizziness	0	1	2	3	4	
3. The idea that someone else can control your thoughts	0	1	2	3	4	
4. Feeling others are to blame for most of your troubles	0	1	2	3	4	
5. Trouble remembering things	0	1	2	3	4	
6. Feeling easily annoyed or irritated	0	1	2	3	4	
7. Pains in heart or chest	0	1	2	3	4	
8. Feeling afraid in open spaces	0	1	2	3	4	
9. Thoughts of ending your life	0	1	2	3	4	
10. Feeling that most people cannot be trusted	0	1	2	3	4	
11. Poor appetite	0	1	2	3	4	
12. Suddenly scared for no reason	0	1	2	3	4	
13. Temper outbursts that you could not control	0	1	2	3	4	
14. Feeling lonely even when you are with people	0	1	2	3	4	
15. Feeling blocked getting things done	0	1	2	3	4	
16. Feeling lonely	0	1	2	3	4	
17. Feeling blue	0	1	2	3	4	
18. Feeling no interest in things	0	1	2	3	4	
19. Feeling fearful	0	1	2	3	4	
20. Your feelings being easily hurt	0	1	2	3	4	
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4	
22. Feeling inferior to others	0	1	2	3	4	
23. Nausea or upset stomach	0	1	2	3	4	

	Not at all	A little bit	Mod	Quite a bit	Extreme
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and doublecheck what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure or harm someone	0	1	2	3	4
41. Having urges to break or smash something	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feelings of guilt	0	1	2	3	4
53. The idea that something is wrong in your mind	0	1	2	3	4

Appendix E

Please rate the following items using the scale below.

1	2	3	4	5
Strongly				Strongly
Disagree				Agree

- ___ 1. On the whole, I am satisfied with myself.
- ___ 2. At times I think I am no good at all.
- ___ 3. I feel that I have a number of good qualities.
- ___ 4. I am able to do things as well as most other people.
- ___ 5. I feel I do not have much to be proud of.
- ___ 6. I certainly feel useless at times.
- ___ 7. I feel that I'm a person of worth, at least on an equal plane with others.
- ___ 8. I wish I could have more respect for myself.
- ___ 9. All in all, I am inclined to feel that I am a failure.
- ___ 10. I take a positive attitude toward myself.

Appendix F

Program Staff Questionnaire

Participant's name _____

For each participant who has consented to participate in the study, please rate her participation in the social supports listed below.

Rate participation with social support on a scale of 1-5 over the past six months. 1 being never and 5 being always.

Home Visitation.....1.....2.....3.....4.....5.....N/A

School.....1.....2.....3.....4.....5.....N/A

Job Training.....1.....2.....3.....4.....5.....N/A

Childcare.....1.....2.....3.....4.....5.....N/A

Groups.....1.....2.....3.....4.....5.....N/A

Department of Transitional Assistance.....1.....2.....3.....4.....5.....N/A

WIC.....1.....2.....3.....4.....5.....N/A

Appendix G

ARE YOU A MOTHER AGE 14-21?

I NEED YOUR HELP

I AM DOING A MASTER'S THESIS RESEARCH PROJECT AND I AM LOOKING AT HOW YOUR FEELINGS ABOUT YOURSELF HELP OR HINDER YOUR GETTING THE SUPPORTS YOU NEED.

THIS INFORMATION WILL HELP CASE MANAGERS, HOMEVISITORS, AND PROGRAM STAFF TO BETTER SUPPORT YOU AND YOUR CHILD.

IF YOU ARE INTERESTED IN PARTICIPATING IN THIS STUDY PLEASE CONTACT REBECCA COLVIN AT 413-629-1128

PARTICIPATION INCLUDES ANSWERING QUESTIONS THAT WILL TAKE A TOTAL OF 20 MINUTES. THEN I WILL TALK WITH YOUR HOME VISITOR WHO WILL TELL ME HOW OFTEN YOU USED VARIOUS KINDS OF SUPPORT.

ALL INFORMATION IS CONFIDENTIAL

WE WILL MEET IN GROUPS AND PIZZA AND CHILDCARE WILL BE PROVIDED.

Appendix H

January 27, 2007

Rebecca Colvin
48 Elizabeth Street, Apt. 102
Pittsfield, Massachusetts 01201

Dear Rebecca,

Your most recent revisions have been reviewed and all is now in order. We are, therefore, happy to give final approval to your project. It is great to be able to locate your study in the community and to meet with both clients and service providers.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Marsha Pruett, Research Advisor