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Social support in African-American adolescent mothers: An exploratory study

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The Ohio State University, 1993

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SOCIAL SUPPORT IN AFRICAN-AMERICAN ADOLESCENT MOTHERS:
AN EXPLORATORY STUDY
DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By
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DEDICATION

To My Son

David L. Chatman-Smith

and

The Chatman Clan
ACKNOWLEDGEMENTS

I want to express my appreciation and gratitude to Michelle Walsh, Edna Menke, and Linda Bernhard who provided me with cognitive, material and emotional support when I needed it. I would not have been able to complete my doctoral education in such a timely manner were it not for the American Nurses Association’s Minority Fellowship and the Elizabeth Gee Fund for Research on Women. Thank you all.

David, my son, you have shared me with my books, classes, computer, and jobs over the past 7 years of your young life. You have exhibited patience and understanding far beyond your age. I am proud of you David. You are a fine young man. The Chatman clan gave me love, lifted my spirits, prayed for me, and never doubted my ability to accomplish my goals. Ann and Elizabeth, no words can express my love and gratitude to the two of you. You are two special sisters to whom I am eternally grateful. Judy, you are a neighbor that many hope for but few have. You have helped me in countless ways. I am also blessed with many friends who remained at my side. Thanks everybody!

I must thank God for blessing me with all of the wonderful people in my life and for giving me the inner strength and knowledge to complete my doctoral education.
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FIELD OF STUDY

Major Field: Nursing
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CHAPTER I

INTRODUCTION

The prevalence of African-American adolescent motherhood and the apparent long term effects on the mother and her child were the impetus for this study (Alan Guttmacher Institute, 1986; Brooks-Gunn & Furstenberg, 1985; Darabi, Graham, Namerow, Philliber, & Varga, 1984; Furstenberg, Brooks-Gunn, & Morgan, 1987; Institute of Health, 1985; Kinard & Reinherz, 1984; Klienman & Kopstein, 1987; Mott & Maxwell, 1981; Office of Technology Assessment, 1988; Voydanoff & Donnelly, 1990). In 1991, unmarried adolescents accounted for 312.5 per 1000 live births in the United States of America (Statistical Abstract of U.S., 1991) which has made adolescent childbearing a social issue. Ninety percent of all adolescents who choose to bear a child in the United States opt to raise their infants and only four percent choose formal adoption (Alan Guttmacher Institute, 1986). The remaining six percent are informally adopted or raised by the extended family (Hill, 1980).
African-American adolescent mothers are the focus of this study for many reasons. Compared to white females, African-American females have higher rates of adolescent motherhood, constitute a statistically significant larger percentage of live births, are less likely to receive adequate prenatal care, have higher rates of infant mortality, are less likely to have health care benefits, and more likely to be of lower economic status (Alan Guttmacher Institute, 1986; National Center for Health Statistics, 1990; Statistical Abstracts, 1991; U.S. Census Data, 1991; U.S. Department of Health and Human Services, 1985).

African-American adolescents accounted for 87 per 1000 births compared to 19 per 1000 births for white adolescents in 1990 (Statistical Abstracts, 1991). The rate of adolescent motherhood is three times greater for African-American females between the ages of 15 to 17 than for whites the same age. African-American females younger than 15 years of age become mothers five times more often than white adolescent females the same age (Statistical Abstracts, 1991). In 1990, 50% of all live African-American births were born to adolescent females compared to 13% for whites (Statistical Abstracts, 1991).

African-American females are less likely to receive prenatal care than are white females. The problem of inadequate health insurance is most severe for minority women. In 1986, 23% of African-Americans compared to 14% of whites had no private or public medical insurance (National Center for Health
Statistics, 1990). Not only is there a lack of health insurance, but there may also be insufficient coverage for women who have Medicaid or private insurance (Alan Guttmacher Institute, 1986).

African-American children are three times more likely to live in poverty than are white children. Forty five percent of all African-American children lived in poor family households and 51% lived in female headed households in 1990. Whereas 15% of white children lived in poor family households and 24% lived in female headed households (Statistical Abstracts, 1991). These statistics reveal that African-American adolescent mothers do not become poor after bearing a child, but are often living in poor, female headed households prior to becoming mothers.

The feminization of poverty has increased the concern for the plight of children reared in single parent households (McLanahan, Wendemeyer, & Adelberg, 1981; Weinraub & Wolf, 1987). Poverty is an economic barrier that decreases access to health maintenance and illness care. Rothenberg and Varga (1981) noted important aspects of the consequences of poverty and adolescent motherhood. They stated:

It is important to remember that social factors do have an impact on child health and development, and that many of these children live in families with limited financial resources. . . they are all potentially subject to the negative health and developmental consequences associated with economic deprivation (p. 816).
Many African-American adolescent mothers opt to live within the household of extended kin to increase social and economic viability. There is an explicit cultural norm in support of extended family relations in African-American families. African-Americans are more likely to reside within extended family households than are whites (Angel & Tiendra, 1982; Beck & Beck, 1989; Farley & Allen, 1987; Hofferth, 1984; Tiendra & Angel, 1982). In Farley and Allen's (1987) study, when income was controlled, extended family arrangements were twice as common for African-Americans than for whites.

A gap exists in current research regarding the influence of African-American family structure on perceived need for social support in African-American adolescent mothers. Family social support in general, and extended family social support in particular, is important when developing programs to enhance social support for African-American adolescent mothers. The purpose of this study was to determine the types and sources of social support provided to African-American adolescent mothers. Participants were also asked to identify unmet social support needs and source(s) from which they perceived these needs could be met. The investigation was guided by the following research questions:
Research Questions

1) What types of social support are provided to African-American adolescent mothers?

2) Who provides social support to African-American adolescent mothers?

3) Do African-American adolescent mothers perceive any unmet social support needs?

Conceptual Definitions

1) Support - The augmentation of a person’s strengths to facilitate the mastery of their environment (Caplan, 1974).

2) Support system - An enduring pattern of continuous or intermittent ties that maintains psychological and physiological integrity over time (Caplan, 1974).

3) Emotional support - Behavior that leads one to believe that others are available to provide comfort, admiration, respect, love and a sense of security (Connell & D’Augelli 1988; Jacobson, 1986).

4) Cognitive support - Information, knowledge, and/or advice that helps an individual to understand his or her world and to adjust to changes within it (Jacobson, 1986).
5) Material support - Goods and services that help to solve practical problems (Jacobson, 1986).

6) Extended Family - A multigenerational interdependent kinship system. It functions to connect family members as a social support system for the welfare and maintenance of the family unit as a whole.

Significance of the Study

Motherhood is viewed as a time of crisis due to the biological, psychological and sociological changes that occur. Miller (1980) noted that adolescent parents are faced with a variety of situational crises that are superimposed on the maturational crisis of adolescence which may be associated with some degree of normal stress. The tasks of adolescence combined with the tasks of motherhood and adulthood may be problematic for adolescent mothers and their children. Adolescent motherhood may increase the need for social support by others such as family, friends, spiritual advisors, nurses, human service agencies, schools and other health care providers.

Developers of current programs have often ignored the fact that adolescent mothers are usually not the sole caretakers of their infants; especially if attending school, working, and living within an extended family household (Furstenberg, 1976; Furstenberg, et al., 1987; Furstenberg & Crawford, 1978; Furstenberg, Moore, & Peterson, 1985; Landerholm, 1984; McAnarney, 1986;
Mercer, 1986; Parks & Arndt, 1990). Experienced adults may teach adolescent mothers basic child care and provide cognitive, emotional and material support.


Two of the most common physiological deleterious effects of adolescent motherhood are higher rates of low birth weight and infant mortality, especially if maternal age is less than 17 years (Klienman & Kopstein, 1987). Low birth weight is associated with an increase in mortality, learning disorders,
intellectual deficits, and neurological dysfunctions later in life. The most common factors associated with these data are poor or no prenatal care, poor nutrition and maternal stress (Baldwin & Cain, 1980; Belmont, Broman, 1981; Brooks-Gunn, & Furstenberg, 1985; Darabi, et al., 1984; Kinard & Reinherz, 1984).

Socioeconomic status, educational attainment and developmental level are the main factors that prevent adolescent mothers from receiving proper prenatal care, practicing proper nutrition, and seeking out supportive counseling to decrease stress (Institute of Health, 1985; Office of Technology Assessment, 1988). Low socioeconomic status is positively correlated with inadequate or no health insurance and poor nutrition (Baldwin & Cain, 1980; Belmont, et al., 1983; Broman, 1981; Brooks-Gunn & Furstenberg, 1985; Darabi, et al., 1984; Kinard & Reinherz, 1984).

Educational inadequacy and socioeconomic instability are prevalent in adolescent mother families. Adolescent motherhood is negatively associated with high educational attainment. Female pregnancy is the leading cause of high school drop out (Mott & Maxwell, 1981). In addition, adolescent mothers often have jobs that are low skill, low occupational status and low income (Furstenberg, 1978; Furstenberg, et al., 1985; Furstenberg, et al., 1987; Mott & Maxwell, 1981; Voydanoff & Donnelly, 1990). Consequently, adolescent
mother families may be under or unemployed, and have inadequate income to support themselves above the poverty line without assistance from others.

An additional consequence of adolescent motherhood is the potential for perpetrating child abuse and neglect behaviors. High risk variables for child abuse and neglect are individuals and groups who are in are isolated, single, have low socioeconomic status, lack social support, and have low educational attainment (Gelles, 1986; 1990; McAnarney, et al. 1986; Pianta, Egeland, & Erickson, 1989). Adolescent mothers are more likely to be single (Statistical Abstracts, 1991), less likely to find stable employment, be self supporting, or be employed, more likely to be lower socioeconomic status, and less likely to attend college (Billy, Landale, & McLaughlin, 1986; Furstenberg, et al., 1987; Gelles, 1990; Voyeranoff & Donnelly, 1990). Hence, adolescent mothers are a high risk group for perpetuating child abuse and neglect behaviors.

Summary

from the perspective of African-American adolescent mothers (Williams, 1991). This descriptive study provides an analysis of social support from the perspective of African-American adolescent mothers. Specific areas examined were types and providers of social support, household structure, and who she asks questions pertaining to motherhood, child care techniques, personal problems, and academic concerns. Participants were also asked who they perceived as the primary child care provider for their children. Exploring social support from the perspective of African-American adolescent mothers may further the conceptualization and knowledge base of social support literature.
CHAPTER II

LITERATURE REVIEW

A literature review of social support, African-American family structure, culture, racial differences, and adolescent growth and development provided the background for this research. Caplan's theory of social support was the framework for this investigation.

Social Support

Three major types of social support, emotional, cognitive, and material are identified in literature. Emotional support is defined by Jacobson (1986) and Connell and D'Augelli (1988) as behavior that leads one to believe that others are available to provide comfort, admiration, respect, love and a sense of security. Cognitive support refers to information, knowledge, and/or advice that helps an individual to understand his or her world and to adjust to changes within it (Jacobson, 1986). Material support is defined by Jacobson (1986) as goods and services that help to solve practical problems. Money, labor, and
time are examples of material support (Connell & D'Augelli, 1988; House & Kahn, 1985; Jacobson, 1986).

The underlying assumption is that social support is positive in nature. However, Tilden and Galyen (1987) discussed the negative side of social support that demands attention at this point. These authors stated "... the costs of relationships must be considered in future research on social support... that explain both positive and negative dimensions of support systems... measurement of the darker side of social support must be made" (p. 13).

Tilden and Galyen (1987) described something other than social support. They evaluated the negative and positive relationships within one’s social system; not one’s social support system. Social support augments a person’s strengths to facilitate the mastery of their environment (Caplan, 1974).

A support system is an enduring pattern of continuous or intermittent ties that maintains psychological and physiological integrity over time (Caplan, 1974). Thus, social support is positive. This study allowed participants to freely discuss their perceptions of social support. Hence, both positive and negative social system interactions were discussed. Though negative interactions were verbalized, they were not considered supportive.

An ongoing dilemma in social support research is that there is no consensus on the operational definition of social support. Nevertheless, social support research has been quite popular among many disciplines, including
nursing, psychology, social work, and sociology since the mid 1970's (Norbeck, 1988). Knowledge of the social support needs of adolescent mothers is evolving (Dormire, Strauss, & Clarke, 1988; Heins, Nance, & Ferguson, 1986; Koniak-Griffin, 1988; Mercer, 1986; Polit, 1989; Schinke, Barth, Gilchrist, & Maxwell, 1986; Von Windeguth, 1989; Unger & Wandersman, 1988). However, the need to define the concept of social support is necessary before adequate prescriptive interventions can be implemented. Social support is defined, used and measured various ways in research, resulting in difficulty interpreting study results and even more difficulty in identifying intervention and prescriptive methods. At the end of their literature review Connell and D'Augelli (1988) concluded:

Most investigators have not attempted to formulate a precise conceptual definition of social support and few have attempted to develop valid or reliable indicators of the concept . . . researchers extract items from available data such as presence or absence of a spouse/confidant, term these items social support or social integration, and then proceed with analysis. No conceptual definitions are attempted (p. 110).

If a concept is ambiguously defined or not defined at all, it is difficult, if not impossible, to empirically test the concept adequately.

Despite the diversity of perspectives and dimensions of social support expounded upon by researchers, common themes occur in literature. Progress in the area of measurement and conceptualization of social support is apparent.
Social support is generally studied from three perspectives: (1) structure—social network analysis which includes network size, strength of ties, density, homogeneity of membership, and dispersion of membership, (2) functions—resources which flow through the network, the social-psychological or perceptual approach which entails emotional support, experienced support, attachment, need satisfaction, and satisfaction with one's significant relationships, and (3) the nature of the relationships between members or social integration—a person's stable relationship with others (Cohen & Syme, 1985; House & Kahn, 1985; Kahn & Antonucci, 1980; Norbeck, 1988; Stewart, 1989; Thoits, 1982).

Within these perspectives, several dimensions of social support are measured. Stewart (1989) identified 8 common dimensions for the measurement of social support: (1) source of social support, (2) disposition of social support which is the availability or enactment of social support, (3) duration or stability of support, (4) direction of social support (reciprocity or asymmetry), (5) the type/functional aspects of social support (i.e. content categories), (6) description or evaluation of social support (i.e. perceived adequacy or inadequacy), (7) the cost/benefit of social support, and (8) level of interaction between all of the aforementioned dimensions. This study addressed sources of social support, availability and enactment of social support, types of social support, and evaluation of social support received.
Conceptual Framework

The conceptual framework of Caplan (1974) and Caplan and Killea (1976) was used in this study. The focus of Caplan’s theory is on the health promoting forces used to master the challenges and stresses of everyday life. Caplan viewed the family as the major provider of social support. Caplan’s theory is based on the General Systems Model generated by Von Bertalanffy (1968). Social support can be defined as an open system that is dynamic and fluid. Health (equilibrium) is maintained by effective communication patterns (feedback) which are mutually understood and accepted by the person receiving support as well as the person providing support.

The assumptions of Caplan’s (1974) and Caplan and Killea’s (1976) conceptual framework are:

1. All living organisms have the capacity to adapt physiologically and psychologically to a variety of environmental circumstances over time.

2. Social aggregates provide individuals with opportunities for feedback about themselves and for validations of their expectations about others.

3. Support systems are enduring patterns of continuous or intermittent relationship with individuals or groups that helps one to maintain physiological and psychological integrity over time.

4. Social support systems buffer individuals against the burden of defective communication feedback in the larger society.

5. Social support augments an individual’s strength to facilitate mastery over her environment.
6. The role of health providers is to foster and strengthen the acknowledgement and use of professional, nonprofessional individuals, groups and organizations within the community.

7. Social support systems facilitate physiological, psychological and sociological health in healthy families but may be detrimental in dysfunctional families.

Support augments one’s ability to adapt to one’s environment (Caplan, 1974). A support system is an enduring pattern of continuous or intermittent ties that maintains psychological and physiological integrity over time and is reciprocal.

Caplan (1976) outlined nine functions of the family for providing social support. The family: (1) acts as a collector and disseminator of information about the world; (2) functions to provide guidance; (3) acts as a source of ideology; (4) acts as a source of material support and concrete aid during times of stress or role transition; (5) is a haven for rest and recuperation; (6) guides and mediates in problem solving; (7) acts as a reference and control group; (8) is a source and validator of one's identity; and (9) contributes to one's emotional mastery. An underlying assumption of social support is that family systems must be healthy before positive effects of social support can be realized.

Though the family is viewed as the major provider of social support, community and society provide support as well. Examples of community and
societal social support are voluntary and mutual help groups, health care
systems, psychological counseling, and human service agencies.

As one develops, interpersonal interactions and social support needs
develop. Change over time and over the life course are important elements of
this theory. Perceived availability, activation, and use of social support are
important components for receiving social support. One must perceive that
support is available before it can be activated and used.

Caplan's theory is often called the buffering hypothesis (Cohen & Syme,
1985; Connell & D'Augelli, 1988; Jacobson, 1986; Thoits, 1982). The term
buffer is used to examine a variety of protective factors that serve to determine
which members of a population remain physiologically and psychologically
healthy. The nature and strength of available support will determine the
effectiveness of buffering factors. The harmful effect of absent or confusing
feedback may be reduced if the individual is effectively embedded in their own
smaller social systems or subcultures. Subcultures provide consistent feedback
regarding expectations, support and assistance with tasks, evaluates
performance and furnishes appropriate rewards and punishments. If these are
not provided by society, they may be obtained from a social subgroup or
subculture. Social support systems buffer individuals by providing
opportunities for feedback (communication) about themselves and for
validations of expectations about others. The buffering effects of social support increases one’s ability to adapt and function in society (Caplan, 1974).

Social Support and Adolescent Motherhood

The importance of an adequate social support system for adolescent mothers has been emphasized by Mercer (1986). She asserted that social support systems can serve a variety of functions, such as cognitive guidance, social reinforcement, material support, social stimulation, and emotional support. Mercer (1977; 1986) asserted that experientially, adolescent mothers may not have lived long enough to observe parenting or may have minimal child care experience. In addition, she stated that emotionally, adolescents are more egocentric about their own needs. A strong support system can be an important resource for a less knowledgeable, less experienced adolescent mother (Field, 1980). The presence of a social support system may provide positive role models and direct support for the young mother experiencing the transition into motherhood (Furstenberg & Crawford, 1978; Mott & Maxwell, 1981; Stack, 1974).

Evidence suggests that social support from significant others and human service agencies is useful for increasing parenting skills, mother child interactions, maternal self efficacy, transition into motherhood, and psychological well being for adolescent mothers. Though very few studies
assess social support provided to African-American adolescent mothers, the interest for providing social support to this population has increased since the deleterious effects of adolescent motherhood have become apparent (Dormire, et al., 1988; Heins, et al., 1987; Koniak-Griffin, 1988; Mercer, 1986; Polit, 1989; Schinke et al., 1986; Unger & Wandersman, 1988). Other researchers have explored the relationship between social support and pregnancy outcomes of adult women (Brandt & Weinert, 1981; Brown, 1986; Cronenwett, 1983; Norbeck, 1988; Norbeck & Tilden, 1983). There are similarities in the need for social support for various populations; however, African-American adolescent mothers may have unique social support needs due to developmental, cultural, economic, and linguistic differences.

Some of the instruments used to measure social support in these studies were tested for reliability and validity. Examples are the Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, & Carrieri, 1981; 1983), the Inventory of Socially Supportive Behaviors (Barrera, 1981a) and Support Behavior Inventory (Brown, 1986). The instruments were normed on white, moderate to upper income, adults (Brandt & Weinert 1981; Brown, 1986; Tilden & Galyen, 1987) and college students (Barrera, 1981a; Norbeck, et al., 1981; 1983). Heins et al. (1987) and Polit (1989) used outcome data to measure agency support provided to adolescent mothers. Schinke, et al. (1986) and Unger and Wandersman (1988) used social support instruments developed
for their study. Dormire, et al. (1988) and Koniak-Griffin (1988) used the NSSQ to measure social support. No social support instruments have been normed on African-American adolescent mothers.

Some researchers have included African-American subjects in their study of social support for adolescent mothers. Koniak-Griffin (1988) examined the relationship between prenatal attachment, self-esteem, and social support in adolescent mothers. Ninety pregnant primiparas aged 14 to 19 years who lived in a residential facility were recruited. The ethnic composition of the subjects was 36.7% Caucasian, 26.7% African-American, 28.9% Hispanic, 5.6% Asian, and 2.2% other. Instruments used included a background questionnaire, the Self-Esteem Inventory, NSSQ and the Maternal-Fetal Attachment Scales.

The overall findings (Koniak-Griffin, 1988) did not support a relationship between self-esteem, social support and maternal-fetal attachment. However, results of the regression analyses showed the main factors influencing overall maternal-fetal attachment and its sub-scales were total functional support available, total system size, whether the pregnancy was planned, and intent to keep the infant. There were several significant correlations observed between measures of social support and self-esteem. Adolescents with strong social support are likely to have higher self-esteem in areas related to home life. Though there was ethnic diversity within the sample, the researcher did not
analyze the data for ethnic differences regarding the relationship between prenatal attachment, self-esteem, and social support in adolescent mothers.

Dormire, et al. (1988) also investigated social support of adolescent mothers. A convenience sample of 18 primiparas aged 15-19 who delivered healthy infants between 37 and 41 gestational weeks, and had no pregnancy complications was included in the study. All but two of the subjects were African-American and in the lower socioeconomic status. No demographics were presented for the two remaining subjects. Data from each respondent were evaluated between the fourth and fifth postpartum week.

The Parenting Stress Index, Nursing Child Assessment Teaching Scale (NCAST), NSSQ, and a demographic data form were used to collect data. Social support and parent-infant interactions were positively related. There was a significant positive relationship between functional support and all dimensions of the parent-infant interaction in the NCAST sub-scales. Affective support was significantly related to interactive capacities of adolescent mothers and their infants. There was a negative relationship between a sense of competence and total support. All NCAST domain scores were correlated with the parental sense of competence. Sensitivity to cues in the interaction was significantly related to support. Mothers who were less adequately attached to their infants were less effective in responding to their infants’ distress cues.
Unger and Wandersman (1988) explored relationships that may exist between family and partner social support and the adjustment to parenthood. A convenience sample of 87 adolescent primiparas of low socioeconomic status, who ranged between the ages of 13-18 years was used in the study. The majority (89%) of the subjects were African-American. Education mean was 10.3 years. Seventy four percent of the subjects lived with one or both parents and 93% were not married. Mothers were interviewed prenatally and when their infants were approximately eight months of age.

The HOME Observation was used to measure the environment and three instruments, designed by the investigators, were used to measure social support, maternal behavior and general life satisfaction of the mothers. Results revealed that the adolescent mothers were moderately satisfied with support from their families and partners. Perceptions of support from family was unrelated to perceived support from their babies' fathers or current male partners at either time. Prenatal and current support from the male partner or baby's father was related to general satisfaction with life. Responsiveness to their infants, HOME scores, prenatal and current support from their male partners were also related. The mean scores on the eight month adjustment variables revealed that the adolescent mothers were functioning at an adequate level.

Several programs have been implemented to increase the level of community and human service support (Heins, et al., 1987; Polit, 1989). Role
modeling, education, and frequent home visits by indigenous workers and/or public health nurses were used to accomplish this goal. Researchers and interventionists seemed to believe that such social support programs are necessary to decrease the deleterious effects of adolescent motherhood on the mother and her child.

Heins, et al. (1987) evaluated a social intervention program designed to reduce the risks associated with adolescent pregnancy and parenthood in a rural population. This program provided education and social support by specially selected and prepared indigenous workers who were used as resource mothers to fulfill the roles of teacher, role model, reinforcer, friend and facilitator. Each caseworker had a caseload of 30 to 35 antepartum and postpartum clients.

The sample group consisted of 575 volunteer subjects whose ages ranged from 13 to 18 years. Eighty-nine percent were African-American, and 11% were white. Ninety-three percent were single. Most (565) of the subjects were successfully matched with a control subject. Each subject in the group was visited monthly during her pregnancy, daily during the hospital stay and regular home visits were made during the infants first year of life. There were statistically significant differences between the groups in the adequacy of prenatal care, small for gestational age infants, and fewer low birth weight infants.
A study funded by the Manpower Demonstration Research Corporation in 1980 was initiated to "redirect" the lives of a sample of disadvantaged adolescent mothers to economic self-sufficiency (Polit, 1989). The purpose of the study was to determine if the Project Redirection model was more effective than generally available social services. Variables measured included employment status, educational attainment, the use of Aid to Families with Dependent Children (AFDC), and repeat pregnancy rate.

The sample consisted of pregnant or parenting female adolescents who lacked a high school diploma, were 17 years of age or younger and lived in a low income household in one of four large cities. A total of 675 adolescents (305 program participants and 370 comparison adolescents) were interviewed three times over a one year time span. Forty five percent of both groups were African-American.

The control group consisted of adolescents who met program eligibility criteria but were living in communities that did not offer the Project Redirection Program. Community volunteers acted as role models and developed individual participant plans with subjects. There were also peer group sessions for social support, mutual problem solving and affirmation of program goals.

The final evaluation occurred in the fifth year of the project. Data were collected from a sub-sample of program participants and comparison adolescents. The comparison group received the routine educational
information regarding parenting, family planning, as well as information regarding employment opportunities from community agencies that provided health care. There was a statistically significant difference between the two groups. More women in Project Redirection held a paying job, had higher average weekly earnings and depended less on AFDC than comparison group members. The program participants had statistically fewer abortions than the comparison group. Project staff attributed this finding to a lack of emphasis on family planning in the program.

Instrumentation included the HOME scale to measure parental skills, the Peabody Picture Vocabulary Test to assess cognitive development, the Eyeberg Child Behavior Inventory to determine the adolescent mother’s rating of child behavior problems and health status interview guide. Program participants scored statistically higher on all measures than non-participants. High risk mothers (e.g. those who were drop outs at baseline) benefitted more from the program than those who were not high risk mothers.

Schinke et al. (1986) evaluated the effect of the Coping Skills Preventive Intervention program on adolescent mothers’ parenting skills, child care self efficacy and utilization of social support systems. Seventy nine volunteer subjects aged 14 to 18 years of age participated in the study. One third of the sample was white and two-thirds were nonwhite. The subjects chose to be in either the experimental or non-experimental group. Chi square and univariate
analysis of the two groups showed no initial differences between groups. Data collection methods included a questionnaire and videotape recordings. Pre-test, post-test and follow-up measures were conducted with both groups.

The experimental group scored higher on measures of social support, cognitive performance, paraphrasing, delaying and direct requests on the videotape. They also scored higher on the post-test in assertion, persistence and calmness. At the three month follow-up, experimental group subjects scored higher on measures of social support, cognitive performance, parenting ability, child care self efficacy, and psychological well being.

Studies suggest that social support systems influence socioeconomic, psychological and physiological outcomes of adolescent pregnancy and subsequent motherhood. Research has not addressed if one’s cultural beliefs and family structure affects these outcomes.

Little research has focused on the role of significant others in providing social support to African-American adolescent mothers or how they may be instrumental in helping to decrease the sociological and economic effects of African-American adolescent mothers and their children. The use of nonstandardized instrumentation (Unger & Wandersman, 1988), prenatal and early post-natal assessment of social support (Dormire, et al., 1988; Koniak-Griffin, 1988; Unger & Wandersman, 1988), lack of operational or conceptual definitions of social support (Dormire, et al., 1988; Heins, et all, 1987;
Family Structure

Medalie (1978) contended that family structure, economic base, and educational standards change when children are born, grow and leave the home. A change in one family member affects all family members. The following literature review delineates family structure, cultural, economic, and educational consequences of African-American adolescent motherhood.

There are important differences between African-American and white family structures (Census Data, 1984; Voydanoff & Donnelly, 1990). Extended family arrangements are particularly prevalent for African-American adolescent mothers and their children. Census Data (1984) revealed that 74% of 15 to 19 year olds with children were living with family members or friends, while only 26% maintained their own households (Voydanoff & Donnelly, 1990). For low income families, economic constraints, lack of assistance with institutional day care assistance, and insufficient numbers of child day care facilities, increases the likelihood that child care responsibilities will be shared among extended family members.
Cultural differences exist regarding the role that grandmothers play in the rearing of their grandchildren. Compared to whites, African-American grandparents play a more active part in the childrearing of their grandchildren, possibly because they reside in the same household as their grandchildren (Beck & Beck, 1989; Hogan, Hao, & Parish, 1986) which provides a greater opportunity for involvement. It may also be due to an increased incidence of marital dissolution and unemployment among African-Americans which increases this type of living arrangement in African-American families.

A classic longitudinal study by Furstenberg, et al. (1987) further substantiates differences that exist between African-American adolescent mothers and white adolescent mothers. Racial differences were found in marriage, education and economic variables. African-American mothers were less likely to marry or consider marriage as a viable option than were white adolescent mothers. When African-American adolescent mothers did marry, they were less likely to stay married than white adolescent mothers (25% and 50% respectively) at the 17 year follow up.

The decreased propensity for considering marriage as a viable option in African-American females was originally attributed to class structure (especially the development of a permanent African-American underclass), welfare dependency, cultural norms and group differences in education (Fossett & Kiecolt, 1990; Taylor, et al., 1990). Currently, the decreased propensity

Furstenberg, et al. (1987) found that African-American mothers were more likely to complete high school than white adolescent mothers. African-American adolescent mothers were also more likely to live within extended households than white adolescent mothers. This living arrangement gave African-American mothers the opportunity to complete high school and/or find employment. Though African-American adolescent mothers were more self-sufficient economically than white adolescent mothers, their income levels were less (Furstenberg, et al., 1987). Sixty-six percent of the African-American mothers had incomes below $15,000 per year which is not much above poverty level. Mayfield-Brown (1989) has attributed income disparity to a lack of skills, incomplete high school education, racism, and discrimination toward African-American females.

Furstenberg, et al. (1987) contended that their sample did not exhibit stereotypical, jobless, welfare dependent adolescent mothers with high fertility
and high school drop out rates. Many of the mothers were employed (even though the jobs were low pay and low status), most had finished high school and some had gone to college, most had low fertility rates and were not dependent on AFDC. However, even if these mothers were not as stereotyped, their life chances for economic independence and post secondary education attainment were less than women who bear children later in life.

Adolescent Growth and Development

Adolescent mothers' age and level of cognitive development must be considered when assessing social support needs. Maternal age may be associated with the amount of knowledge young mothers possess about child rearing and perceptions of their children (Mercer, 1986). Erikson (1968) developed eight stages of psychosocial development. He asserted that all people pass through each stage sequentially. Identity versus identity confusion is the stage Erikson defined as critical to adolescent development. The process of determining who one is, what values are important, and what attitudes should be taken into adult life are cumulative effects of experiences that occurred during previous psychosocial stages. Identity formation is the primary psychosocial task of adolescence (Erikson, 1968). Adolescents form idealistic impressions of family life, friends and social relationships by experiencing a
variety of roles and relationships. During adolescence, less emphasis is placed on family and more importance is given to peers (Erikson, 1968).

Piaget and Inhelder (1969) asserted that adolescents gradually evolve from a stage of concrete operations to formal operations. The concrete operational mode is characterized by concerns for the here and now. Formal operations allows one to make abstractions and to see the long term consequences of behavior. Although cognitive functioning moves to abstract conceptual levels during adolescence, it is not until around the age of 15 years that deductive reasoning with the ability to maintain hypotheses and arguments for solutions of problems begins to be grasped (Piaget & Inhelder, 1969).

Elkind (1976) described several related affective dimensions of adolescent cognitive development that can be incorporated into what is described as the formal operational mode by Piaget and Inhelder (1969). These dimensions are identified as part of the unique egocentrism of adolescence (Elkind, 1976).

Egocentrism, a normal developmental phase of adolescence, is defined by Elkind (1976) as the lack of differentiation between one's own point of view and that of others. Elkind identified three interrelated consequences of adolescent egocentrism. First, there is a general focusing on the self and a great deal of self absorption. Adolescents are very concerned with their own behavior, body changes and physical appearance. Second, adolescents believe
others are constantly focusing attention on them (i.e. the imaginary audience). Third, adolescents develop a personal fable that says that they are special and unique and that the laws of nature do not necessarily apply to them. These concepts may directly affect the parental task of forming an empathetic relationship with their infants. Egocentrism may prevent adolescent mothers from delaying their own needs and pleasures for those of their infants. Their own thoughts, feelings and preferences may be projected to their infants.

Yoos (1987) used developmental theory to outline four characteristics of adolescent egocentrism that may affect adolescent parenting. First, adolescent thinking may still be at a concrete level that may prevent them from being able to anticipate the responsibilities of motherhood before experiencing them. This may also hinder adolescent mothers from recognizing or understanding infant behavior or anticipating infant needs. The second concept, self-absorption, may preclude their ability to delay their own needs and pleasures for those of the infant. Third, adolescent mothers may project their own thoughts, feelings and preferences to the infant and have difficulty identifying their infant’s feelings as separate and different from their own. The fourth characteristic, an imaginary audience, may prevent them from seeking help with questions about child care and inhibit spontaneous play with their infants.

An investigation by Zuckerman, Winsmore, and Alpert (1979) examined the influence of adolescent growth and development on adolescent motherhood.
They hypothesized that the needs, concerns and childrearing attitudes of adolescent mothers may be unique due to the simultaneous demands of motherhood and adolescence, and may present certain insoluble conflicts unless the needs of both were met. Fifty five mother-infant pairs were studied: 23 primiparous adolescents who were 18 years of age or less, eight primiparous females 19 to 21 years of age, and 24 multiparous females aged 21 years and older. Eighty seven percent of the total sample was African-American. Subjects were interviewed in their homes at two weeks and three months postpartum. The interview guide was developed by the investigators.

Ninety-five percent of the sample lived in extended family households and 81% of the mothers reported receiving support from their babies’ fathers. Adolescent mothers reported seeking health advice from their mothers while older women reported seeking similar advice from health professionals. At the second interview, more adolescent mothers had someone in the home to share infant care. More adolescent mothers perceived their baby as greedy during feeding and fewer adolescents had positive statements about breast feeding. Compared to the other two groups, more adolescent mothers expressed insecurity about their role as mother. More adolescent mothers were concerned about their baby recognizing them as the mother if child care was shared with another person. Older women also voiced insecurity in their role as mother at two weeks; however, their insecurity vanished at three months. Adolescent
mothers continued to experience insecurity at the three month interview. More adolescent mothers at interview one were bothered about not knowing what their baby needed or wanted. Adolescent mothers lived in extended family households, perceived and used extended family members and the baby’s father to provide social support.

Summary

The basic concepts and assumptions of Caplan’s (1974) and Caplan and Killea’s (1976) framework are reflected in much of the research reviewed for this investigation. Two assumptions of the research reviewed are: (1) when social support is provided by family members, significant others, and their communities, deleterious effects of adolescent motherhood are lessened; (2) the family and community are open systems for providing social support.

Several researchers examined and measured functions of the family as outlined by Caplan (1974) and Caplan and Killea (1976). Unger and Wandersman (1988) explored relationships that may exist between family and partner social support and the adjustment to adolescent motherhood. These researchers discovered that adolescent mothers with a strong family social support system were moderately satisfied with their life and were functioning at an adequate level as a parent. When studying prenatal attachment and social support in adolescent mothers, Koniak-Griffin (1988) found that when
adolescent mothers had a strong social support system, they were likely to have higher self-esteem in areas related to home life. Dormire’s, et al. (1988) study yielded similar results. These researchers measured the concepts of the family as a (1) feedback guidance system, (2) guide and mediator in problem solving, (3) source of practical service and concrete aid during times of stress and role transition, (4) source and validator of their identity, and (5) contributor to emotional mastery (Caplan & Killea, 1976).

Functions of the community and professional health care providers are also apparent. Heins, et al. (1987) and Polit (1989) used community members to facilitate the effectiveness of their community programs. Expert professionals designed, facilitated, implemented and evaluated program outcomes. Program results revealed that community social support had the following effects: (1) increased employment rates, (1) decreased the use of AFDC, (3) increased earnings (though still within the poverty range), (4) increased parenting skills and child care self competence, (5) decreased perceptions of stress, (6) increased the cognitive performance of children, (7) increased positive verbalizations and interactions with between adolescent mothers and their children, and (8) increased psychological well being.

When adolescent females become mothers, the roles, functions and boundaries of the family system change. This descriptive study examined support needs of African-American adolescent mothers from subculture groups
such as family, friends, neighbors, church, health care providers, and human service agencies. Information about community and society social support was sought by asking questions about involvement and satisfaction with various social agencies and community organizations.

Nurses must be cognizant of family structure, economic, cultural and developmental differences that exist in African-American families. Studies must be conducted to investigate how cultural values (e.g. extended family), family structure (e.g. single parenthood), poverty and cognitive development influence the need for social support. Identifying the social support needs of African-American adolescent mothers may decrease the deleterious effects associated with adolescent motherhood.
CHAPTER III

METHODS

Research Design

This descriptive study examined social support from the perspective of African-American adolescent mothers. Descriptive research is used to explore and describe what exists (Ary, Jacobs, & Razavieh, 1985). The purpose of this research was to describe social support provided to African-American adolescent mothers.

Sample

A total of 22 African-American adolescent mothers participated in the study. For inclusion in the study, participants had to be African-American adolescent mothers aged 14 to 19 years, have completed at least the eighth grade, and have children who were no more than 36 months of age, and free from life-threatening illness, disabilities, and congenital anomalies.
Sampling Procedure

The convenience sample was recruited from ECCO Family Prenatal Clinic, The Columbus City Health Department, Doctors Hospital North, churches, friends of the investigator, and referrals from participants. The investigator determined which adolescent mothers met the inclusion criteria by seeking answers to the following screening questions: (1) How old are you? (2) What is the highest grade level you completed? (3) Was your child full-term or premature? (4) When was your child due? (5) When was your child born? (6) Does your child have any health problems? and (7) If yes, what are they? Each mother who met the inclusion criteria was asked to participate in the study. None refused to participate in the study.

Potential participants were contacted either by telephone or in person. The purpose of the study and time commitment were discussed with each potential participant (See Appendix A). If she agreed to participate, an appointment was arranged for an interview. Before the interview was conducted, a consent was signed by adolescent mothers or if unemancipated minors, their legal guardians (See Appendix B). Interviews were conducted in private areas of the ECCO Family Health center, participants’ homes, or a mutually agreed upon location. Interview length ranged between 27 and 70 minutes. The study was reviewed by The Ohio State University’s Behavioral and Social Sciences Human Subjects Review Committee (See Appendix C).
Pre-Testing

Several instruments have been used to assess social support in a variety of populations. Variables measured by these instruments may not address many of the issues related to African-American adolescent motherhood because of developmental, cultural, economic, and linguistic differences that may exist. It was felt that a plausible resolution to this dilemma was to use instruments on dissimilar populations and augment the data with a semi-structured interview.

Three instruments were used for pre-testing purposes. The MOS Social Support Survey (Sherbourne & Stewart, 1991), the PRQ 85 developed by Brandt and Weinert (1981; 1987) and a semi-structured interview developed by the investigator. Five African-American adolescent mothers were used to conduct pre-testing of the instruments. Participants found the MOS Social Support survey and the PRQ 85 confusing, and stated they had not experienced many of the scenarios presented in the PRQ 85. In addition, the investigator concluded that the instruments were not specific enough to identify social support provided to adolescents.

There was a need to identify specific situations in which social support was needed for African-American adolescent mothers which may be different from those of adults, other economic and ethnic groups. Neither instrument provided this data. Thus, the interview guide was used exclusively for the
remainder of the participants. Qualitative data obtained from pre-test participants were combined with those of the final study group.

**Interview Guide Development**

Twenty eight questions were developed by the investigator to assess social support (See Appendix D). The interview guide is a semi-structured format. The purpose of a semi-structured interview is to allow participants to express their opinions freely, clarify their positions, vent their feelings and stimulate free thought (Sudman & Bradburn, 1988).

The clinical experiences of the investigator and an extensive literature review of social support were used to identify specific content areas for the interview guide. Content areas assessed were: (1) types of social support provided, (2) sources of social support, (3) availability and enactment of social support, and (4) satisfaction with social support provided. Participants were asked to give specific examples of social support provided, what was said to make them feel as if they are receiving social support, and actions performed. The interview guide let participants identify sources of social support and allowed them to verbalize their own unique needs for social support.

Consideration of cultural, developmental and maturational levels of participants, cognitive and linguistic abilities, role relationships between adults and adolescents, as well as the adolescents’ ability to comprehend abstract
concepts (Faux, Walsh & Deatrick, 1988) were essential elements for development of the interview guide. Pre-testing of the instrument revealed that revisions were necessary.

The interview guide was revised to include a satisfaction scale for the provision of social support. To determine satisfaction with social support received, participants were asked to rank social support on a scale from one to ten. Ten was the highest rank and one the lowest. Specific areas ranked were social support received from family, friends, the baby’s biological father or the adolescent mothers’ current male companion, and others. Participants also ranked information received from others regarding motherhood, child care questions, personal problems, and school concerns.

To enhance response validity and reliability, wording was revised to assure that questions were understood and that the language was suitable for this population (Amato & Ochiltree, 1987; Faux, et al., 1988). Content validity of the interview guide was obtained by review of the questions by the dissertation committee members. Further evaluation of appropriateness involved performing a FOG index to determine the reading level of the final interview guide and demographic data sheet. The result was an eighth grade reading level. Sequencing of questions was from general to specific as suggested by Sudman and Bradburn (1988). The interview ended with a general question that asked if there were any additional comments.
Data Processing

At the completion of each interview, field notes were audio taped and transcribed by the investigator. Audio taped interviews were evaluated for clarity of verbalizations. The pre-test tapes were then reviewed by the investigator and one faculty member to determine if: (1) questions were stated clearly, (2) all questions were asked, (3) the investigator probed for clear answers when appropriate, (4) questions were not leading and did not encourage socially desirable answers, and (5) the information sought was being obtained. The remaining 17 tapes were reviewed solely by the investigator to answer the above questions.

Audio taped interviews were transcribed verbatim by a typist. The investigator read each transcribed interview while listening to each audio tape to ensure accuracy of transcription. Transcripts were corrected when necessary. They were coded and recurrent themes generated from the data. In addition, the data were coded for the preconceived conceptual definitions of cognitive, emotional and material support. The software program, Ethnograph, was used to facilitate coding and accurate data retrieval.

Data Analysis

The conceptual framework and conceptual definitions of social support and social support systems of Caplan (1974) guided data analysis. Types of
social support were coded using pre-existing definitions provided by Connell and D'Augelli (1988) and Jacobson (1986). Thus, a content analysis was performed to assess the occurrence of preconceived categories of social support.

The constant comparative method was used throughout data collection. Constant comparative method is the process by which data collection and data analysis occur simultaneously (Glaser & Strauss, 1967). Concepts and propositions that emerged from data collection guided subsequent data collection. Spontaneous discussion of family and individual values regarding abortion and the fact that none of the adolescents planned or desired to be pregnant lead to the inclusion of the following questions: Did you consider aborting? Why or why not? What did you do to avoid getting pregnant? If participants verbalized birth control method(s), they were asked the regularity of birth control usage. These questions were asked of the final 15 participants. Data were collected until no new categories emanated (i.e. saturation).

Data analysis revealed that there were differences in perceptions of emotional support provided, use of human service agencies, and individuals who provided information about human service agencies. To better distinguish these differences, participants were categorized in two ways: (1) contact with Child Protective Services (CPS) and (2) age. Involvement with CPS was due to child abuse and neglect behaviors of the participants’ parents. At the time of the study, nine participants were either previously or currently involved CPS
and thirteen had never been involved with CPS. Age groups were: (1) less than seventeen years of age and (2) seventeen to nineteen years of age. Participants voiced similar responses for other types of social support and themes; thus, no further examination of demographic variables was needed. Inter-rater reliability was examined to ascertain agreement of researcher-established category definitions and preconceived codes. Demographic data were analyzed using descriptive statistics.

Credibility was established by verbally assuring the participants that their responses would not be shared with their parents, teachers, clinic personnel, or anyone else unless given permission to do so (Faux, et al., 1988). For adolescents in particular, it is necessary to have the same gender and race when possible to interview participants to establish greater rapport with participants (Faux, et al., 1987). For this study, the investigator, who was also the interviewer, is an African-American female.

An additional credibility concern for adolescents is the need for privacy. Interviews were conducted in an area of their home, clinic, or mutually agreed upon location that provided the most privacy possible. Credibility of data analysis is further established by using verbatim responses of participants for analysis. To facilitate cooperation, participants were assured at the beginning of the interview that there were no right or wrong answers (See Appendix A).
CHAPTER IV

RESULTS

This chapter begins with a description of the sample. The second portion of the chapter delineates the results of research questions one and two which were: What types of social support are provided to African-American adolescent mothers? and Who provides social support to African-American adolescent mothers? The final segment of this chapter addresses research question three which asked: Do African-American adolescent mothers perceive any unmet social support needs? Eight themes: (1) child care competency, (2) father figure/male role model, (3) violence, (4) loss of adolescent freedom, (5) reconstruction of future education and economic goals, (6) family values, (7) fear of rejection and (8) role restraint, emerged during data analysis. The definitions of themes are in Appendix E.

Description of the Sample

Twenty-two African-American adolescent mothers participated in the study. Ages of participants ranged from 16 to 19 years (mean = 17.5,
standard deviation (SD) = 1.03). Participants were between 14 and 18 years of age when their first child was born (mean = 16.5, SD = 1.27).

Fifteen participants were asked if they used birth control to prevent pregnancy and nine stated they had. Birth control methods used were birth control pills, condoms, and DepoProvera. Those who used birth control pills stated they had side effects such as nausea, so they did not use the pills regularly. Condom and DepoProvera use was also inconsistent. Adolescent mothers who used condoms as a form of birth control stated they did not use condoms each time they had sexual intercourse. Participants who used DepoProvera injections did not return for injections every three months as prescribed.

Five participants stated they had friends who had Norplant or received DepoProvera injections. Adverse reactions such as breakthrough bleeding and amenorrhea were experienced by their friends. Therefore, participants did not view these birth control methods as options they would select for themselves. None of the five discussed other forms of birth control. One mother said, "Norplants make you sterile for five years," and she wanted to have another child in less time; thus, she did not want to use Norplant. All but one of the 22 participants denied planning or wanting to be pregnant.

Nine (41%) participants were experiencing their second pregnancy and had one child. Twelve (55%) of the participants had experienced only one
pregnancy. At the time of the interview, only one participant had two children and was pregnant for the third time. Medical confirmation of pregnancy ranged between one and nine months (mean = 4.5, SD = 1.2).

All participants had given birth to normal, healthy neonates. The ages of their first child ranged from 2 to 36 months (mean = 14.5, SD = 9.5). Twenty (92%) of the participants were single/never married, one had been married for three years, and one was divorced. Seventeen (77%) were still dating the biological father of their child(ren) and five (23%) were not.

The highest level of education completed by participants ranged from ninth grade to one year of college. Twelve (55%) were still attending high school. Two participants were in the ninth grade, four were in the tenth, three were in the eleventh and three were in the twelfth. One participant obtained a General Education Diploma (GED). Five (23%) subjects were high school graduates and four of them were attending college. Four (18%) were not attending school; two because of their pregnancy, one had no child care, and the other stated she was too ill to attend school during her first pregnancy and had not returned after the birth of her child. Table 1 illustrates the marital status, number of pregnancies and grade in school of participants.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single/Never Married</td>
<td>20</td>
<td>92</td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Number of Pregnancies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>12</td>
<td>55</td>
</tr>
<tr>
<td>Two</td>
<td>9</td>
<td>41</td>
</tr>
<tr>
<td>Three</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Grade In School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ninth Grade</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Tenth Grade</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Eleventh Grade</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Twelfth Grade</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>High School Drop Out</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>High School Graduate or GED</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Attending College</td>
<td>4</td>
<td>18</td>
</tr>
</tbody>
</table>
Household Composition

Participants were asked with whom they lived "most of their lives." Eleven (50%) lived with their mothers in female headed households, five (23%) lived in two parent households, and six (28%) resided with other relatives. In addition, four participants had also lived in settings such as institutions (14%), correctional facilities (14%), foster homes (18%), and one adolescent lived in a homeless shelter for a "short while" after her child was born.

The total options for living arrangements are greater than 100% since many adolescents had experienced multiple types of living arrangements throughout their lives. Changes in living arrangements were often the result of conflict between participants and their parent(s) or guardian. Conflicts related to pregnancy and/or pregnancy outcomes were the most frequent cause of residency changes. During stages of conflict, participants resided in the homes of friends, relatives and/or male companions and their families. When conflicts were resolved, participants often returned to their original households. Exceptions were adolescent mothers who were currently or previously involved with CPS (n = 9). These adolescent mothers were usually emancipated and lived independently of family members, or resided within extended family households due to unresolved conflicts with their parent(s).

At the time of the interview, nineteen (88%) of the participants lived in extended family households and three (12%) lived in nuclear family households.
Nuclear family households contained adolescent mothers, male companion or husband, and their children. Extended family households contained adolescent mothers, their children, participant's parent(s) or legal guardian(s), nieces, nephews, aunts, uncles, cousins, grandparents, and/or anyone they considered to be family members. One adolescent mother lived with her male companion; two participants were sisters who shared an apartment.

Financial Support

Financial support was assessed by requesting that each participant list "ways you get money to live on" (See Appendix D). Specific questions were obtained from Williams' (1991) interview guide. Participants had several sources of financial support. Eight (36%) of the adolescents obtained financial support from their mothers' jobs, four (18%) from their own jobs, ten (45%) from other relatives, two (9%) from the baby’s father, five (23%) from the baby’s father’s family, and 19 (86%) from AFDC. The data suggest that participants and their families were in the lower economic range. Table 2 outlines household composition and financial support.

At the time of the interview, seven (32%) of the participants did not know the employment status of their mothers. Nine (41%) of the participants’ mothers were employed outside the home as office workers and seven (32%)
**TABLE 2**

Household Composition and Financial Support  
*(N = 22)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Composition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female Headed Household</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Two Parent Household</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>Living with Other Relatives</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Living with Male Companion</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Financial Support*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother's Job</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Father's Job</td>
<td>7</td>
<td>32</td>
</tr>
<tr>
<td>Own Job</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>10</td>
<td>45</td>
</tr>
<tr>
<td>Baby's Father</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Baby's Father’s Family</td>
<td>5</td>
<td>23</td>
</tr>
<tr>
<td>AFDC</td>
<td>19</td>
<td>86</td>
</tr>
</tbody>
</table>

*Participants gave more than one source of financial support.*
were unaware of their mothers' occupation. Two (9%) of their mothers were incarcerated, two (9%) were unemployed, one (4%) owned her own business, and one (4%) was a full time student.

The educational attainment of the participants’ mothers ranged from eleventh grade to a graduate degree. Ten (45%) of the participants did not know the educational attainment of their mothers, two (9%) stated their mothers completed up to the eleventh grade, six (28%) were high school graduates, and the remaining four (18%) had some college, a technical degree, or a bachelor’s degree, and one mother had earned a Master’s degree.

Twelve (55%) of the participants were unaware of their fathers’ occupation. Six (28%) stated their fathers were laborers, and the remaining four (18%) were incarcerated (n = 1), unemployed (n = 1), receiving disability (n = 1), and owned his own business (n = 1). Fifteen (68%) did not know the highest grade level completed by their fathers. The remaining seven (32%) stated their fathers were high school graduates. Table 3 illustrates parent(s) job status and education attainment.

Ten (45%) of the participants’ male companions were employed; however, only two (9%) of the babies’ biological fathers provided financial support to their children on a regularly scheduled basis. All male companions provided money, if asked, whether they were the biological father of the baby or not. Male companions’ education levels ranged from tenth grade to
Table 3

Parent(s) Job Status and Educational Attainment
(N = 22)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Percent</th>
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<tr>
<td><strong>Participant’s Mother</strong></td>
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<td><strong>Job Status</strong></td>
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<tr>
<td>Eleventh grade</td>
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<tr>
<td><strong>Educational Attainment</strong></td>
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<tr>
<td>High School Graduate</td>
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<td>32</td>
</tr>
<tr>
<td>Unknown</td>
<td>15</td>
<td>68</td>
</tr>
</tbody>
</table>
three years of college. Three (14%) of the mothers did not know the educational attainment of the babies’ father nor his employment status. Two (9%) of the baby’s fathers were incarcerated at the time of the interview.

**Child Care Responsibilities**

Child care responsibilities were assessed to determine who was the primary child care provider for the participants’ children. Sixteen (73%) of adolescents stated they were responsible for their children approximately 76% - 100% of the time, four (18%), 51% - 75% of the time, and two (9%), 26% - 50% of the time. None stated they were responsible for their children less than 25% - 50% of the time. Seventeen (78%) of the participants stated their mothers were most often responsible for the care of their child when they were not, one (4%) stated the baby’s father was, three (13%) a day care center, and one (4%) her current boyfriend. All participants had previous child care experience.

**Types of Social Support**

This section addresses research questions one and two. These questions are: What types of social support are provided to African-American adolescent mothers? and Who provides social support to African-American adolescent mothers? African-American adolescent mothers in this investigation were
provided with cognitive, material, and emotional support by their biological mothers, fathers, foster parents, friends, grandparents, cousins, uncles, aunts, siblings, nieces, nephews, health care agencies, social workers, school counselors, teachers, and substitute mothers. Participants had biological mothers and substitute mothers.

The most consistent providers of all three types of social support for adolescents in this study were their biological or substitute mothers. Substitute mother is defined by the investigator as an adult female who functions and performs the role of mother to a participant. Three adolescent mothers had adult women whom they designated as their substitute mothers. Both the adolescent and the adult female mutually agreed upon this designation. The families of substitute mothers acted as substitute families for participants as well. None of the three adolescents who had substitute mothers and families were in contact with their biological families.

**Cognitive Support**

The need for cognitive support was verbalized by many adolescent mothers. Topics discussed in this category are child care competency, parenting skills, organization, child growth and development, illness care, and human service information.
Child Care Competency

Participants often verbalized concerns regarding their ability to care for their children. This theme was labeled "child care competency," the feelings of doubt or fear verbalized by the mother regarding her ability to adequately care for and/or raise her child(ren). Verbalizations such as "I just don't know what to do for him because, you know, I'm not an experienced mother . . . this is my first time around" and "You think like, well, how do you know if you going to be raising them right? Or how do you know what you're teaching them is right?" symbolizes the theme of child care competency. Many of the participants felt unprepared to be mothers although all of them had previous child care experience. As one adolescent stated:

I still wasn't prepared for a little newborn that had to depend totally on me by myself and not nobody else . . . When he was first born, I didn't, I was fumble-fingers. I didn't know how to give him a bath, . . . I was constantly asking my mom, mom how do I do this, is the bottle too hot, . . . should I change him now . . . ?

Parenting Skills

To alleviate child care competency concerns, adolescent mothers actively sought cognitive support from those within their social system. Their mothers were the primary, though not exclusive, providers of cognitive support for participants. Their mothers provided information, knowledge, and advice during their transition into motherhood. Preparation by their mothers for the
transition into parenthood began, for many adolescents, soon after pregnancy was confirmed. Statements from their mothers such as "... you have to grow up now, you can't think like a[n] adolescent no more, you're an adult now" and "... it's not going to be easy, you haven't run into life yet, you going to have a lot of responsibility" suggest their preparation for the transition into motherhood. Mothers of the adolescents were also instrumental in facilitating the identification of the role of mother. That is, they defined motherhood for their adolescent daughters. As one participant stated,

> My mom told me when you become a mother, you got to act like a mother. So, then a mother is taking care of her kids, making sure him or her you know, have what they need.

When asked, the mothers of the adolescents taught them parenting skills, such as basic child care techniques, organization, how to care for or treat various illnesses and injuries, as well as when and how to seek medical attention for their child. Basic child care techniques included teaching adolescents how to feed, hold, bathe and comfort their babies; how, what type and when to buy food, as well as how to buy material items such as clothing. An example of cognitive support regarding basic child care is illustrated by a mother concerned about the comfort of her infant during the summer months. She stated:
Ah, you know she gives me advice. Like the other day, it’s kind of crazy but, she told me to put my son’s hair in rubber bands right? To let his scalp cool. And I was like, rubber bands? You know because he was really sweating a lot and he has thick hair and a lot of it. So, I thought he was looking goofy with all the rubber bands in his hair but he cooled off and wasn’t sweating so much.

Basic child care techniques as described above were expounded upon by many of the participants. Though the adolescents were often able to identify child care problems, they were often unable to contemplate resolutions for their problems.

Solutions to daily organization of adolescent and parenting responsibilities were addressed as well. Organization of child care was a major concern for many of the adolescents. They were unable to organize and perform the tasks involved with the multiple roles of mother, student, adolescent, and employee. Cognitive support from others was sought and obtained from others to alleviate this dilemma. A participant who had considered dropping out of school to simplify her life illustrates this. She stated,

When I come in and I have a F on a paper and it’s because I couldn’t study because of the baby. And because the phone keep ringing and I want to talk, but then I have to do this for her. And I forget about studying.

The need for cognitive support for organizational skills was apparent when their children had multiple, simultaneous needs (e.g. comfort and hunger).
Participants often lacked the ability to conceptualize or implement the tasks necessary to intervene appropriately. This is portrayed by an adolescent mother who stated of her mother:

I was asking all these questions and she was being patient with me and teaching me how to be a mom and teaching me what to do and stuff and how there's certain, there's a certain way you have to do things if you want to get everything done in the day... Okay, you want to make his bottle and he's crying, pick him up and make his bottle at the same time... don't leave him, don't let him just sit there and cry.

This pragmatic solution was very useful in helping adolescents organize child care activities and provided practical parenting skills. This situation was not unique to this participant; many of the adolescents' mothers provided similar information to help them organize and perform the tasks involved with multiple roles.

Child growth and development was an additional concern for adolescent mothers. Child growth and development information was generally obtained from their mothers, friends, and male companions. When asked, "Who do you most often talk to about child care questions?" the responses varied. Concerns, however, were relatively consistent. Questions regarding when to begin and how to accomplish toilet training were frequent. Most adolescents anticipated difficulty in accomplishing toilet training and felt that help would be necessary.
Additional child growth and development concerns pertained to normal developmental milestones as outlined by the following participants.

Just like, like how they're supposed to, ah, grow and like mentally and physically and what they're supposed to be accomplishing at his age and stuff like that.

When does she sit up, well what time does she sit up, what time that she could eat the baby pretzels . . . what time you think she start walking . . . start eating real food. And I had questions like, when you think I can start her potty training? Like I asked her [friend] like when she be able to eat table foods and she said like 8 or 9 months.

Still another adolescent mother could not understand her toddler's temper tantrums nor why he would insist on playing with what she felt was an inappropriate toy for a male child. She sought answers from her husband. She stated:

Like if [my son] wanted a toy from [my daughter] and I took it from [my daughter] and he goes through tantrums. I'd be like, why would he want to play with the doll baby instead of a motorcycle. And he helps me understand that.

The above are examples of child growth and development knowledge sought from friends, family members and male companions. According to the participants, the information provided was useful and helped them solve problems as well as anticipate both current and future developmental milestones.
Illness Care

Anticipatory guidance from the adolescents' mothers was apparent. Very often, it was their mothers who volunteered information about child care during illnesses. Their mothers identified health problems, provided the necessary information to resolve the problem, and demonstrated the appropriate techniques involved with administering proper interventions. For example, one adolescent verbalized, "Well, half the time, I get them telling me before I even ask about it. He's coughing too much, put your shoes on, [and] go buy him some Benadryl." Or as another adolescent stated "... it's like, you just go ahead and walk to the store and get the medicine and then when you get back we'll take care of her."

Their mothers and grandmothers taught them how to care for common illnesses, such as diaper rash with home remedies, or a cold with various over the counter medications, when appropriate. They were instrumental in teaching adolescent mothers when to call health care providers as well as helping them identify pertinent information that health providers would need to make decisions about the child's care.

However, it was also apparent that most of the participants' mothers encouraged as well as expected participants to eventually take the responsibility for caring for their child(ren) during an illness as well as an injury. This is exemplified by the following statements:
She'll [her mom] do it first and then she'll tell me to watch so I'll know how to do it.

She [her mom] leave stuff up to me but she shows me how and my father, he basically does the same thing.

She [her mom] told me if you stay calm then the situation will be handled a lot better. If you're not calm, you know, you don't want to panic and stuff, but you got to think about the kid first. If you're not calm, then the kid won't be calm.

Human Service Agency Information

Participants were also supplied with cognitive support regarding human service agencies. This information was provided by nurses, social workers, and their mothers. Only three adolescent mothers specifically named a particular nurse as a provider of cognitive support. Nurses were discussed in the context of the agency in which they were employed. That is, they would state "they" are all nice, or "they" helped me a lot when I come to the clinic. However, according to participants, nurses rendered information and implemented health care services, prenatal and pediatric health care, support during labor and delivery and were instrumental in assisting the adolescent mothers to find educational alternatives and programs, such as the Women Infants and Children (WIC) program.

Nine of the participants were either currently or previously involved with CPS. Thus, social workers were an integral part of many of their lives. Social
workers encouraged and found ways for adolescents to accomplish educational and career aspirations. They also helped them acquire infant/child care services, AFDC, financial aid for college, WIC, and directed them to proper agencies to obtain Section 8 housing from the state government. The mean age for this sub-group was 18, and they were more likely to be emancipated, live in their own apartment, be attending or planning to attend either a two or four year college, and to see their current economic status as temporary.

The remaining 13 participants received information about infant/child care services, AFDC, and WIC from their mothers. None of these thirteen participants discussed having received information regarding Section 8 housing from the state government or college funding from their mothers or others. The mean age for this sub-group was 17.2 and several were still attending high school which may indicate that college tuition costs may not have been a pressing concern. In addition, they lived within their parent(s) household.

Overall, there was no difference in the need for cognitive support between CPS participants and those who were not involved with CPS. Adolescents who were not in contact with their biological family members had successfully established substitute families who provided cognitive support. However, they reported asking child care questions and talking about school concerns with teachers, day care workers and school counselors in addition to their substitute mothers and family members.
Material Support

Material support was provided by extended and nuclear families, male companions and their families, and friends. The types of material support provided to the adolescent mothers included child care respite, money, and material items such as food, clothing and care seats. Participants made no distinction between the amount of or satisfaction with material support provided between nuclear and extended family members. If nuclear family members were not able to provide material support, extended family members would. As one adolescent offered, "If I don't have money my mother, father and grandmother will buy things."

Child Care Respite

When asked "Tell me about the help you receive from others," child care respite was usually the first type of material support described by adolescent mothers. Their mothers, fathers, male companions, and grandparents provided child care while they attended school or work. Family members also provided child care respite if adolescent mothers were ill or when instructed by medical personnel to rest frequently throughout the day during their pregnancies. This is illustrated by a quote from a participant who was pregnant for the second time: "My dad, a lot of times he'll say, go on and take your nap or go ahead and rest". Still another adolescent asserted:
And when I’m not feeling good, she [mom] helps me out. If I need a break, somebody in my family will take the baby and take her somewhere, take her for a ride or something like that. Or if I don’t feel like getting up to feed the baby, they feed the baby. Oh, and they’ll feed me too. That’s just my family.

Younger siblings, cousins, nieces, and nephews also played a role in providing child care. When asked, "Tell me about the help you receive from your family in general," children within the family were named as providers of material support. Younger siblings, cousins, nieces and nephews were usually available and willing to interact and play with the participants’ children. An example was offered by one adolescent mom who said:

My little brother, he’s going to be 11 this year, and my sister, she’s 8 this year. And they play with him when he’s ready to play. . . they’ll take him outside in the backyard. . . they’ll put his shoes on and take him out there and let him run around and stuff. . . they watch him real good for me.

This participant stated that she and her neighbors would "keep an eye" on the children as they played outside. Thus, children as well as adults provided child care respite for adolescent mothers.

When discussing child care respite, a theme which the investigator titled "violence" emerged. Violence is defined as acts, threats or fear of violence within the adolescent’s social system and/or society. Adolescents and their families were very aware of the threat of violence and abuse toward their
children. Many adolescents and their families did not trust institutional day care because, as an adolescent mother asserted, "I just don't trust people, you know, with all the things with child molesting and child abuse." Thus, when seeking child care respite, family members, male companions and their families, and/or very close friends were the only individuals considered. As one adolescent mother stated:

I don't trust [baby] with everybody cause I don't know. People, kids be getting smacked around and stuff. I don't want my babies getting smacked around. She can't talk anyway. When she start talking, she can go more, basically. She don't, I mean, she can talk, but she can't say she been mistreated or anything. So, I don't let her go that many places without family being around.

Despite the fact that adolescent mothers and their families were cognizant of free child care services through the state government, most of the participants were reluctant to use it because they felt there was a possibility of their children being abused. Four adolescents who used day care services were emancipated and not in contact with any family members. These four mothers did not verbalize any fears nor concerns regarding the potential threat of violence toward their children while in institutional day care.

Requested, as well as impromptu child care respite was provided by male companions. If the participant was ill, needed to be away from the child temporarily, or if their male companion wanted to spend time with the child, child care respite was available. The following assertions characterize this.
Um, like if [baby] sick and he just cries all day long and I'm real tired, he'll [male] take him.

He will come over and he will stay so I can sleep at night. And he helped like I can bring her over there to his house. And she can stay the night with him so I can get some sleep.

He takes her off my hands. Like I need, like I don't have a job, so I'm not away from her at all times.

You know we have like the shared parenting plan. He keeps him certain amount of days and I keep him... so I can have some rest and you know.

Male companions were very significant providers of child care respite. Seventy seven percent of the participants were dating the biological father of their child(ren). These males were actively involved with the care and responsibility of their children. The remaining 23% were receiving material support from their male companions who were not the biological fathers of their children. Male companions interacted with the children of adolescent mothers on a regular basis and were an important part of their social support systems.

Acquisition of Items

All participants acquired items such as baby clothes, diapers, milk, transportation, and money from others. Only four (18%) of the adolescents were employed at the time of the interview and felt some responsibility to have
a job to provide material items for their children. One adolescent who said, "If they keep buying for her like this, I won’t have to buy her anything" exemplifies the feelings of the remainder of the participants. Family members usually purchased items needed by the participant or her child(ren) instead of furnishing her with money to purchase items.

Child care items such as food, clothing and furniture were purchased by others when needed or as others desired to do so. As one adolescent offered, "Like my grandmother will give her things, my aunt will buy just like little things she see, she will buy." Still another adolescent asserted, "They bring home milk and pampers and baby stuff. I don’t have to buy all that. They bought her a car seat, and helped me get a baby bed and stuff like that." When items such as food, diapers and milk were depleted, requests were made for assistance from family members and/or male companions. For example, two participants asserted:

Times where I can’t get my money, she [mom] has money, you know and stuff like that and she’ll buy what she [the baby] need.

My dad, if he has money, he’ll buy [name] some clothes or stuff or he’ll buy him some pampers, he’ll pay, lot of times they alternate. My mom buys pampers one time, my dad buys pampers.

Male companions were frequent providers of material support. They provided money, clothing, transportation, food, milk, and diapers. While only
2 participants reported receiving regular weekly payments from male companions, all received monetary support for child care needs when requested. This is illustrated in the following quotes:

When I need some Pampers and stuff for her I tell him to give me the money for it and when she needs some milk or something. Then he just give me the money for it and stuff.

My boyfriend is real helpful. He, he'll give me money like for, like if I tell him okay, [name] doesn't have enough pampers, you know, I can, you know, he'll say okay, I'm coming over with the money now.

When I need a ride to the doctor's if he not driving that day he give me money to get there or if I got money to pay for the visit, he'd give me the money to pay for the visit for her and me too.

The families of their male companions provided material support similar to material support received from participants' families. However, material support provided was not as consistent as that provided by their nuclear and extended family members. The families of their male companions purchased items such as clothing, food, milk, money, and provided child care respite.

Material support from friends of the adolescent mothers basically involved the purchase of clothing and toys for their children. An additional source of material support was offered by adolescent mothers who had moved into other households either before or since they became mothers. Over 50% of the participants had moved to different households throughout their lives due
to family violence and/or conflict. The provision of housing, clothing and food were delineated by this group as an important source of material support. One adolescent who was homeless for a time stated of her adult friend:

Karen took me in. She has kids of her own, a one bedroom apartment. A one bedroom. But she took me in. She gave us money, like I was her child.

Reciprocity for the provision of material support was apparent by a statement from one adolescent who asserted of her best friend, "Like if I ask her to go get something from the store for me, she go get it. She ask me to do something, I do it for her. So we like sisters." Many of the participants had similar statements about their friends.

Material support as provided by family, male companions and others is stated well by an adolescent who said of her mother:

That's one thing about my mother. She never let you go without food, clothing or a roof over your head. She makes sacrifices to do it. When it concerns kids, she's there and for the kids, if I need anything, and I can't get it, she helps me to get it. Oh, as far as me, I tell her, she'll look at me and go [name] that's too tight. She'll go, you need something. Or she'll see something out there she might like for me she'll pick it up. But for kid-wise, she picks up mostly anything for them.

Though she was speaking specifically of her mother, her statement is indicative of how participants spoke of material support provided by family, male companions and others.
Emotional Support

Emotional support was provided by household members, extended family members and community members. Individuals within their social system made them feel loved, cared for and worthwhile. One adolescent stated, "I knew that I had people on my side to help me, to follow me through and I, you know, they was proud of me. . . " "Being there" was a frequent statement from adolescent mothers when describing emotional support from others. Statements such as, "Like if you ever need anything I'll be there for you" were frequently verbalized.

Participants most often discussed their mothers when describing emotional support. When they addressed the responsibilities of motherhood and the need for and receipt of cognitive support, statements indicative of emotional support surfaced. Mothers provided adolescents with encouraging statements such as, "Keep hanging in there, you'll be all right" and "... it's going to be ok, it's going to be ok." Their mothers also praised and complimented them for their successful transition into the roles and functions of motherhood. This is exemplified in a statement by one adolescent mother who offered the following about her mother:

She's like well, she says, I'm a good mother and she tells me stuff like that, you know? She tells me she's proud of me you know, I've really done good.
When asked how she felt about help from her mother, one adolescent answered
"I felt a lot better. I felt a lot better because I got something, I got a piece of
information from somebody who I knew cared about me and I cared about
her."

Sixty eight percent of the adolescents lived in nuclear family households
and 32% lived in extended family households. Participants usually included
both nuclear and extended family members when discussing help received from
their family. The statement, "You know you have a good strong family, I have
a family that will always be there if I need them. No matter what happens
between us, if ever I need them, they will always be there," encapsulates the
emotional support discussed by adolescent mothers. To further illustrate, a
quote from an adolescent who had been reared by her aunt and uncle stated of
her extended family members:

One thing me and my aunt had a real close relationship. I
go, any kind of problems I had I went to her instead of my
mother. My uncle, if I ever need him, he's there. Cheryl
[aunt], if I ever need her, she just helps me, so she's there,
Sammy [uncle], he's there.

Emotional support received from male companions, whether he was the
child's biological father or not, was consistent. If their current male companion
was caring for a child that was not biologically his, adolescent mothers felt
grateful. The following verbalizations typify emotional support received from male companions.

He was helping me, he was keeping my spirits up and you know he never let my self-esteem go down. He gave me the strength that I needed to just carry on... He comes to me and asks me how I'm doing, what's the matter.

I can talk to him about personal problems and I know that he won't say nothing to nobody.

It makes me feel good because he said, I mean we, he still cares about us and stuff. He still comes around.

The theme "father figure/male role model" emerged when discussing male companions. Father figure/male role model is an expressed need or desire for a male companion who acts as a positive male role model for her child(ren). This theme was consistent for adolescents who had male children as well as for those who had female children. Participants were grateful for the presence of males in their lives, as well as their children's lives especially if they were no longer dating the child's biological father. Comments such as "My son, he looks up to him like a father" and "he treat him like he his, he won't let him go without" represent the sentiments of many participants.

If the biological father was an integral part of the child's life, adolescents felt surprised, happy, and grateful because "... a lot of girls, you know, their kids' dads ain't around, so you know I feel good that he's going to take care of him" or as one adolescent offered:
You know, he’s going to be able to grow up with two parents. Not living in the same home, but we’re still there. And you know, he’s not going to be wondering, well, where’s my dad? Why he’s not here and all that other stuff so, you know I feel real happy about that.

Adolescent mothers and their male companions felt the need for children to grow up with a father figure. A participant who felt overwhelmed with the responsibilities of single parenthood offered the following insightful statement, "They need a father as well as a mother, and me playing the father and mother role is hard." Other adolescents discussed the need for a father in their children’s lives as it related to their own or their boyfriend’s loss of such a figure:

You know, he told me, cause he didn’t grow up with his father, he told me every, every kid needs a dad . . . I feel the way he feels that, I feel like every kid needs a dad, especially if you’re a boy. You need that father figure right there.

And you know I was trying because, for her, not for me because I don’t want him. So, and I didn’t have my father, and I wanted her to have her father around even though we weren’t together . . .

One adolescent was so concerned about this topic that she asked her father and the baby’s father if they would always be there for her daughter. The baby’s father assured her that he would always be there to love his daughter. She stated:
And he [participant's father] felt that ah, if she didn't have a father, that he [participant's father] was going to be her father . . . I just want to look at it where, you know, she'll always know who her father is. Her father, she'll be able to say, Hi daddy, and know who her daddy is.

Male companions were significant contributors of emotional support for the entire group of participants. The biological father's presence or lack of presence affected participants. It was important that their desire for male companionship as well as those of their children be met. They actively sought ways to have those emotional needs met. Male companions made them feel respected and loved and were available to provide caring and security.

Only one adolescent mother discussed emotional support from clinic personnel. She stated "The clinic, it's more like on a personal level, they don't see you as a, as a specimen or a business, you know? They see you as, like person." No particular discipline or person was delineated as being more or less emotionally supportive of adolescents during their clinic visits. One adolescent described emotional support from clergy and a church member. They provided emotional support by "calling to see how I was" and sharing parenting experiences with her. This adolescent discussed the fact that her pastor prayed with her.
CPS and Non-CPS Perceptual Differences of Emotional Support

Adolescent mothers who were involved with CPS received the same types of emotional support from substitute family members and male companions as those who were not involved with CPS. However, when asked how they felt about the help they received from others, the CPS group responded differently than participants who had not been involved with CPS. The CPS group discussed emotional support received in terms of being wanted and loved. They felt as if they were finally members of a family. For example, one adolescent stated, "Like they make me feel like part of the family." Still another adolescent mother asserted:

It makes me feel good, like I'm accepted, just some way I haven't felt like that before. I feel good because then I don't be feeling alone, to where I can't you know, deal with stuff.

When asked how she felt about help she received from her current male companion, one adolescent said: "It makes me feel good because I never had anybody like that. I never had someone to sit down really and just say my feelings and somebody talk to me back." CPS adolescent mothers had similar feelings about the emotional support received from the baby's father's family. As one adolescent stated, "They just make me feel accepted, like you know, unconditionally." Hence, substitute families and male companions provided CPS mothers with a sense of belonging, feelings of comfort, love and a belief
that they were respected and that others were available to provide caring and security.

In contrast, participants who had not been involved with CPS assumed and expected emotional support from family members and significant others. Thus, there were no differences in the types of emotional support received between groups; however, perceptions and expectations for the provision of emotional support differed.

**Age Group Differences in Emotional Support**

Older adolescents, aged 17 to 19 years, felt they could obtain emotional support by talking to their mothers about many of their personal problems, as well as problems or questions about child care and motherhood. Three older adolescents' mothers said this of their mothers:

My mom, she's definitely there for me. Like right now I'm pregnant and I'm going, me and my boyfriend have been having problems and she's been, she's really been there.

I can talk to her about anything and I just go and tell her stuff . . . she's consoled me and stuff.

If there's anything I need to talk to her about because I have something on my mind, I call her then come and talk about it.
In contrast, younger adolescent mothers, less than 17 years of age, spoke of emotional support from their mothers in reference to the transition into motherhood and its roles and functions. They also felt a need to verify that they were still loved and cared for by their mothers despite the fact they became pregnant during adolescence. The following statements typify this.

[She] gives me lots of support, just sit beside me . . . She stuck beside me and took care of me . . . No matter what went wrong, she was there for me.

She wasn't just going to put me down and forget all about me and this and that.

Younger adolescents were more likely to obtain emotional support by talking to friends almost exclusively about their personal problems. The status of their relationships with the father of their child(ren) or current male companion was the most frequent personal concern discussed. Friends provided emotional support by being available to talk to them and share feelings. As one adolescent verbalized:

She helps me by, not by helping out with the baby and stuff, but like if I need a friend to talk to she's there . . . She just, I mean she just, I talk to her . . . she helped me as much as she could. She was there. She came to the hospital when my baby was born. I mean she's a good friend. I talk to her about anything. It makes me feel like somebody cares . . . I feel good that somebody's willing to, take time out for me . . . I knew that I had some friends I could count on.
Friends helped to validate the adolescent mother’s feelings about her life as a mother as well as her life as an adolescent. Sharing feelings with another adolescent rather than with an adult, they felt, would yield different levels of empathy, understanding, and emotional support. The following comments illustrate this.

I know that there’s somebody I can talk to who’s around my age, who is you know, who’s close enough to my age where she can relate exactly to what I’m talking about.

So, we sit down. I can sit there and talk to her on the level you know, well, I know she’ll respond to me. Not like, well you crazy and stuff like that . . . She’s always there for me and I’m always there for her.

Reciprocity of emotional support to friends is apparent. From the above statement, it is evident that adolescent mothers not only received emotional support from friends, but provided emotional support to friends as well. Table 4 illustrates the major providers of each type of social support.
### Table 4

**Major Providers of Social Support**

<table>
<thead>
<tr>
<th>Types of Social Support</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  GM  EF  MC  MCF  F  A</td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td></td>
</tr>
<tr>
<td>Parenting Skills</td>
<td>X  X</td>
</tr>
<tr>
<td>Illness Care Information</td>
<td>X  X</td>
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<tr>
<td>Human Service Information</td>
<td>X</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Material</strong></td>
<td></td>
</tr>
<tr>
<td>Child Care Respite</td>
<td>X  X  X  X  X  X  X  X</td>
</tr>
<tr>
<td>Acquisition of Items</td>
<td>X  X  X  X  X  X  X  X</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td>X  X  X  X  X  X  X</td>
</tr>
</tbody>
</table>

Unmet Social Support Needs

This section addresses research question three: Do African-American adolescent mothers perceive any unmet social support needs? When asked if there were ways others could help them that they were not helping and if they felt as if they received enough help from others, participants denied the need for additional social support. When asked who they asked questions about child care, the initial response was often, "I already know a lot about taking care of kids because I always used to baby sit [siblings, nieces, nephews, etc.] all the time." However, when probed, participants had many child care questions and others were available to answer them. In many instances, their mothers anticipated the needs of their grandchildren and either taught the mother how to intervene or implemented the proper care themselves. It was apparent that others with experience in child care were available to provide social support in sufficient amounts.

Participants said they received enough help from family, friends, male companions, and others. Social support was ranked on a scale from one to ten. Ten was the highest rank and one the lowest. Social support from family ranked at 9 or above with the exception of one participant who ranked family support as 5. Without the outlier, the mean ranking of social support from family was 9.8 (SD = .02). Inclusion of the outlier yielded a mean of 8.5 (SD = 1.2).
Social support received from friends ranged from 5 to 10 (mean = 8.5, SD = .7). Male companion support ranged from 5 to 10 (mean = 8, SD = 1.8). Support from others ranged from 7 to 10 (mean = 8.5, SD = 1.2). Participants ranked receipt of social support regarding to motherhood from 8 - 10 (mean = 9.6, SD = .2). Child care questions ranked between 7 and 10 (mean = 9.5, SD = .3). When discussing personal problems, adolescents ranked support from 6 to 10 (mean = 8.9, SD = 1). School concerns ranged from 6 to 10 (mean = 8.9, SD = 1).

Other Findings

Other themes emerged that are not within the realm of social support but were significant findings: (1) Loss of adolescent freedom, (2) reconstruction of future goals for education and economic independence, (3) family values, (4) fear of rejection, and (5) role restraint. Each theme will be discussed separately.

Loss of Adolescent Freedom

The loss of adolescent freedom for participants was perceived restrictions or alterations in adolescent activities (e.g. going to the movies or attending parties) since becoming a mother. The loss of adolescent freedom often emerged when adolescents were asked, "How has your life changed since you
became a mother?" Prior to becoming mothers, adolescents were able to participate in social activities and spend time with their friends as desired. However, parenthood decreased their ability to participate in activities. For example, three participants asserted:

Before, I could leave when I wanted to, go when I wanted to, do what I wanted to do. And now, I don’t. . . Before I got pregnant, I was like, wild as far as I went out like every weekend . . .

Well, before I got pregnant, I used to go out all the time. I used to go over to my friends house, I used to go everywhere. And now, it’s just, I don’t go no where but sit at home and go over to my friend’s house or my boyfriend’s house, something like that. I don’t go out no more.

I just cut it, I just cut everything as far as fun. I know when to have fun and I know when not to have fun. But, I just cut myself to the point of being a mother and a adolescent.

When asked how they felt about restricted participation in social activities, participants often discussed violence. For many of the adolescents, the threat of violence justified their decrease in social activities. The following comment depicts this theme as it relates to participants’ decreased involvement in social activities.

I don’t like being out there especially when you hear about all the stuff that’s going on in the news and stuff. People getting shot and killed and picked up and stuff. I don’t want to be out doing nothing.
Participants rationalized that it was preferable not to be as involved in social activities as before, due to the violence experienced by others within their social system as well as society.

Participants voiced ambivalent feelings about the responsibilities of motherhood and the desire to have the freedom of non-parenting adolescence. Motherhood and its responsibilities were acknowledged and accepted by adolescent mothers. However, they also regretted limited access to friends and social activities. Several participants felt as if they "grew up too fast" and that they were experiencing responsibilities beyond their developmental capacity. As one adolescent stated, "Being a adolescent and all, the timing for motherhood is off." The realization of the loss of adolescent freedom crystallized after the birth of their children. Responses from the following participants depicts this.

Your teenaged years you been pressed for all these years and when they come, you got a baby. You can’t do all those things because you have a responsibility.

I was in high school at the time. That was your prime time. You know? Being in high school, going to games and stuff . . . I could still have fun.

I still thought I could go out and have fun, be a adolescent. I had to sit down and think, I'm a mother, I can’t do that. . . . I don’t get to do too much of fun things any more cause I got a kid.
Now I'm starting to think more that I grew up too fast or something. Cause I was only 17. I hadn't even gotten out of school yet. I was still a senior in school so that's not right. Then all of a sudden, I'm a mom and I can't do what my friends is doing and I'm, I have to be at home with this baby . . . it, it was too much . . . I don't regret the kids, I regret the timing.

Motherhood meant relinquishing personal desires and providing for the needs of their children. As one adolescent remarked:

When you get a child, it's not about going out, not about leaving your kids with anybody. And there's not a lot, you know, doing what you want to do. It's about the kids and what they need.

Ambivalence toward the loss of adolescent freedom as well as the acceptance of the loss is summarized well by one participant who stated:

I don't resent it or anything like that. Sometimes I feel like, you know, I wish I could go. But then, you know, she, I think she's worth it.

The loss of adolescent freedom was also apparent when adolescent mothers wanted to attend social activities without their children. If they wished to spend time with friends, child care was usually not provided by significant others. Only two adolescents stated that others would provide child care during their recreational activities. Several made the distinction between child care respite to attend school, work or job interviews and its availability for recreational activities. That is, if the adolescent mothers wished to participate in recreational activities, they had to take their child(ren) with them or find
someone to provide child care. The assertion, "If [baby] can't go, then I don't go," was offered by many adolescent mothers. Family members expected adolescent mothers to take the responsibility for their child(ren) unless there was what they considered a legitimate need for child care respite such as school, work, job interviews or illness.

When child care respite was offered by friends, it was usually at their convenience and not that of the adolescent mothers. Many adolescent mothers verbalized feelings of disappointment toward their friends regarding the lack of child care respite. An adolescent who was promised child care respite prior to the birth of her infant illustrates this.

I just don't ask cause they come by and get her when they want to. I ask them to take her when I want to do something and they busy or got something else to do, so I just don't ask. They come by and they’ll say, where the baby at? My friends come by and take care of her. So I let them take her when they want to, but I don't ask them to do it.

The loss of adolescent freedom was an outcome of adolescent parenthood. The reality of the loss of adolescent freedom was apparent soon after the birth of their children. Their mothers prepared them for the responsibilities of parenthood both during and after pregnancy. An adolescent who was contemplating her future as a mother offered the following comment.
Being a mother means] Taking care not only of yourself but another person besides yourself that's yours, you know? Not a person you could go pick up and take back home, this person be with you forever, eighteen years.

Reconstruction of Future Educational and Economic Goals

The theme "reconstruction of future goals for educational and economic goals" is defined as the adolescent's and/or her guardian's felt need to restructure plans for future educational endeavors due to the responsibilities of parenting. This theme also entails the questioning of one's ability to successfully meet one's education goals which would result in economic independence. Both the participants and their parent(s) often questioned participants' ability to obtain educational and economic independence. This theme often evolved when asked how they felt when their first pregnancy was initially confirmed. Uncertainty about their future education and life plans often surfaced as illustrated by the following participants.

I felt my plans and my life was all coming to an end cause I had plans on going to college, so I felt, I was like oh goodness I can't do what I want, I can't go to school, if I want to go to school with this baby. How am I going to go to school?.

Um, I felt sad and confused because I didn't know what the future was going to hold.
I felt real scared thinking how was I going to support him and how was, ah, how everything was going to go . . . . I have to keep my mind focused on one thing - building a life for me and him so we won't have to, you know, have to be struggling all the time . . . . I want to be a child psychologist and I want to go to Ohio Dominican, right? So I want to stay in school.

One adolescent who was pregnant for the second time aspired to work with computers, but becoming pregnant had usurped her plans. She asserted, "The only thing that upset me was that I couldn't go back to school. I couldn't do everything that I wanted to do." She later asserted how she envisioned her life should be.

I should be having myself set to the point where I have so much money saved up in the bank so if I did have a child it would be there. My life, I would have my own place, my own car and be in college. Take off any time I want to, have a job, have money in my pocket. Where I can buy me any kind of clothes I want, have any kind of hair-do I want, anything.

Her statements represent the feelings about future educational and economic aspirations of most of the participants.

Despite the fact that they felt unable to continue with original ambitions for educational and economic independence, most adolescents had developed alternate strategies to meet their goals. Those whose original intentions were to attend a 4 year college, altered their plans and opted for a junior college. The purpose of altering types of educational institutions was due to their responsibilities as mothers. As a participant stated:
You know, I’m going to do it. I’m going to a 2 year college so I can be home and deal with her. Cause I was looking forward to going to Georgia. To a 4 year college. But I’m a just go to a 2 year college instead to start.

Adolescent mothers realized they would have to care for their children during their college education and they relied on significant others to provide child care during that time.

Participants who had not envisioned plans for economic independence prior to becoming mothers established economic and educational goals after the birth of their children. As one adolescent stated, "I don’t want to be flipping burgers and making no money for the rest of my life." They felt the need to provide for their children economically. Motherhood solidified their life plans for economic viability. As three adolescents disclosed:

Like at first I didn’t want to go to school or anything. But now, I want to go to school. I’m ready to make something of my life so I can teach her to do things better . . . . I want to become something in my life. Graduate and get my grades up in order to be what I want to be.

Now that I got her, I just, I know, well, now I know in March I’m going to hair school. And I know I’m going to finish at North Adult. Now I know what I want to do.

Like me, I’m trying to, you know, work, so that he can have everything he needs without me asking my mom or my father all the time. Because, you know, that’s not his mother or father.

The reconstruction of future goals for education and economic viability was necessary for many participants. Initial concerns regarding their ability to
become economically viable were replaced by alternate plans. According to the participants, the restructuring of life plans will result in meeting these goals later in life. However, their aspirations remained constant despite the fact that they were adolescent mothers.

**Family Values**

Family values emerged when discussing the timing of child bearing and abortion. Family values are defined as issues related to religious ideologies and values in which either an individual or family member verbalizes belief. Family values were an integral part of social system conflict. Conflict developed when there were differences of opinion or actions that were contrary to family values. One adolescent's mother was disappointed when she shared the news of her third pregnancy and told the adolescent mother that she could not afford nor did she need another child. This adolescent's religiosity justified being pregnant to her as she felt her children were a gift from God. The adolescent stated:

> I guess God thinks I'm doing something right. He gave me another one cause if he didn't want me to have these, he would have been done took it. So, she's dealing with it now.

Another adolescent discussed the relationship between pregnancy and marriage. Her conflict was due to her own values and that of being an
unmarried adolescent mother. She maintained that being married and bearing children should occur sequentially. Her family was very disappointed with her first pregnancy and even more disappointed when she became pregnant a second time. They informed her "the first time was a mistake, but the second time shouldn't have happened." She asserted:

Being a Christian family, you don't get pregnant and I, I felt ashamed . . . . Cause to me being pregnant is not, especially if you not married, you don't get pregnant . . . that's the way I feel about it. It's something I live with though cause the problem won't go away.

The same adolescent experienced ambivalence regarding her religiosity and abortion. She was very dismayed about both pregnancies and stated:

I think that if I wasn't from a Christian family, I probably would have gotten an abortion two times. But then since I'm totally against abortion, then that's why I have to go ahead, I have to carry this baby and I have to deal with it.

Another adolescent who tried to abort her fetus by drinking vinegar also discussed the morality of abortion.

But when I went to the doctor and they told me I was pregnant, I got depressed. I tried to kill it and that didn't work. God was telling me no, no.

Her uncle confirmed family values by disclosing "we don't, don't nobody in this family believe in abortions and taking another life is not right." Her religious beliefs were so strong regarding abortion that she stated:
That's one thing I do believe that if you don't do right by Him [God], you don't do nothing, you don't get nothing you want. But I didn't go through with it.

Family values emerged when four participants and their mothers disagreed about terminating their pregnancies. None of the four adolescents wanted to abort, but their mothers considered abortion an option and strongly suggested that the adolescent do so. One adolescent sought her grandfather's help when this situation ensued.

She [mom] tried to make me get a abortion. I didn't. My grandpa said I don't got to do that stuff if I don't want to. He said this family don't believe in abortions.

Her grandfather was instrumental in reaffirming family values to both the adolescent and her mother. Once he verbalized family values regarding abortion, the adolescent's mother discontinued her effort to force her daughter to abort.

A second adolescent twice refused laboratory tests when her mother forced her to visit an abortion clinic. Her father defended her desire to continue with her pregnancy, just as the first adolescent's grandfather had done. The third adolescent felt forced to abort her first pregnancy. To avoid the same ordeal, she delayed confirming her pregnancy and informing her mother of the pregnancy until her seventh month. The fourth adolescent continuously refused to discuss abortion as an option with her parents. All conflicts related to child
bearing and abortion were resolved through discussion prior to the birth of each adolescent's child.

None of the participants would accept abortion themselves, but felt it may be fine for others. For them, abortion was "murder" and they could not justify its use as a means of birth control or to terminate a pregnancy that was an unfortunate occurrence in their lives. Two respondents discussed the justification of abortion in cases of rape, incest, or when the mother's life is threatened. No other participants discussed when or if abortion would ever be justified.

**Fear of Rejection**

The theme "fear of rejection" surfaced when adolescents were asked how they felt after they found they were pregnant. Fear of rejection is defined as expressed feelings of shame and guilt, and feeling as if they disappointed significant others by becoming an adolescent mother. Words such as ashamed, depressed, sad, and scared were common when participants initially discussed their pregnancies with parent(s) or guardians. All participants reported their parent(s) expressed disappointment when informed of their pregnancy. They felt they had disappointed and disrespected their parents as well as let their parents down. One adolescent stated:
It was the lowest thing I could do to them cause they respect me. I felt really bad.

As a consequence, they were initially reluctant to ask for social support from significant others. One respondent commented, "I don't put her off on anyone. I never put her as an excuse for not doing something." Still another commented, "I really don't expect anything from anybody. Whatever they give is fine with me."

The fear of rejection was further exemplified by the fact that participants did not discuss personal problems with family members because they felt too ashamed. A participant asserted, "If something is really deep inside about myself, I don't discuss it with anyone. I try to work it out on my own."

Another mother said, "When I'm depressed, I keep it to myself." Yet another proclaimed, "My problems are too personal to talk about to other people."

Family members and male companions were, according to participants, very supportive of them. Significant others readily provided material, cognitive and emotional support.

Rejection was actualized in some instances. One participant's father threatened to beat her when he was informed of her pregnancy, but her mother prevented this from happening. The participant felt her father/daughter relationship had changed significantly since she became an adolescent mother. Another adolescent's mother threw items around the room and told the
adolescent that she had to abort or move out of her mother’s house. Two participants were emotionally abused by their mothers and their child’s father throughout their pregnancies. One adolescent’s mother left her in doubt as to whether or not she would have a home to return to once her child was born. Her child’s father initially denied paternity and told her she was worthless. Another adolescent’s mother informed her that she was incapable of caring for and raising an child. Her baby’s father also denied paternity, discontinued contact with her and his child, and stole the money she planned to use for an abortion (she later decided against aborting when funding was available).

Two adolescent mothers stated the biological fathers of their babies were jealous of their current male companions. Each refused to visit or provide financial support for their children. Another adolescent stated she and the baby’s father had an argument two months prior to the interview and she had not seen or heard from him since the argument.

Role Restraint

The theme "role restraint" emerged when participants discussed how they felt about help received from others. Role restraint is defined as perceived environmental restraints that prevent an adolescent mother from performing her role as mother. Many participants felt as if their mothers and families were helping them "too much" and taking on the role of "mother" for their children.
This resulted in adolescent mothers' feeling as if they were spectators in the lives of their children. One adolescent offered, "I don't do nothing for her and they're practically raising her." They feared their children were not attached to them and that their children were confused about who their "real mother was."

Role restraint is exemplified by a participant who commented:

Sometimes she [her mother] goes overboard and I feel like she's trying to take over you know? Like if my daughter would fall down or bump her head or something, I would go and get her and she would want my mother and that. It hurt my feelings and it would make me angry too. It just, sometimes it just seemed like she was trying to take over. It seemed like she was trying to be a mother to my daughter.

Yet another adolescent mother stated of her mother and family:

Cause most of the time she's taking over, in the morning when he gets up, she fixes his food and she's, you know, she gets him out of bed. She'll go change him, she'll feed him and stuff. As a matter of fact, I think that they raise him more than I do. They always there.

When participants were unable to perform the role of mother due to role restraint, they questioned whether they would be able to adequately care for their infants once they achieved economic independence and moved into a residence of their own.

I'm constantly saying, "mom, if you always doing things, I'm going to be used to you and I'm going to oversleep when I'm in my own apartment. I'm going to be used to it. It's going to be harder for me." And I think that's something that I'm not going to be able to do until I do get my own place while I'm here.
Thus, taking on the role of mother was very important to participants. They were willing to take the responsibility for their children. One adolescent stated that being a mother meant:

> Watching over her, teaching her how to do things, teaching her right from wrong, dressing her, buying her stuff, trying to get her ready for school, potty training her.

Role restraint conflicts were often resolved as a result of adult to adult relationships that developed between participants and their mothers. Participants said they developed strong identification with their mothers and often shared child birth experiences, parenthood stories, stress of single motherhood, finances and budgeting issues, and in general, began to identify with her mother as one mother to another. One adolescent asserted, "she’s [mom] beginning to realize I’m a woman." Other examples of an adult to adult relationships are illustrated by the following excerpts.

I ask her, like how does she cope with the stress after having three, and you know, I only have one and I feel like I’m stressed out and stuff. How does she ah, manage, how does she feel trying to figure out how is she going to get these pair of shoes that he need. Or you know, how is he going to get this dresser that he doesn’t really need but you know, you want him to have.

I just ask her well, what did you go through when you had my brother? And, was it as hard as it is now? Stuff like that. How long was your labor?
You know, before I had my son, I couldn't understand why I couldn't do this and why I couldn't do that. But now, I can understand exactly why. Cause I know, I guess because I could say if [my son] was in my position and I was in my mom's position, I wouldn't want him doing that. What I have asked my mom to do, I wouldn't want him doing.

Mom would say, we don't have this, we don't have that. And she was like, well, it's hard being a mother, paying bills and all that. Now I understand what she was going through now, more than I did then.

Summary

This chapter discussed cognitive, emotional, and material social support, and providers of each type of social support. Differences were noted between CPS and non-CPS mothers in who provided knowledge of human service agency information, perceptions of emotional support and their expectations for people providing emotional support. Age differences were noted regarding who adolescent mothers sought to provide emotional support for personal problems. Participants were very resourceful in seeking out, activating and using social support from family, friends, male companions, health care providers, and human service agencies.

None of the participants verbalized unmet social support needs. They were satisfied with social support received from others. Five additional themes emerged which were not social support, but were significant findings for this
population. Loss of adolescent freedom and reconstruction of future goals for education and economic viability are the consequence of adolescent motherhood. Family, friends, male companions, and others were available to facilitate adjustment to new roles and responsibilities that were a consequence of adolescent motherhood. Family values, fear of rejection and role restraint issues resulted in changes in family structure, roles, economic base, and education standards. Thus, adolescent motherhood changed relationships between adolescent mothers and their families, friends, male companions and others.
CHAPTER V

DISCUSSION

The results of this study are limited due to the small sample size, the use of a convenience sampling procedure, and non-standardized instrumentation. These limitations prevent generalizing findings to all African-American adolescent mothers. However, the homogeneity of ethnicity and the heterogeneity in life circumstances (i.e. CPS versus non-CPS, younger versus older, and differences in levels of education) provided an opportunity to investigate whether there were differences in the receipt of social support between groups. Though the results are limited to participants in this investigation, important findings were observed which provide a foundation for future investigations involving social support and African-American adolescent mothers.

Demographic analysis revealed that the majority of participants lived with their mothers and other family members which is congruent with Census data (1984). Their mothers were responsible for their children when adolescent mothers were not. Most participants were single and were lower
socioeconomic status. Similar demographics were observed in other studies involving adolescent mothers (Brooks-Gunn & Furstenberg, 1985; Dormire, et al., 1988; Furstenberg, et al., 1987; Heins, et al., 1987; Hogan, et al., 1990; Koniak-Griffin, 1988; Landerholm, 1984; McAnarney, 1986; Mercer, et al., 1977; 1984; Parks & Arndt, 1990; Polit, 1989; Schinke, et al., 1986; Unger & Wandersman, 1988). Over half of the participants had one child and 41% were pregnant with their second child. The large percentage of second pregnancies can be attributed to the fact that most participants were recruited from prenatal clinics. The majority of the sample lived in single parent households most of their lives.

Major providers of cognitive support for participants were biological or substitute mothers and grandmothers. Their mothers prepared them for motherhood prior to the birth of their children, defined motherhood, taught them parenting skills, and became positive role models. These findings are consistent with Flaherty, Gaveria, and Pathak (1983) and Mercer (1977; 1986) who found that the mothers of adolescent mothers were major providers of cognitive support.

The mothers and grandmothers of participants also taught them how to care for and treat various illnesses and injuries as well as when and how to seek medical attention. Participants stated their mothers and grandmothers often identified illnesses before they did and intervened to resolve illnesses.
Adolescent mothers were involved in the care of their children during illnesses; however, the need for treatment was determined by others.

An additional topic of concern for participants was child growth and development. They were interested in knowing the age to begin toilet training and techniques used to toilet train children. Information about developmental milestones such as sitting up, walking, and the appropriate age to introduce table foods were also of interest. Adolescent mothers reported seeking and receiving this information from family members, friends and male companions.

Cognitive support was necessary as participants stated they were unable to organize child care; especially when their children had multiple, simultaneous needs. Despite the fact that all participants reported previous child care experience, many felt unprepared for motherhood. They lacked the ability to conceptualize or implement tasks necessary to intervene appropriately. The lack of basic child care knowledge may have contributed to their need for cognitive support.

Biological or substitute mothers and social workers informed participants of the availability of various human service agency support. Differences were noted between information provided by participants' mothers (i.e. non-CPS adolescent mothers) and social workers (i.e. CPS adolescent mothers). Types of support discussed by their mothers were WIC, AFDC, child day care facilities, and health care agencies. Social workers provided information about
WIC, AFDC, child day care facilities, funding for education, and housing. Non-CPS mothers did not report receiving information about housing options and college funding from their mothers. This may be due to the fact that CPS mothers were older, had higher education levels, and were more likely to be emancipated and live independent of biological or substitute family members. Thus, the age and educational attainment of participants may determine their interest or need to discuss college funding and/or housing options.

Only three participants discussed specific nurses who provided social support. However, probing questions about health care received, revealed that nurses referred participants to WIC, school nurses, school programs for adolescent mothers, and provided perinatal and child health care. Participants responded in positive terms when discussing health care received. Answers provided may have been due to social desirability because the investigator is a nurse. It is clear that nurses provided social support to adolescent mothers; however, they did not perceive it as significant in most instances. Participants felt as if they received enough help from nurses and other health care providers.

Material support provided included child care respite, material items for their children, transportation, and money. Child care respite was the most frequent type of material support discussed by participants. Adult family
members, younger siblings, cousins, nieces, and nephews provided child care respite.

The threat of child abuse and mistrust of institutions prevented many participants from using free child care services available from the state government. Instead, the majority of the sample used family members, male companions, and male companions' families for child care respite. Extended family members were an integral part of participants' definition of family. No distinctions were made between nuclear and extended family members. For this sample, close family ties, economic constraints and lack of trust in institutional day care resulted in child care responsibilities that were shared among nuclear and extended family member households. These findings are consistent with those of McAdoo (1982) who concluded that it is a cultural norm for African-Americans to rely on kin rather than institutions when in need.

Grandparents and parents of adolescent mothers were actively involved with the rearing of their grandchildren. Beck and Beck (1989) and Hogan et al. (1986) noted this as a cultural norm. These researchers attributed grandparent involvement in child rearing to easy accessibility. Grandparents were more likely to reside within the household of their grandchildren which provides a greater opportunity for child rearing involvement. While this statement is partially true, grandparent involvement was apparent regardless of residential
location. Involvement with, and dependence on extended family members spanned beyond household boundaries. The active role of grandparents was apparent even when adolescents lived in separate households.

Male companions provided money, clothing, furniture, transportation, and child care respite. Only two adolescent mothers reported receiving regular child support payments from the baby's biological fathers. However, all participants received monetary support from male companions when requested, which is consistent with the findings of Rivara, Sweeney, and Henderson (1986) and Vaz, Smolen, and Miller (1983). The families of participants' male companions also provided material support similar to that received from the adolescents' own families, but with less frequency and consistency. Participants' family members were less apt to provide money, but purchased items needed for adolescent mothers and their children.

Emotional support was received from family, friends, male companions and male companions' families. Older and younger adolescent mothers differed in individuals selected to provide emotional support. Older teens were more likely to discuss personal problems and concerns with their mothers and friends; whereas, younger adolescent mothers were more likely to discuss personal problems with their friends almost exclusively. Talking exclusively to friends about personal concerns limited the ability of younger adolescent mothers' use of additional sources of emotional support that were available.
The use of adults for emotional support may have decreased anxiety related to the personal concerns of younger adolescent mothers.

There were also differences between CPS and non-CPS mothers in their perceptions of emotional support. CPS mothers felt as if they finally belonged to a family and voiced surprise and pleasure when discussing emotional support. In contrast, non-CPS mothers expected emotional support and were not surprised when they received it.

Male companions were perceived as emotionally supportive as well. They were viewed as positive father figures/male role models and provided participants with companionship. Seventy seven percent of the participants in this study were dating their baby’s biological father which is consistent with findings reported by Brown (1983), Rivara et al. (1986), and Vaz et al. (1983). Those who were no longer dating the biological father of their children had developed relationships with other males who provided emotional support.

The buffering effects of social support (Caplan, 1974) were apparent. The nature and strength of available support determines the effectiveness of buffering factors (Caplan, 1974). Receiving emotional support was important for allowing adolescents to feel confident in themselves as individuals. It was also a necessary element for their perception of the availability and activation of all three types of social support. Emotional support is often intertwined with cognitive support and material support, especially when provided by significant
others. This occurred because the provision of information and material items often indicated that someone cared about them and their babies. If adolescent mothers felt they would be provided with emotional support, they were more likely to feel free to request cognitive and material support from others.

Biological and substitute family ties were strong for this sample and the perceived availability of social support was clear. Others were available to provide guidance when necessary; however, independence in child care responsibilities was the apparent ultimate goal of the cognitive guidance provided. Involvement with family, friends and male companions provided adolescent mothers with consistent feedback regarding expectations, support and assistance with tasks.

As proposed by Miller (1980), the tasks of adolescence combined with the tasks of motherhood and adulthood were problematic for the adolescent mothers in this study. Biological or substitute mothers were the most consistent providers of all types of social support; however, extended family members and male companions were additional important sources of social support.

One mechanism that has provided resilience to African-American families for generations has been the extended family. Studies of African-American families have identified the significance of the extended family pattern for the survival, stability and advancement of African-American families (Hill, 1980). African-American adolescent mothers in this study perceived the
availability of cognitive, emotional and material support from nuclear and extended family members, friends, male companions and their families, and successfully activated it. Overall, they were satisfied with social support received.

Additional findings that are not social support, but are significant for future research involving adolescent mothers were observed. Topics discussed are adolescent growth and development, the loss of adolescent freedom, reconstruction of educational and economic goals, family values, fear of rejection, and role restraint.

Interesting findings were noticed when comparing theories of male cognitive development to the development of female participants. Some findings were contrary to the theories of Piaget and Inhelder (1969), Elkind (1976), Yoos (1987), and Erikson (1968). Participants exhibited multiple developmental stages simultaneously. Most were at the cognitive stage of formal operations (Piaget & Inhelder, 1969). They were able to make abstractions and envision the long term consequences of adolescent parenthood. Participants differed from Piaget and Inhelder's (1969) theory in how they viewed their future. These adolescents were not only interested in providing or envisioning their own futures, but those of their child(ren) as well. This was exhibited by their willingness to continue their education for economic independence and accept their loss of freedom due to parenthood.
Egocentrism did not prevent participants from differentiating between their needs and the needs of their children, contrary to Elkind’s (1976) and Yoos’ (1987) theory of egocentrism and adolescent motherhood. Participants were able to identify child care needs and were interested in learning how to meet those needs. They actively sought child care knowledge from their mothers and grandmothers. It was not unusual for participants to delay their own needs and pleasures for the needs of their infants.

The transition into motherhood was difficult for many of the adolescents. Nonetheless, social support from significant others created an atmosphere conducive to a successful transition into motherhood. Being a mother entailed responsibility not only for themselves but for their infants as well. Similar results were found by Howard and Sater (1985) who stated that the adolescent mothers in their study were interested in learning how to be good mothers.

The psychosocial task of identity formation (Erikson, 1968) was apparent, but differed from Erikson’s theory. Participants were not only forming their identities as individuals, but as mothers, students, and employees as well. Erikson also stated that adolescents put less emphasis on family and more emphasis on peers. The findings of this study do not support this contention. The need for social support from family members during the transition into motherhood altered this developmental task. Involvement with nuclear and extended family members was imperative for increasing parenting
skills, providing basic daily needs, child care respite, and emotional support. In addition, family involvement allowed participants to continue education endeavors. This does not negate the fact that friends were important. Friends were not reported to be more important than family members, however. Family support was ranked higher than support received from friends. All participants maintained close ties with biological or substitute family members.

A developmental assessment of women, which is a more appropriate developmental guide for this sample, is offered by Belenky, Clinchy, Goldberger, and Tarule (1986). Belenky, et al. (1986) delineated several developmental stages described as "Women's ways of knowing" which differ from previous theories based on male development. Women's ways of knowing were not age specific, but they did occur sequentially. That is, none of the ways of knowing was tied to any specific age group, but the sequence of development was constant.

The developmental stage of "received knowledge" (Belenky, et al., 1986) was evident in this study. "Received knowers" obtain knowledge from authorities and make decisions based on the opinions of authority figures. Belenky, et al. (1986) stated, "... women in this position [received knowers] listen to others for direction as well as for information" (p. 40). Received knowers believe that all knowledge, including knowledge of self, originates outside of the self. Participants viewed their mothers, grandmothers and other
females who had knowledge of motherhood and child care, as authorities. The adolescent mothers discussed motherhood and child care concerns with authorities such as mothers, grandmothers, female peers, and female cousins.

Belenky, et al. (1986) stated, "... received knowers feel confident in their ability to absorb and to store truth received from others" (p. 42). Participants absorbed and stored knowledge from their mothers by sharing childbirth experiences, parenthood stories, stress of single parenthood, finances, and budgeting concerns. The supportive relationship between the two females resulted in feelings of mutuality, value, love and respect as noted by Mercer (1977).

Belenky, et al. (1986) found that when women lacked subculture support, "maternal" human service agency personnel who exhibited "knowledge about raising babies" became sources of social support. This was the case for many of the adolescent mothers in this investigation, especially adolescents involved with CPS.

Foster care mothers and social workers were used as substitute mothers. CPS mothers were also more likely to use day care workers as child care experts. In addition, CPS participants were more aware of and more likely to use federal and state programs that would potentially permit them to become less economically dependent on society. Belenky’s, et al. descriptions of the use of maternal human service agencies may explain why participants with
strong family social support relied more on significant others than human
service agency personnel.

The loss of adolescent freedom was addressed by all participants.
Adolescent motherhood resulted in the loss of freedom and the reconstruction of
future educational and economic goals. The only solution to this problem is the
prevention of adolescent motherhood.

Researchers have shown that adolescents are inconsistent users of birth
control (Moore & Peterson, 1989; Sonenstein, Pleck, & Ku, 1989). The lack
or inconsistency of birth control use among adolescents has been attributed to
cognitive development (Gerrard, 1987; Whitley & Schofield, 1986; Winter,
1988). These researchers asserted that for adolescents to consistently use birth
control, they must acknowledge and accept the fact that they are sexually active
and not feel guilty about their sexual activity.

Participants voiced shame and guilt about being sexually active and
consequent motherhood. Adolescent pregnancy was contrary to family values
and often resulted in conflict and the fear of rejection. Family values and
religious beliefs were discussed by participants; however, the role of values and
beliefs for determining sexual activity, birth control use, and adolescent
pregnancy is not clear. There was incongruence in family values, religious
beliefs and actions of participants. The relationship between family values,
religiosity, sexual activity, use of birth control, adolescent pregnancy, and
adolescent motherhood should be explored further. The lack of knowledge, misconceptions about various birth control methods, inconsistency, and lack of birth control use in this sample indicates an urgent need for birth control education.

The fear of rejection emerged when participants stated they did not discuss personal problems with others. The lack of a confidant may indicate the need for social support that was not realized by participants. This finding may be the consequence of development. Belenky, et al. (1986) asserted that received knowers are more likely to be defined by others, more dependent on others, and make decisions based on the opinions of authority figures. Belenky, et al. (1986) stated:

If one can see the self only as mirrored in the eyes of others, the urgency is great to live up to others' expectations, in the hope of preventing others from forming a dim view.

If a received knower perceives the possibility of rejection from an authority figure, it is unlikely that she will share personal problems with that person. Thus, there is a need for others such as nurses and family members, to anticipate some of the social support needs of adolescent mothers.

Participants were in the process of establishing independence from their families and concurrently having to rely on them for support which posed a dilemma. Though the need for independence was evident, the need for
dependence on others was also apparent. Striving for independence may have prevented adolescent mothers from acknowledging or being aware of their needs for social support and consequently eliminate their ability to verbalize needs.

It should also be acknowledged that rejection was realized in some instances. This occurred when the biological fathers of their children denied paternity and refused to visit and/or provide financial support to their children. The relationships with these males terminated and more satisfactory relationships were established with other males.

Interactions between participants and their mothers were not always harmonious; however, conflicts reached resolution by the time their infants were born. Those who had not resolved conflicts with their biological mothers had substitute mothers with whom they developed more harmonious relationships. The use of and need for substitute mothers may have been due to the fact that nine of the mothers were involved with CPS. CPS was very instrumental in finding alternate social support resources for these participants.

**Implications for Future Research**

This study should be replicated with African-American adolescent mothers who do not reside within the household of kin to determine if residency influences the receipt of social support. All but three participants in this study
resided in households with adults. The proximity of family members may have resulted in dependence on family members because they were easily accessible. If extended family support is consistently provided, regardless of household residency, participants will discuss their support when interviewed.

While it is clear that mothers of participants were very supportive, little is known about the support provided by male companions. Investigations of social support provided by male companions are also needed. It is proposed that interviews similar to the one used for this investigation be conducted with adolescent mothers and their male companions.

Further assessment of the buffering effects of social support for African-American adolescent mothers over time is recommended. It appeared that buffering effects of social support enhanced the transition into adolescent motherhood. However, long term buffering effects are not known. African-American adolescent mothers should be recruited during their first prenatal visit and followed through the first five years of their infants’ lives. A longitudinal study would enable researchers to assess the consistency and long term effects of social support provided to African-American adolescent mothers. Specific outcome measures for further investigation include education attainment, job and income status, dependence on AFDC, child health and education, birth control use, and number of children.
**Clinical Implications**

Though nurses were infrequently discussed by participants, results of this study indicate that nurses were instrumental in providing social support to adolescent mothers. Nurses must become proactive in meeting social support needs of African-American adolescent mothers. This can be accomplished by teaching African-American adolescent mothers parenting skills, child growth and development, care for their children during illnesses, first aid techniques, toilet training techniques, organization of child care, and by referring them to community sources of social support. Anticipatory guidance regarding perinatal care, child care, the importance of immunizations, birth control options, and pregnancy prevention must also be implemented by nurses. It is proposed that education and anticipatory guidance occur in health care settings and in the homes of African-American adolescent mothers. Participants in this study were extensively involved and influenced by biological or substitute family members. Nurses must determine if proposed interventions and educational efforts are congruent with the values and beliefs of person’s identified as most influential in African-American adolescent mothers lives. The inclusion of family members is imperative for increasing program success.

Collaboration between health agencies and school nurses is an additional way that nurses can provide support to African-American adolescent mothers. Referrals from schools to appropriate health care agencies, public health nurses,
and health care providers may increase the frequency of prenatal care, especially for low income African-American adolescent mothers. The consequence may be lower infant mortality and morbidity rates and a decrease in other deleterious effects of African-American adolescent motherhood.
APPENDIX A
Hi, my name is Deborah Chatman. I am a graduate student at the Ohio State University’s College of Nursing. I am interested in finding out how African-American adolescent mothers feel about the help and support they receive from others once they become mothers. I am conducting this study under the supervision of Michelle Walsh, Ph.D, R.N.. Your participation in this research will involve approximately one hour of your time.

The study involves an interview which asks details about who helps and supports you as well as how you feel about that help. The interview will be audio taped recorded. The information you give will not be shared with your family, friends, clinic personnel, or teacher, unless you give permission to do so. You are encouraged to answer all of the questions during the interview; however, you may quit at any time and not answer any questions that you do not wish to answer. For volunteers from the clinics, I will add - If you choose not to participate in the study, your care at the clinic will not be affected.
CONSENT FOR PARTICIPATION IN
SOCIAL AND BEHAVIORAL RESEARCH

I consent to participation in (or my child’s participation in) research entitled:

Social Support in African-American Adolescent Mothers: An Exploratory Study

Michelle Walsh, R.N., PhD or his/her authorized representative has explained the purpose of the study, the procedures to be followed, and the expected duration of my (my child’s) participation. Possible benefits of the study have been described as have alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any question I have raised have been answered to my full satisfaction. Further, I understand that I am (my child is) free to withdraw consent at any time and to discontinue participation in the study without prejudice to me (my child).

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: ________________________ Signed: ________________________

(Participant)

Signed: ________________________

(Principal Investigator or his/her Authorized Representative)

Signed: ________________________

(Person Authorized to Consent for Participant-if Required)

Witness: ________________________

HS-027 (Rev. 3/87) --(To be used only in connection with social and behavioral research).
Research Involving Human Subjects

ACTION OF THE REVIEW COMMITTEE:

With regard to the employment of human subjects in the proposed research protocol:

9280180 SOCIAL SUPPORT IN AFRICAN-AMERICAN ADOLESCENT MOTHERS: AN EXPLORATORY STUDY, Michelle Walsh, Deborah Chatman, Family and Community Nursing

THE BEHAVIORAL AND SOCIAL SCIENCES REVIEW COMMITTEE HAS TAKEN THE FOLLOWING ACTION:

_____ APPROVED

_____ DISAPPROVED

X APPROVED WITH CONDITIONS

_____ WAIVER OF WRITTEN CONSENT GRANTED

* Conditions stated by the Committee have been met by the Investigator and, therefore, the protocol is APPROVED.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject’s participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subjects Review Committee for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the Review Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date: September 19, 1992

Signed: [Signature]
(Chairperson)

HS-025B (Rev. 8/90)
INTERVIEW GUIDE

PART 1

I am going to start this interview by asking you some general questions about your life as a mother, how you felt when you first found out you were pregnant, and the kinds of help you get from others. I would like for you to give me as much information about each question that you can think of or that you think is important. I would like to remind you that your answers to the questions are confidential. However, if you tell me about things that may be harmful to you or your child(ren) such as abuse, or that is illegal, I am obligated by law to report it.

1. Tell me some of the things you like to do.

2. What was it like when ___ was a newborn?
   a) How did you feel?
   b) Who helped you take care of ___?

3. Tell me what it's like being a mother now.

4. When did you realize you were pregnant?

5. How did you feel when you first found out you were pregnant?
   a. Did you want to be pregnant?
      1) Did you consider an abortion?
      2) Why or Why not?
   b. Did you plan your pregnancy?
1) What did you do to prevent getting pregnant?

2) How often did/do you use ___ (birth control method)?
   c. How old was your mother when she had her first child?

6. Who was the first person you told you were pregnant after you knew you were pregnant?

   
   If not her mother and/or father: How did your mother and/or father react?
   
   If not the father of the baby: When did you tell the father of the baby?

8. How is your life different now compared to the way it was before you became pregnant?

9. Who has been the most helpful to you since you became a mother?
   a. What kind of help has ___ given you?
   b. What has ___ done to make you feel as if she/he is helping you?
   c. What has ___ said to make you feel as if she/he is helping you?
   d. Tell me how it makes you feel when ___ helps you.
   e. Are there any ways they could help you that they’re not?

10. Of all your family members, who is the most helpful to you?
    Give me an example of how ___ has been helpful to you.

11. Tell me about the help you get from your family in general. (Probe for what they say and do that is helpful).
    a. How does the help you get from your family make you feel?
    b. Do you feel as if you get enough help from your family?
    c. Are there any other ways they could help you that they’re not?
d. On a scale of 1-10, how satisfied are you with the help you get from your family?

12. Is there anybody else that’s helpful? (Probe for school, church, work, neighbors etc.)
   a. How does the help you get from ___ make you feel?
   b. Do you feel as if you get enough help from ___?
   c. Are there any other ways ___ could help you that they’re not?
   d. On a scale of 1-10, how satisfied are you with the help you get ___?

13. Tell me about the help you get from your friends. (Probe for what they say and do that is helpful).
   a. How does the help you get from your friends make you feel?
   b. Do you feel as if you get enough help from your friends?
   c. Are there any ways they could help you that they’re not?
   d. On a scale of 1-10, how satisfied are you with the help you get from your friends?

14. Do you receive help from anyone other than your family and friends? (Probe for what they say and do that is helpful).
   a. Tell me about the help you get from ____.
   b. How does the help you get from ____ make you feel?
   c. Do you feel as if you get enough help from ____?
   d. On a scale of 1-10, how satisfied are you with the help you get from ____?

15. If your family or friends were not able to provide you with enough help, where would you turn to have these needs met?
   a. What kind of help would you expect from this person/place?
b. Has this person/place helped you before?

16. Who do you talk to most often about:
   a. being a mother?
      1) Can you give me an example of something you talked to ___ about being a mother?
      2) What kind of help did ___ give you?
      3) How did you feel about the help that ___ gave you?
      4) On a scale of 1-10, how satisfied were you with the help you received from ___?
   
   b. child care questions?
      1) Can you give me an example of a question you had that ___ answered for you?
      2) What kind of help did ___ give you?
      3) How did you feel about the help that ___ gave you?
      4) On a scale of 1-10, how satisfied were you with the help you received from ___?
   
   c. personal problems? (Give an example if necessary i.e. like a problem you may have with a friend or the baby’s father).
      1) Can you give me an example of a problem you had that ___ helped you with?
      2) What kind of help did ___ give you?
      3) How did you feel about the help that ___ gave you?
      4) On a scale of 1-10, how satisfied were you with the help you received from ___?
   
   d. concerns about school?
1) Can you give me an example of a problem you had about school that ___ helped you with?

2) What kind of help did ___ give you?

3) How did you feel about the help that ___ gave you?

4) On a scale of 1-10, how satisfied were you with the help you received from ___?

Now I'm going to ask you a few question about the baby's father.

17. First of all, do you have any contact with him?

18. How often do you see ______?

19. How would you describe your relationship with ______? (Probe to see if he comes to see the baby only, is she still going out with him, does she live with him etc.).

20. Does ______ help you?

If yes: Tell me about the help you get from ______.
   a. How does the help you get from the ______ make you feel?
   b. Do you feel as if you get enough help from ______?
   c. On a scale of 1-10, how satisfied were you with the help you received from _?

21. What is the last grade ______ completed?

22. Is ______ working? Does ______ provide financial support?

I am now going to ask you questions about the person in your life that you feel has been the most helpful to you since you became a mother.

23. Who has been the most important (influential) person in your life?
a) How has _____ influenced you or been important to you?

Now I want to ask you a few questions about the health care services you are receiving from various agencies.

24. What services are you and your child(ren) currently receiving? (Probe for nursing, medical, social services, counseling, WIC, job training, birth control etc.)
   a) Is there one or more particular person(s) at ___ that has been helpful to you?

   If they name one or more persons at any of the agencies that has been helpful:
   b) How has ___ been helpful to you?
   c) How do you feel about the help that ___ gave you?
   d) Are there any other ways that ___ could have been more helpful to you that she/he was not?

25. Tell me how you feel about these services (discuss each one separately).

26. Do you feel that there are other types of help that you should receive from these agencies that you are not getting?

27. Are you associated with any organization in your community such as the recreation center or church?

   If yes: Tell me about your involvement with (church, recreation center, organization etc).
   a) How has this (organization, church etc.) been helpful to you?
   
   b) How do you feel about the help that you have received from this (organization, church etc.)?
   
   c) Are there any other ways that (organization, church, etc.) could have been more helpful to you that it/they were not?

28. Is there anything else you would like to say that I have not asked about?
DEMOGRAPHIC DATA SHEET

PART 2

Date: _________  Age: _________

How old were you when ___ was born? ___ (Do for each child).

Child(ren)'s ages: ________________________________________

Marital Status:  ___ Single/never married
                 ___ Married  ___ How long?
                 ___ Divorced or separated
                 ___ Widowed

Educational Status:  ___ High school graduate
                    Presently in the ___th grade
                    Completed through the ___th grade
                    ___ Not presently in school
                    ___ Plan to finish high school  When? ___
                    ___ Received GED
                    ___ Attended college

If not currently in school: Why did you leave school?
                    ___ didn't like it
                    ___ got pregnant
                    ___ had to care for baby/no child care
                    ___ other (Specify) ____________________________

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How far would you ideally like to go in school?
___ 9th-11th grade
___ 12th grade
___ Junior college
___ Bachelor's degree
___ Graduate or professional school
___ Other (Specify) ____________________________

How far do you really think you'll be able to go in school?
___ 9-11 grade
___ 12th grade
___ Junior college
___ Bachelor's degree
___ Graduate or professional school
___ Other (Specify) ____________________________

Home environment: ___ How many people live in your home?

___ Sister/s
___ Brother/s
___ Cousin/s
___ Niece/s
___ Nephew/s
___ Your child/children
___ Aunt/s
___ Uncle/s
___ Child's father
___ Your boyfriend/husband
___ Your grandmother
___ Your grandfather
___ Your mother
___ Your father
___ Others: ___________________________________
With whom have you lived for most of your life? ______
___ mother only
___ father only
___ both parents
___ other relative (Specify) __________________________
___ guardian (Elaborate) _____________________________
___ institution (Specify) _____________________________
___ foster homes (If yes) How many? _____ When? _____
___ other (Specify) _________________________________

Child care:

Prior to becoming a parent, did you have experience taking care of infants or other children? _____ Yes _____ No

Do you have the responsibility for your child approximately:
___ 100% - 76% of the time?
___ 75% - 51% of the time?
___ 50% - 26% of the time?
___ Less than 25% of the time?

When you are not taking care of your child who is most often responsible for her/him?
___ Maternal grandmother?
___ Paternal grandmother?
___ A relative?
___ A friend?
___ Baby’s father?
___ A day care center?
___ Others? ________________________________

Who takes care of you baby when you are in school?
___ Maternal grandmother?
___ Paternal grandmother?
___ A relative?
___ A friend?
___ Baby’s father?
___ A day care center?
___ Others? ________________________________
Financial Support: I'm going to read you a list of ways many people get money to live on. Can you tell me if your family gets any money from:

___ your mother's job.
___ your father's job.
___ your own job.
___ your other relatives.
___ the baby's father.
___ the baby's father's family.
___ AFDC.
___ parents unemployment compensation.
___ parent's veteran's benefits.
___ parent's social security.
___ child support.
___ other ____________________________________________

Do you have a job now? _____ Yes _____ No

If yes: What kind of a job do you have?

_________________________________________________________________

How many hours a week do you work? ______________

What is your hourly wage? ____________________________

Where do you work? ________________________________

What is your mother's occupation? ____________________

What is your mother's job title? ______________________

What is the highest grade level or degree your mother completed?

_________________________________________________________________

What is your father's occupation? ______________________

What is your father's job title? ________________________
What is the highest grade level or degree your father completed?
Definitions of Themes

1) Family Values - Issues related to religious ideologies and values in which either an individual or family member verbalizes belief.

2) Child Care Competency - Feelings of doubt or fear verbalized by the adolescent mother regarding her ability to adequately care for and/or raise her child(ren).

3) Loss of Adolescent Freedom - Verbalizations of restrictions or alterations in activities since becoming a mother.

4) Reconstruction of Future Educational and Economic Goals - The adolescent’s and/or her guardian’s felt need to restructure plans for future educational endeavors due to the responsibilities of parenting.

5) Father Figure/male Role Model - Expressed need or desire for a male companion who acts as a positive male role model for her child(ren).

6) Violence - Acts, threats or fear of violence within the adolescent’s social system and/or society.

7) Role Restraint - Perceived environmental restraints that prevent an adolescent mother from performing her role as mother.
8) Fear of Rejection - Expressed feelings of shame and guilt, and feeling as if they disappointed significant others by becoming an adolescent mother.
Bibliography


