MENTAL HEALTH PROBLEMS AMONGST PREGNANT AND PARENTING
TEENAGERS FROM THE PERSPECTIVE OF MENTAL HEALTH SERVICE
PROVIDERS

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MENTAL HEALTH PROBLEMS AMONGST PREGNANT AND PARENTING TEENAGERS FROM THE PERSPECTIVE OF MENTAL HEALTH SERVICE PROVIDERS

A Project

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Division of Social Work
Abstract

MENTAL HEALTH PROBLEMS AMONGST PREGNANT AND PARENTING TEENAGERS FROM THE PERSPECTIVE OF MENTAL HEALTH SERVICE PROVIDERS

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Somaly Kong

Teenage pregnancy is a problem that needs to be addressed. America has one of the highest teenage pregnancy rates in the world. Prior research shows that pregnant and parenting teenagers suffer from depression and postpartum depression. This project aimed to examine whether pregnant and parenting teenagers do experience mental health problems such as depression and postpartum depression from mental health service providers’ perspective. This project is a descriptive quantitative study. Survey data were collected from thirty-one service providers in Sacramento County. The findings from this study demonstrated that mental health service providers viewed pregnant and parenting teenagers as experiencing high rates of stress and lack of self esteem more often than problems such as depression and postpartum depression. The implications of the study
are discussed such as the need for mental health screening and ideas for future research are presented.

_____________________, Committee Chair
Maura O’Keefe, Ph. D., L.C.S.W.

_____________________
Date
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Chapter 1
THE PROBLEM

Introduction

It is alarming that the United States of America has one of the highest rates of teenage pregnancy in the world (Birkeland, Thompson, & Phares, 2005, p. 293). This population is underserved, and society has negative thoughts and perceptions of them. There is a lack of research on the mental health needs of this population, and it is important to make society aware of the possible mental health issues, hardships, stressors and obstacles that pregnant and parenting teens experience when having a child at such a young age. This researcher did not experience child birth as a teenager; however this researcher has family members who had a child during their teenage years. Because this researcher had the opportunity to see firsthand how having a child as a teenager affected one’s life, the researcher’s interest began to grow.

Background of the Problem

Although teenage pregnancy and birth rates in the United States of America are not as high as they once were, they still rank the United States of America at one of the highest rates of pregnancies and births among teenagers in industrialized nations (Birkeland, Thompson, & Phares, 2005, p. 293). Teenage pregnancy is associated with mental health issues such as depression and postpartum depression. Depression strikes one out of every four pregnant adolescents, and the rates of postpartum depression among young mothers are just as high. Depression is a major mental health disorder, and it affects women of all ages during childbearing years. There is a major concern that
pregnant adolescents that suffer from depression will not seek treatment, which may lead to suicidal ideation and attempts. Postpartum depression (PPD) is a very severe form of depression that requires immediate treatment. It can be diagnosed as early as a few days or up to a few months after birth. Postpartum depression can last for twelve to eighteen months. Thus if a mother is diagnosed with PPD when her child is six months old, she may not recover until her child is two years old (Hale, 2008). High stress levels are considered to be the main risk factor for postpartum depression.

There are other mental health issues and stressors that can have devastating effects on pregnant and parenting teenagers, such as body image issues, consequences of abortion, and low maternal competency. When asked by Birkeland, Thompson, and Phares, roughly 50% of 194 adolescent mothers expressed feelings of dissatisfaction in regard to their weight and body image. Weight and body image are already major issues among female teenagers that are not pregnant or parenting, and when a teenager gives birth she often retains that weight, finding it difficult to lose. Many teenagers choose to abort their pregnancy which can also have serious consequences. D’Agostino (2006) reported that in December 2005 10-20% of women suffered from adverse and long term reactions caused by abortion (p. 21). The study stated that this lead to at least 130,000 new cases of mental health problems a year in the United States of America.

Statement of the Research Problem

The research problem is a lack of information about mental health problems that pregnant and parenting teenagers experience. This researcher conducted this study because of lack of knowledge about mental health problems, especially the types of
mental health problems pregnant and parenting teenagers experience. This researcher also wanted to know the different types of social support this population receives, how accessible mental health services are to this population, and how often this population is utilizing those services.

**Purpose of the Study**

The primary purpose of this study was to identify the types of mental health problems and stressors that pregnant and parenting teens experience. In addition this researcher was curious to know what kind of social support was given to pregnant and parenting teenagers. Service providers were surveyed to explore their perspective on mental health problems their clients experience on a day-to-day basis. The personal insight from service providers offers a different outlook on this population, and supplements the published research available to this researcher.

The secondary purpose of this study is to use the written responses on the survey and share them with the participating agencies. This researcher would like to make the various comments and concerns available to the agencies so they can be aware of the concerns address them. The purpose is to spread awareness of the problem.

**Theoretical Framework**

There are many theories and perspective that can be used to describe social work with pregnant and parenting teenagers. This researcher has chosen to utilize ecological perspective and the risk and resiliency model. The ecological perspective is an approach to social work practice that addresses the complex transactions between people and their environments (Greene, 2008, p. 199). Ecological perspective is an extension of the social
work profession that enhances both the intrapsychic life of the client and the client’s environmental conditions or situation. Social work is a form of social treatment committed to an array of direct and indirect intervention deeply rooted in the profession (Greene, 2008, p. 199).

The ecological perspective gained traction for social workers and their profession in the 1970’s as part of a trend towards improving environments and quality of life. This perspective has adopted so many theoretical concepts that it is difficult to establish its precise boundaries. However, this perspective can be traced to the founders of their profession who attempted to help clients with material services and tries to remedy their economic, social and health problems (Greene, 2008, p. 201). The ecological perspective is important for social workers and other professionals whose goal is to seek services for their client. In order to obtain services for their clients, these professionals must know precisely what they need help with. Pregnant and parenting teenagers are trying to understand their new role in their environment; they do not need the added stress of trying to locate services.

The ecological approach to human behavior is the homogenous system that forms a person and their environment (Greene, 2009, p. 208). The main emphasis is on the mutual transaction a person has with their environment and vice versa. According to Zastrow & Kirst-Ashman (1997) there are major concepts associated with ecological systems theory. In reference to this research, the social environment may include school, peer pressure, type of home/environment the teenager grew up in, healthcare, human services, or socioeconomic status. The transaction is how the pregnant or parenting
teenager interacts with their social environment. The coping mechanism implies that they endured struggle to overcome their issues as to how they adapt or respond to new conditions or environments. Being pregnant or parenting at a vulnerable age, promotes mutual reliance on other individuals leading to their interdependence.

The second model that can be applied to pregnant and parenting teenagers is the risk and resiliency model. This model was pioneered through developmental psychopathologists due to their curiosity regarding why some children succeed despite adversity (Greene, 2008, p. 315). According to Greene (2008), Werner and Smith conducted a longitudinal study of 201 children living in poverty, *Kauai’s children come of age*, that produced evidence about distinguished children who overcame crime and become competent and caring adults (p. 315). The authors identified five major factors that contributed to success, including temperament, family support style, skills and values, opportunities, and macro level factors.

The risk and resilience approach has influenced social work practice literature (Greene, 2008, p. 316). This approach recognizes that the exacerbation of social work problems has made it significantly more difficult to fulfill social work’s historical obligations to disadvantaged and vulnerable populations. Greene (2008) states that Gitterman dedicated a text to the risk and resilience theory in which contributors discussed “distressing life conditions and demanding societal conditions,” including violence, poverty, and oppression (p. 315).

Greene (2008) defines risk and resiliency. “Risk is a factor that influences or increases the probability of the onset of stress or negative outcomes following adverse
events” (p. 320). Resilience can be described as achieving the ability to cope with adversity, stress, and deprivation. Pregnant or parenting teens encounter risks and endure resiliency as they interact with various social systems suggesting a systemic view of resiliency. Greene (2008) states a systemic view suggests the determination of the goodness of fit amongst a person and their environment, whether it is positive or negative (317).

This model is perfect in the sense that social workers and other professionals can use this to empower the population. Being pregnant at such a young age adds more challenges to their life, but they can overcome their situation by being resilient. The term resilience can be used to describe one’s ability to respond to risks (Greene, 2008, p. 218). The individual has the ability to cope with adversity, stress and deprivation. This can be accomplished through the accessibility of services and with the support of social workers, other professionals and family members.

**Research Questions**

This is a descriptive exploratory research. The research questions that will be answered in the study include:

1. What types of mental health problems do pregnant and parenting teenagers experience?

2. How severe are the mental health problems that pregnant and parenting teenagers experience?

3. What kind of social support do pregnant and parenting teenagers have?
4. What kind of contraceptive, if any, did pregnant and parenting teenagers use?

5. What is the extent of pregnant and parenting teenagers’ knowledge of contraceptive use?

**Definition of Terms**

The following are terms that this researcher used for this study.

Teenagers: being between the ages of thirteen and twenty-one.

Pregnancy: carrying a fetus to full term.

Abortion: terminating the pregnancy, a procedure called dilation and curettage (D&C) can be performed which will scrap and scoop the fetus from the uterus.

Post Partum Depression: mood disorder following delivery of a child that can last from twelve to eighteen months. Some of the symptoms include chronic depressive moods along with social isolation.

**Assumptions**

This researcher found through a review of literature that the epidemic of teenage pregnancy affects all social classes in society. Society assumes that poor individuals from a low socio-economic background are the ones that have children out of wedlock at a young age. But this is not the case, as teenage pregnancy affects all social classes. The upper and middle classes are simply able to provide better, more private care for their pregnant teenager.
Justification

The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention given to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (NASW, 2011). Pregnant and parenting teenagers are a population who is underserved and overlooked in society. Through this researcher’s study, few resources and guides were found to be available for this population to access. As a social worker it is important to recognize and follow core values that have been set out by the National Association of Social Work consisting of service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence (2011).

Pregnant and parenting teenagers encounter social problems that social workers can address through the core value of service. The goal would be to help this population receive necessary services and support. A commitment to social justice is important for social workers working with this population; it is the job of a social worker and other professionals to promote knowledge about the oppressed (2011). Social workers strive to ensure access to needed information, services, and resources and meaningful participation in decision making for all people (NASW, 2011). This study is beneficial because it sheds light on these young girls, and the resources that this researcher was able to find will be available for them to access.

Delimitations

There are a number of limitations to this study. This study is limited by the inability to survey the targeted population, as pregnant and parenting teenagers are
considered to be “high risk.” Another limitation is that the sample for this study is limited, since all of the participants are from the Sacramento area and work in Sacramento County. The researcher surveyed service providers to give a perspective on the presenting problems that they encounter while working with pregnant and parenting teenagers.

The findings that this researcher found through the study can only be used in Sacramento County since the participants were all from Sacramento. This research finding cannot be used for other neighboring counties.

**Summary**

This chapter briefly discusses the background problem of teenage pregnancy. It also touches on the relevant theories that can be used to understand teenage pregnancy. The next chapter will discuss the problem more in depth with a review of pertinent literature that this researcher has found.
Chapter 2

LITERATURE REVIEW

Introduction

This researcher chose the topic of mental health problems amongst pregnant and parenting teenagers because there is not enough attention being shown to this population. Generally this population is viewed by society as deviant and poor. Themes associated with teen pregnancy include the societal class most affected by teenage pregnancy, and the stigma associated with being pregnant at such a young age. Other themes involve the mental health problems a teenager experiences when pregnant, and the preventative programs and resources available for this population to access. This topic needs to be explored more in depth in order to examine flaws and deficits in the research, and determine what kind of preventative efforts need to take place.

This chapter is a review of the literature concerning teenage pregnancy and mental health issues, such as depression and postpartum depression. This chapter will examine the current statistics of teen pregnancy, the relationship between socioeconomic status and teen pregnancy, the factors associated with teen pregnancy, and the consequences that pregnant teens suffer. This chapter will also focus on depression and teen pregnancy, postpartum depression and teen pregnancy, other mental health problems that are caused by teen pregnancy and preventative programs that help teens avoid becoming pregnant.
**Current Statistics**

In the United States of America approximately 1 million teenagers become pregnant each year and 500,000 teenage girls give birth (Birkeland, Thompson, & Phares, 2005, p. 293). Estimates also indicate that 19% of Caucasian women and 40% of African American women will become pregnant by the age of eighteen (Birkeland, Thompson, & Phares, 2005, p. 293). One in three teenage girls in the United States is estimated to get pregnant before the age of 20 (“Teen Pregnancy,” 2009). The adolescent pregnancy and birth rate in the U.S. has declined 15% since 1990, but, despite that decline, 455,158 young women under the age of 20 gave birth to children in 2001 (Sarri & Phillips, 2004, p. 538). These figures place the United States at one of the highest rates of pregnancy and births for adolescent mothers among industrialized countries (Birkeland, Thompson, & Phares, 2005, p. 293).

The rates of teen pregnancy have changed over time. The rates of teenage pregnancy for those aged fifteen to nineteen was 62.6 per 1,000 in 1920; it dropped during the depression to 56.7 in 1930 and 53.5 in 1940. Teenage pregnancy birth rates soared after World War II to 79.5 per 1,000 in 1950, and escalated again in 1957 to 97.3 (Vinovskis, 2003, p. 403). After this peak in 1957, the rates began to decline. Despite increases in adolescent sexual activity after 1960, teenage births continued to decline. Birthrates per 1000 for females aged fifteen to nineteen dropped from 89.1 in 1960 to 68.3 in 1970; they continued to decrease to 53.0 in 1980 and then rose slightly to 59.9 in 1990 (Vinovskis, 2003, p. 404).
Although teen pregnancy decreased during the 1960s, 1970s and 1980s, premarital sexual activity among teenagers rose during this period. The proportion of females aged fifteen to nineteen who engaged in premarital sex rose from 29% in 1970 to 42% in 1980; by 1988 that percentage had increased to 52%. At the same time, improvements in contraceptive techniques such as the development of birth control pills in the 1960s made it easier to avoid unintended pregnancies (Vinovskis, 2003, p. 405).

There are several reasons offered in the literature for the decline in teen pregnancies. Some analysts believe that the major reason for fewer teenage pregnancies is abstinence, and some say that there is a greater use of contraceptives (Sawhill, 2006, p. 55). Regardless of what some analysts are speculating regarding the reasons behind fewer pregnancies, there are five reasons collected through Sawhill’s research. The first reason is attributed to more health education awareness of the possibility of getting Sexually Transmitted Diseases (STD’s) such as Acquired Immune Deficiency Syndrome (AIDS). Secondly there are more conservative attitudes towards sex today, which make it less acceptable to engage in casual sex; thirdly is the widespread availability of contraceptives such as Depo-Provera. The fourth reason is the changes that have come with the new Welfare Reform, as it offers less long term assistance. As part of this new reform, welfare offices are seeking paternity tests to make absent fathers pay for child support. The fifth reason is, as of 2006, the recent strength in the economy, as there are far more reasons to complete high school and higher education in order to have greater opportunities in life (Sawhill, 2006, p. 57).
Between 1990 and 2005 there was a 41% decline in pregnancies among females aged fifteen to nineteen - from a peak of 116.9 pregnancies per 1,000 girls to 69.5 per 1,000. Between 1991 and 2005, births among teen girls decreased 35% (Preidt, 2010). Some experts believe the teen birth rate decline that occurred in the 1990s may have been due to effective pregnancy prevention programs (Preidt, 2010). However, after more than a decade of decline, the United States teenage pregnancy rate increased 3% in 2006. Research indicates that in 2006 the pregnancy rate among teenage girls was 71.5 per 1,000 (Preidt, 2010). Furthermore, there was an increase of 7% among African American teenage girls which increased their rate to 126.3 per 1,000. For Hispanic teenage girls during this same period there was an increase to 126.6 per 1,000, and for non-Hispanic Caucasian teenage girls the rate only increased to 44 per 1,000 in 26 states in 2006 (“About Teen Pregnancy,” n.d.). Researchers are not sure whether the increase in teenage pregnancy rates between the years 2005 and 2006 is only a short-term increase or the beginning of a new trend in teen pregnancy. Some state that there is no definitive reason for the upward trend in teen births.

**Socio Economic Status and Teen Pregnancy**

There is speculation that most teenage pregnancy occurs in lower social economic classes among those living below the poverty line. When it comes to high teenage pregnancy rates the lower class does have high numbers, but a majority of teenage mothers are not, in fact, poor. This epidemic of teenage pregnancy is not rooted in the lower class; it is actually a widespread problem in families of all different economic structures and economic means (McKay, 2006, p. 157). Researchers have found that 41%
of U.S. teenage parents come from homes at or above 200% of the federal poverty line, and 70% of those teenage parents come from two parent households (Docksai, 2010).

It is common that individuals in society tend to shame those of lower social economical status. Interestingly, about 70% of U.S. adults assume that teenage mothers are raised by single parents (Docksai, 2010). Many people make the assumption that teens that are from lower class families are more likely to have children. Most Americans believe that teen pregnancy is a problem that only afflicts certain groups, such as poor and single parent families. While they are disproportionally represented, the highest numbers are not from those groups (Docksai, 2010). It is acknowledged that teens from poor families do have high rates of pregnancies, but most teen mothers are not poor.

Teen mothers have many different reasons for getting pregnant. Some believe that it will advance their relationship with the father of their child, and other mothers say they want the unconditional love that a child will give to them. Most mothers though say that their pregnancies were unplanned. Neighborhood culture can have a direct influence over the risk of teenage pregnancy. Limited community resources and social disorganization often result in fewer social services, poor schools, lack of recreational opportunities, and high unemployment (Sarri & Phillips, 2004, p. 538). However, teenagers who have parents that work in high paying jobs are provided with more efficient care and tend to have more privacy. Middle and upper class parents are able to afford the best services from health care professionals and have the financial means to pay for a full time care provider so that teenage mothers can continue their education.
Factors Associated With Teen Pregnancy

There are many factors that can lead to teenage pregnancy. Causal factors related to adolescent pregnancy span political, social, and individual domains. The primary factors associated with teenagers becoming pregnant are that they have limited access to contraception, abortion, and sex education (Sarri & Phillips, 2004, p. 538). Sexualized behavior, such as consuming sexualized television shows, movies, and music at home will only reinforce sexual activities. When older children and teenagers are desensitized to sexual activity in the home they stand the chance of viewing sex as something they are supposed to do because they are teenagers. Females are often exposed to sex in their homes and neighborhoods, and thus conclude that it is not viewed as deviant behavior (Sarri & Phillips, 2004, p. 538).

Poverty, the demise of the traditional two parent family, drug use, and normative community behavior have also been associated with teenage pregnancy (Sarri & Phillips, 2004, p. 539). Living in poverty can cause children and teens that are expected to be in school and dependent on their parents to miss school in order to take care of younger siblings, or they are expected to go to work and help pay the bills. Many of them also face periods of homelessness, physical and sexual abuse, parental rejection, substance abuse, delinquency, and depression (Sarri & Phillips, 2004, p. 539). Societal values usually emphasize that when a teen becomes an adult they get married and form a two parent household. However, this is not always the case; in urban areas the neighborhood culture can lead to single parent families. Sarri and Phillips (2004, p. 538) note that young women in inner city Chicago accepted the ‘ideal’ of marriage but were pessimistic
about their own chances, largely because marriageable partners were scarce in their neighborhoods.

The transition from teenager to pregnant teenager is especially difficult due to the fact that a teenager is trying to establish an identity, and to assert emotional autonomy from their family of origin while still remaining connected. It is very conflicting for a teenage mother to incorporate their life role with their maternal role (Birkeland, Thompson & Phares, 2005, p. 292).

**Consequences of Teen Pregnancy**

Most of the pregnancies that happen amongst teenagers are unintentional. When engaging in sexual activities many teenagers are not aware of the possibility of getting pregnant. When teenagers get pregnant unexpectedly, or unintentionally, their future becomes unstable, leading them to either not finish high school or possibly only getting a general equivalency diploma (G.E.D.) instead of a high school diploma. Not only do pregnant teenagers have difficulties in school, but it is unlikely that they will get married; rather they continue to engage in more sexual activities that will most likely lead to more children out of wedlock (Sawhill, 2006, p. 52). It is a vicious cycle that is likely to continue; one child will result in another, and possibly even a third child. Teenage mothers will be overwhelmed and forced to spend their days being full time mothers which will not leave any time for them to pursue their education.

Public costs from teenage childbearing totaled $120 billion from 1985 to 1990; $48 billion could have been saved if each birth had been postponed until the mother was at least twenty years old (Thomas & Looney, 2004, p. 66). The cost of teenage
childbearing was lower during the years 1991 and 2004 since there was a decline of birth rates by 46% (“By the Numbers,” 2006). Studies have found that the U.S. government in 2004 incurred at least $9.1 billion in costs related to teen births, despite significant decreases in teen pregnancy and birth rates since the early 1990s; the birth rate and teen pregnancy rate from 1991 through 2002 decreased by 30% and 36% respectively (“Teen Births Cost,” 2006).

The U.S. government pays more for children born to girls that are under the age of seventeen; $8.6 billion of the $9.1 billion the government paid in 2004 birth-related care was for girls age seventeen and younger (“Teen Births Cost,” 2006). According to the report, the costs included $1.9 billion for health care, $2.3 billion for child welfare, $2.1 billion for incarceration and $2.9 billion in lower tax revenue (“Teen Births Cost,” 2006). Children that are born to mothers who are adolescents end up costing the country more money to help care for them or incarcerate them. In addition, girls who gave birth at ages younger than seventeen are more than twice as likely to have a child placed in foster care or to be reported for child abuse or neglect than women who had their first child after reaching the age of twenty (“Teen Births Cost,” 2006). The research suggests that public costs would go down by billions of dollars if adolescents waited until they were in their early twenties to give birth.

The impact of adolescent pregnancy has been documented along with associated social, academic, and economic problems. For example, pregnant teenagers are more likely to have future unintended pregnancies, have limited educational achievement, rely on public assistance, and receive lower wages for employment (“About Teen Pregnancy,”
Many teenagers engage in impulsive, high risk, and self destructive activities. Unprotected sex is one of those activities, and for some teenage mothers being pregnant is one of the best things that can happen to them. A young, impulsive teenager will be forced to take responsibility and make healthier choices when she finds out she is pregnant.

**Depression and Teen Pregnancy**

While teenage girls will have to become more responsible due to a pregnancy that was unintended, is the risk of a teenager mother being diagnosed with depression the consequence of maturity? Depression is a major mental health disorder that affects all ages of women during childbearing years. Dr. Hodgkinson (2010) notes that there are few studies that examine depression among pregnant teenagers, even though there are reports suggesting that pregnant teenagers are at a higher risk of depression than pregnant adults (p. 16). Dr. Hodgkinson is in agreement with the risk factors for depression such as family history, childhood adversity, social isolation, and exposure to stressful life experience (Hodgkinson, 2010, p. 16). One of the main concerns associated with pregnant teenagers having depression is that this mental illness may go untreated. If depression remains untreated it may lead to suicidal ideation and attempts. The relationship between maternal depression and birth outcomes remains poorly understood, especially among pregnant teenagers.

The general definition of depression is a psychological disorder that affects a person's mood changes, physical functions and social interactions. The stigma surrounding depression stems from a lack of understanding of the condition (lunameow,
People assume that those suffering from depression have a simple case of the blues or have a setback in their life that is making them sad. Suffering from depression does not mean that a person is weak, whiny, or seeking attention. Most people suffer quietly because they do not want to inconvenience others or be seen as a whiner. This in turn fuels the feelings of isolation, further adding to the problem (lunameow, 2007).

When an adolescent suffers from pregnancy depression she may not seek out services to help her defeat the depression. There are services that are available; unfortunately some adolescents may not have the same access to these services as others. However, access to these services does not mean that depressed teenagers will seek help. The adolescents that want to be helped and the teenagers that are found to be depressed through some form of screening are the ones that are going to seek out help. Pregnancy depression is severe, long lasting, and may have incapacitating effects (“Pregnancy Depression,” 2009). Depression can last for varying amounts of time. If a person suffering from depression seeks treatment they can recover much quicker than somebody who does not seek help. Depression can last for years and even decades if it is not treated, and, depression during pregnancy is much more intense and severe due to the imbalance in a woman’s hormones and emotions.

New mothers often experience multiple stressors, including decreased financial resources, physical exhaustion, task overload, role restriction and confusion, social isolation, and depressive symptoms (Birkeland, Thompson, & Phares 2005, p. 292). The demands that come from this challenging time period can become increasingly difficult for new adolescent mothers. The emotional distress associated with their adjustment to
Parenthood is amplified for these individuals, who may be less prepared to meet the financial responsibilities and the interpersonal challenges of parenting (Birkeland, Thompson, & Phares 2005, p. 292).

Pregnant teenagers are diagnosed with depression more often than most people think. Depression actually occurs in one out of four individuals, so it stands to reason that pregnancy depression is found in one or two out of every ten pregnant teenagers (“Pregnancy Depression,” 2009). Certain studies have focused on particular groups of teens, such as the study conducted by Shanok and Miller (2007) which found the rates of teenage depression to be between 26% and 44% with a focus among poor urban minorities (Shanok & Miller, 2007, p. 199).

There are many factors that make up depression. These factors were categorized in the study by Shanok and Miller (2007) using the Beck Depression Inventory (BDI) and the Edinburgh Postnatal Depression Scale (EPDS). The most common factor, represented in 30% of those experiencing depression, is the category called shame and guilt which consists of the clients crying, feelings of being punished, difficulty working, less satisfaction, critical of self, feeling like a failure, guilt and sadness. The second most common factor is represented in 9% of those with depression by the category called anxiousness which consists of worrying, feeling scared or panicky, having difficulty sleeping and fatigue. The third factor, represented in 7%, is the category called discouragement which consists of feeling discouraged about the future, a loss of interest, and feeling like a failure. When the client has a negative relationship between shame and
guilt, and yet is happy about having a baby it is likely that she is being teased and bullied (Shanok & Miller, 2007, p. 207).

As stated earlier, in the study by Birkeland, Thompson, and Phares (2005), that decreased financial resources, physical exhaustion, role confusion and social isolation are suffered along the symptoms of depression. Since pregnancy involves so many changes with the body through hormones and biochemistry it is normal to experience depression (“Pregnancy Depression,” 2009).

An interesting study, *Maternal Depression, Suicidality, and Birth Outcomes Among Pregnant Teenagers* (2007), conducted by Dr. Stacy Coates Hodgkinson at Howard University specifically examined depression and teenage pregnancy. Hodgkinson (2007, p. 11) found that pregnant teenagers are at a greater risk for depression than adult pregnant women. Also pregnant teenagers diagnosed with severe depression were found to have lower birth rates compared to those pregnant teenagers who were not experiencing depression (Hodgkinson, 2007, p. 11).

A later study by Dr. Hodgkinson (2010) investigated the impact of depressive symptoms on birth outcomes of infants born to teenagers and found that not only are pregnant teenagers who have depression at higher risk to deliver infants with low birth rates, but suicidal ideation is also a huge risk factor that leads to low birth rates (Hodgkinson, 2010, p. 17).

**Effective Treatment Approach with Depression**

One study, conducted by Dr. Miller using Interpersonal Psychotherapy (IPT) to prevent and treat depression in pregnant and newly parenting teenagers, involved 80
participants ages thirteen to nineteen who were either pregnant or parenting. IPT is a short term validated treatment for depression, and is used to treat the four problem areas of role transitions, interpersonal dispute, interpersonal deficits and grief (Shanok & Miller, 2007, p. 199). The purpose of this study was to help clients (pregnant teenagers or parenting teenagers) clarify and then renegotiate their current interpersonal problems. The goal of the treatment was to determine the effectiveness of IPT in treating depression among pregnant and parenting teenagers; the treatment plan included stressors such as low socioeconomic status.

IPT was used to encourage pregnant and parenting teenagers to identify gains and losses in their transitions, and to generate alternative ways to assume their new role. In this process pregnant and parenting teenagers were helped to identify social and material support. The philosophy of IPT treatment involves the belief that every single pregnant teenager will have to transition through different stages in their life; the stages include childhood to adulthood or the transition to motherhood. When these transitions are not properly recognized or supported it can be very damaging to the self and significant others, and symptoms of depression will be present (Shanok & Miller, 2007, p. 200). The data were gathered in three domains: therapy sessions, self reporting measures by answering a questionnaire on a broad range of topics, and from the perspective of all clinicians that worked on the study.

In therapy sessions the common themes that came up were that pregnant and parenting teenagers felt anger and sadness along with their depression. These teenagers were faced with feelings of being trapped or powerless; feeling wronged when a
significant other or family member was sad or rejecting, and when anger or sadness served as a form of power. When it was time for the clinicians’ feedback and professional assessment they mentioned irritability and anger as the primary symptoms of depression among the participants. The feeling of being angry was also mentioned in the context of how the client viewed her life circumstance.

The most important thing that would have made a significant difference in the way a pregnant teenager viewed herself had to do with validation. Validation of the pregnancy would have been important to each individual that participated in this study (Shanok & Miller, 2007, p. 203). These girls went through their entire pregnancy feeling worthless, rejected and without proper support from the father of the child, her parents, and her peers. Throughout this study each participant was able to help validate feelings and concerns that other members of the group were going through. This support gave all of the participants an outlook that included the possibility of finding some form of healing. The researchers also found that even though a pregnant teenager or parenting teenager was able to have a positive transition through their stages, it was still possible for them to suffer from some form of depression (Shanok & Miller, 2007, p. 202).

Factors Associated with Depression Research

According to Figueiredo and colleagues (2007) “A pregnant teenager or parenting teenager will most likely experience depression during pregnancy, socio-economic stressors, parity, and negative delivery with lack of social support” (p. 103). Pregnant teenagers may be more at risk of depression due to their age rather than their pregnancy, but there is still not sufficient evidence to support that theory (Figueiredo, Pacheco, &
Costa, 2007, p. 103). However, there is evidence to show that depression is very common among women during the transition to parenthood regardless of age, and that teenagers or younger women who do not live with their partners are at increased risk of depression. It is very important for all pregnant teenagers to have routine screenings regardless of whether they experience severe, mild or no symptoms of depression. This will help pregnant teenagers and service providers become more aware and consistent with the services needed to ensure a full recovery.

**Postpartum Depression and Teen Pregnancy**

Postpartum depression (PPD) is a mood disorder that can begin any time during the first year after delivery (Reid & Meadows-Oliver, 2007, p. 289) and is a form of severe depression that requires treatment. It is sometimes said that postpartum depression occurs within 4 weeks of delivery but it can happen just a few days or several months after childbirth (“Postpartum Depression Glossary,” n.d.). Postpartum depression recovery may take anywhere from twelve to eighteen months. This means a mother diagnosed with PPD at six months after delivery may not be considered fully recovered until her child is two years old (Hale, 2008).

Examining PPD from a theoretical perspective is difficult since there is no theoretical basis for it. However, there are indications of how postpartum depression correlates with teenage pregnancy (Birkeland, Thompson, & Phares, 2005, p. 292). Postpartum depression can be understood by acknowledging that there are several contributing factors such as biological, psychosocial, poor social support and having a history of depressive symptoms while being pregnant.
Teenage mothers who experience chronic depressive mood along with social isolation in the postpartum period, may have an increased risk for development of problematic maternal behaviors. High stress levels are also considered to be risk factors for postpartum depression. Adolescent mothers with high stress levels reported more depressive symptoms in the third trimester and at 4 months postpartum than did adolescent mothers with low stress levels (Reid & Meadows, 2007, p. 292). These young mothers are undergoing many changes in their lives; and any kind of stressors can be detrimental to their health and the health of their infant. The incidence of postpartum depression is as high as depression (Figueriedo, Pacheco, & Costa, 2007, p. 103). The transition to motherhood is a pivotal time of psychological, developmental, and biological change for a teenager. Furthermore the emotional distress in regard to the financial responsibilities and interpersonal challenges of parenting will be amplified for a pregnant teenager.

Conventional wisdom suggests that women who have suffered from depression are more likely to suffer from postpartum depression. There are some other factors that can lead both teenagers and adult women to develop postpartum depression, such as having low income, subsisting on welfare, not finishing high school, unplanned pregnancy, and not having a relationship with a partner. In the study conducted by Birkeland, Thompson, and Phares (2005), the results suggested that the first year postpartum is a challenging period for adolescent mothers, and many adolescent mothers confront this difficult time with limited psychological and social resources.
Reid and Meadows-Oliver (2007) conducted a study using the Center for Epidemiological Studies Depression Scale (CES-D) to collect data. CES-D is a 20 item self-report questionnaire that is designed for the general population. The sample size for the study was 48 adolescent mothers. Regression analysis revealed that adolescent mothers’ status of being welfare-reliant or having dropped out of school was predictive of depressive symptoms at six months postpartum (Reid & Meadows-Oliver, 2007, p. 292).

According to Birkeland, Thompson, & Phares (2005), studies with adult mothers have shown that high levels of depressive symptoms negatively affect mother-infant interactions as well as the infant’s cognitive, emotional, and social development (p. 293). Teen mothers also tend to vocalize less with their infants, to be less flexible with their children, and are at a higher risk for child maltreatment. Infants of depressed mothers are less likely to look at their mothers or show positive affect and they have lower physiologic reactivity. In addition, depressed adolescent mothers are at greater risk for depression in adulthood.

Other Mental Health Problems/Stressors

Mental health issues other than depression can be caused by body image problems among teenage girls both after giving birth as well as after having an abortion. Birkeland, Thompson, and Phares conducted a study of 194 adolescent mothers who, when asked about their body image, teenagers were very harsh critics. About 50% of the participants disclosed feelings of dissatisfaction regarding their figure and weight which the authors suggest could lead to the development of an eating disorder. Weight issues plague adolescent girls regularly without the event of a pregnancy. In fact, the National Task
Force on Prevention and Treatment of Obesity (1994) has declared childbearing a critical period for major weight gain (Birkeland, Thompson, & Phares, 2005, p. 293). Many new mothers retain some of the weight gained during pregnancy, and some of them struggle to lose weight months after giving birth.

Some teen pregnancies end in abortion; abortions can have complications. There may be emotional consequences to abortions, as some women say that they feel sad, and some use more alcohol or drugs than they did before (“Teen Pregnancy,” 2009). Pro choice activists claim that a teenager that has an unwanted child will suffer more mental health issues than a teenager that has an abortion, but there is more evidence that points to the contrary. In its December 2005 report, the South Dakota Task Force to Study Abortion, appointed by Gov. Mike Rounds (R.), cited an expert as saying that “the literature on the psychological effects of abortion conducted over the last several decades indicates that a minimum of 10-20% of women experience adverse, prolonged, post-abortion reactions. This translates into at least 130,000 to 200,000 new cases of serious mental health problems each year in the U.S.” (D’Agostino, 2006, p. 21). Activists that are pro-choice claim that carrying an unwanted child to full term is more psychologically damaging than abortion. D’Agostino (2006), states that the scientific evidence continues to pile up proving the opposite: Abortion is more psychologically harmful than carrying a child to term (p. 21). This researcher was unable to find literature on women who have depression when carrying an unwanted pregnancy.

D’Agostino reported on a study conducted by Professor David Fergusson on an unknown number of women ages fifteen to twenty-five that showed that abortion can
carry serious consequences. Forty-one percent (41%) of these women had become pregnant on at least one occasion prior to age twenty-five, with 14.6% having an abortion. Those having an abortion had elevated rates of subsequent mental health problems including depression, anxiety, suicidal behaviors and substance abuse disorders (D’Agostino, 2006, p. 21). There was not sufficient evidence from this study regarding how many women participated in the survey, or how many were actually affected by having an abortion.

Maternal competency is important for pregnant teenagers to learn. It helps them become self-sufficient so that they can perform certain behaviors required by their new maternal role. Competency is similar to self-efficacy in that it pertains to one’s confidence or belief that she can perform certain behaviors effectively (Birkeland, Thompson, & Phares, 2005, p. 293). Many pregnant teenagers will have low maternal competency due to the fact that they are criticized about their ability to parent and raise their child. Due to this, low competency may be a greater concern for teenage mothers.

**Preventative Programs/Research**

Most research dealing with teenage pregnancy has concluded that comprehensive prevention programs are the best approach to interventions in this complex problem. Biological factors such as gender and age cannot be changed in preventing teenage pregnancy, but other antecedents can be viewed as manifestations of social organization or being disadvantaged. These antecedents include collaboration of community services such as counseling, outreach, crisis services, community linkage, and referrals for health and social services. With open communication and a defined mission (preventing teenage
pregnancy and supporting parenting teenagers) community agencies and resources can build consensus, manage conflict, and create action plans for helping these at risk teenagers.

Even if teenagers know about contraceptives, are they able to access them? For teenagers that are growing up in poor areas and experiencing traumatic events in their lives, the last thing on their minds is locating health care facilities. Becoming a teenage mother is a hard concept to deal with. According to Sarri and Phillips (2004), the negative consequences of getting pregnant are well documented (p. 539). It can result in homelessness, physical and sexual abuse, depression, and dependence on welfare. Teenage mothers have had bad experiences and outcomes with the welfare system when the services offered did not meet their needs, when teenage mothers are not involved with their service plans, and when they rely too heavily on their parents and do not assume responsibility (Sarri, & Phillips, 2004, p. 540).

Teenage mothers are more likely to seek out services and resources than teenage fathers. When a teenage mother is ready to utilize certain services it is very important to ensure that the services are accessible (Sarri, & Phillips, 2004, p. 541). The location and hours need to be convenient for a teenager to access. It makes no sense to have hours of operation from 8:00a.m. to 5:00p.m. when they are in school and transportation and childcare could be an issue. Pregnant and parenting teenagers need to seek medical help and social support at accessible locations. If not there could be an increased risk for behavioral and cognitive deficits for their child (Thomas, & Looney, 2004, p. 66).
There are ways to help engage pregnant teenagers and parenting teenagers by using effective models of intervention including social support and nurturance as well as educating teenagers on child development and parenting (Thomas, & Looney, 2004, p. 67). The use of a psycho educational approach teaches teenagers parenting skills within a relationship focused model. The purpose of using this model is to target intervention on depression, self esteem and parenting attitudes. The study of 41 participants from this model was effective in improving parenting attitudes and beliefs. It helped motivate a change in behavior, improving understanding of mental health promotion and working with health care professionals (Thomas, & Looney, 2004, p. 76).

With all of the information gathered and analyzed from the research stated above, it is clear that the most damaging mental health disorders that a pregnant and parenting teenager face are depression and postpartum depression. There are many speculations and research conducted to locate the actual cause behind these disorders. There are several reasons that are contributing stressors, including simply going through the pregnancy to full term, lack of support from the father of the child, lack of support from family members, and a previous mental health diagnosis. In the research stated above the best way to overcome this hardship is to seek help from mental health care professionals, to participate in any form of counseling, such as individual or group, to receive validation from support groups, and to take the time to review and access resources. All resources can be accessed and found through the help of a social worker, community member, or church member. This researcher found that there was a lack of information about the programs available to pregnant and parenting teenagers.
Conclusion

After reviewing the literature it can be stated that depression, postpartum depression, and other mental health issues are all associated with teenage pregnancy. Depression occurs in one out of every four pregnant teenagers (“Pregnancy Depression,” 2009), and the incidence of postpartum depression in teenage mothers is just as high as depression. There are a range of other mental health problems and stressors that can affect teenage mothers, such as body image issues, consequences associated with abortion, and low maternal competency.

Teenage pregnancy affects upper, middle, and lower class adolescents. Stigmas associated with mental health problems come from societal misunderstanding and prevent pregnant teenagers from seeking help. Many people believe that they are suffering from the blues, are being weak or whiny, or are simply seeking attention. Pregnant teenagers have preventative programs available to them, but many are either unaware of their availability, have limited access to the programs, or choose not to utilize them. Even though there are many other stressors in the lives of teenage girls, pregnancy has shown to be the major contributing factor to mental health problems in adolescents.
Chapter 3

METHODOLOGY

Introduction

The purpose of this research is to gain a better understanding of mental health issues among pregnant and parenting teenagers from the perspective of service providers. Service providers were asked to participate in this study due to their knowledge and rapport with the population. This chapter will discuss the research design, the research questions, the variables, study participants, data gathering procedures, and protection of human subjects.

Research Design

This is a quantitative-descriptive exploratory study using survey methods to obtain information about mental health problems. This study is categorized as quantitative research because the goal is to see if there is any correlation between mental health and pregnant and parenting teenagers. According to Rubin and Babbie (2010), descriptive survey research typically refers to characteristics of a population (p. 137). That is why “the researcher converts data to a numerical form and subjects it to statistical analysis” (Babbie & Rubin, 2010, p. 501).

According to Royse (2008), descriptive studies in the quantitative tradition are large-scale efforts that attempt to characterize a population group in a definitive way (p. 29). A survey allows the researcher to analyze numerous questions on one topic. Surveys also allow multiple variables to be analyzed at one time (Rubin and Babbie, 2010, p. 368). This researcher was able to analyze the data that was collected through the surveys...
from the different agencies. The participants were all service professionals who work in the mental health field with a population of teenage mothers.

**Research Questions and Variables**

This is an exploratory descriptive study that seeks to answer the following questions from the perspective of mental health service providers:

1. What types of mental health problems do pregnant and parenting teenagers experience?

2. How severe are the mental health problems that pregnant and parenting teenagers experience?

3. What kinds of social support do pregnant and parenting teenagers receive from the father of their child, maternal families and paternal families?

4. What kinds of contraceptive use did pregnant and parenting teenagers use?

5. What is the extent of pregnant and parenting teenagers’ knowledge of contraceptive use?

Since this is an exploratory study, no hypotheses is proffered.

**Participants**

Participants in the study are service providers from the following agencies: La Familia, Planned Parenthood, Sutter Teen Program and Chicks in Crisis.

La Familia is a counseling agency whose mission is to help improve the quality of life for at-risk youths and families of diverse backgrounds. This agency offers multi-cultural
counseling, outreach programs and services to families. A home visiting program that
serves families including pregnant women and children 0-5 years of age is part of La
Familia.

Planned Parenthood’s mission is to ensure that everyone has the knowledge, opportunity
and freedom to make every child a wanted child, and every family a healthy family. The
participants from this agency include Health Educators and Teen Success facilitators.

Sutter Teen Program’s vision is for pregnant and parenting teens and their families to be
in healthy relationships, to be educated, to ensure for themselves safe and healthy futures.
The participants from this agency include Case Management Counselors for pregnant and
parenting teens living within the City and County of Sacramento.

Chicks in Crisis is an agency that provides services to all pregnant and parenting mothers.
This agency helps pregnant and parenting women make informed decisions that help
reduce the number of infants facing abandonment, foster care, abuse and even death.

A total number of thirty-one surveys were completed. The participants included case
managers, health educators and home visitors.

**Data Gathering Procedures**

In September, 2010 this researcher had personal contact with a Child Protective
Services (CPS) Supervisory Social Worker who had a master list of agencies and
resources for pregnant and parenting teenagers in foster care. There were a total of twelve
different agencies on the master list. This researcher contacted all of the agencies and
explained to them why this researcher was contacting them. About half of the agencies
responded, but only four agencies were able to give their consent to participate in the study.

In March, 2011 this researcher distributed surveys to Sutter Teen Program, La Familia, Planned Parenthood, and Chicks in Crisis. The surveys and consent letters were placed together in a manila envelope, and another envelope labeled completed surveys was provided. The task of handing out the surveys to the staff was given to the designated person at each agency.

The researcher used SPSS to input the data collected through the surveys. The researcher used descriptive statistics that included mean, mode, range and standard deviation. The researcher examined the tables and charts of the input data and looked for common themes among the participants’ responses.

**Protection of Human Subjects**

Prior to the research study, program directors and managers authorized this researcher to distribute surveys to appropriate staff members. Four agencies, La Familia, Planned Parenthood, Sutter Teen Program, and Chicks in Crisis, gave written consent for their service providers to participate in this researcher’s study. Letters of consent from the agencies can be accessed in the appendix. Informed consent was obtained by using an information sheet. Participants were given an information sheet that stated that participants were giving their consent by completing the survey. Participating in the survey was voluntary, there were no negative consequences for refusing to participate, and participants could refuse to answer any question or stop at any time. There was no risk or harm for service providers due to the fact that they are professionals working with
the population. The Request for Review by the Committee for the Protection of Human
Subjects at California State University, Sacramento deemed this study “no risk” for the
participants because of their profession.

There were no names used in the study. No one had access to the box at each
agency except for the researcher. The surveys were placed in a secure drawer at the
researcher’s home; the researcher was the only one allowed to access the data. After the
data collection and input was completed, all surveys were destroyed.

Summary

This chapter discusses the study being a quantitative-descriptive research. This
researcher collected thirty-one surveys from the four agencies and entered them into
SPSS. The following chapter will discuss the findings that this researcher analyzed from
the surveys.
Chapter 4

THE FINDINGS

Introduction

The purpose of this study is to identify the types of mental health problems and stressors that pregnant and parenting teens experience. Also this study will include how much social support they receive while being pregnant and a parenting teen. This chapter presents data findings. Descriptive information is presented on the socio demographics of the sample as well as descriptive information (including mean, and median) of participants perceptions of the most frequently encountered mental health problems of pregnant or parenting teens. There will be several sections: socio demographics of sample, descriptive information on mental health problems, social support, and contraceptive use. This chapter will have tables and figures that will display interesting information from the findings.

Demographics

The participants consisted of thirty-one mental health service providers that work with pregnant and parenting teenagers in Sacramento County. As presented in Table 1 there were 28 females (90.3%) and 3 males (9.7%). The largest ethnic group among the participants were Caucasian (N=11), followed by African American (N=5), Asian (N=3), and Hispanic (N=5). Over 51.6% of participants have their Bachelor’s Degree (N=16), and only 19.4% have their Master’s Degree (N=6). The mean age for participants was 38.48, and the mean number of years in their professional field was 12.53.
Table 1

Demographics

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<td>5</td>
<td>16.1</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>1</td>
<td>3.2</td>
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<tr>
<td>Bachelor’s</td>
<td>16</td>
<td>51.6</td>
</tr>
<tr>
<td>Master’s</td>
<td>6</td>
<td>19.4</td>
</tr>
<tr>
<td>Clinical License</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean: 38.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD: 11.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in Field</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean: 12.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD: 9.20</td>
<td></td>
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</tr>
</tbody>
</table>

Social Support

Participants were asked to rate (using a Likert scale 1 = “not at all supportive” to 5 = “extremely supportive”) the levels of support that pregnant and parenting teenagers
receive from the father of their child and from the maternal and paternal families. As presented in figures 1 through 3, participants responded that 40% of maternal families are either “extremely supportive” or very much supportive of pregnant and parenting teens. None reported “not at all supportive.” With regards to paternal families participants responded that 7% of paternal families are “not at all supportive” of parenting teens and 8% were either “extremely supportive” or “very much supportive” of pregnant and parenting teens. With regards to fathers 3% are “not at all supportive and only 3% were “very much supportive” of pregnant and parenting teens.

Table 2

*Participant’s reports social support for pregnant and parenting teenagers*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Support</td>
<td>3.37</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Paternal Support</td>
<td>2.55</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Father Support</td>
<td>2.53</td>
<td>3.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>
Figure 1. Social support from maternal family

Figure 2. Social support from paternal family
Figure 3. Social support from father of child

Contraceptive Use

Participants were asked to give a percentage to the following types of contraceptives that pregnant and parenting teens use: condoms, Depo Provera, IUD, birth control pills, Plan B, birth control patch and Nuvaring. As presented in Table 3, condoms were the highest use of contraceptive, followed by Depo Provera and IUD.
Table 3

*Participant’s reports pregnant and parenting teenagers contraceptive use*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>40.16</td>
<td>50</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>24.44</td>
<td>50</td>
</tr>
<tr>
<td>IUD</td>
<td>20.82</td>
<td>5</td>
</tr>
<tr>
<td>Birth Control Pills</td>
<td>19.56</td>
<td>10</td>
</tr>
<tr>
<td>Plan B</td>
<td>4.54</td>
<td>00</td>
</tr>
<tr>
<td>Birth Control Patch</td>
<td>4.33</td>
<td>00</td>
</tr>
<tr>
<td>Nuvaring</td>
<td>2.71</td>
<td>00</td>
</tr>
</tbody>
</table>

*Figure 4. Client's use of contraceptives*

**Contraceptive Knowledge**

Participants were asked to use a Likert Scale and indicate the levels of knowledge that pregnant and parenting teenagers have of different forms of contraceptive use. The
Likert Scale had 5 as being Very Knowledgeable and 1 having None knowledge.

Condoms again had the highest mean of being the most knowledgeable use of contraceptive. Participants were asked to indicate the levels of knowledge that pregnant and parenting teenagers have of different forms of contraceptives use using a Likert scale from 1 = “no knowledge” to 5 = “very knowledgeable.” As presented in Table 4, condoms again had the highest mean of being the most knowledgeable contraceptive.

Table 4

*Participant’s reports pregnant and parenting teenagers knowledge of contraceptive use*

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Mean</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>4.00</td>
<td>4</td>
</tr>
<tr>
<td>Birth Control Pills</td>
<td>3.72</td>
<td>3</td>
</tr>
<tr>
<td>Depo Provera</td>
<td>3.23</td>
<td>3</td>
</tr>
<tr>
<td>IUD</td>
<td>2.96</td>
<td>3</td>
</tr>
<tr>
<td>Birth Control Patch</td>
<td>2.65</td>
<td>2</td>
</tr>
<tr>
<td>Plan B</td>
<td>2.44</td>
<td>3</td>
</tr>
<tr>
<td>Nuvaring</td>
<td>2.44</td>
<td>2</td>
</tr>
</tbody>
</table>
Figure 5. Client's knowledge of condoms use

Figure 6. Client's knowledge of Depo Provera use
Experience of Mental Health

Participants were asked to indicate by percentage the types of mental health problems their teen clients experience. The list included the following mental health problems: stress, parenting stress, self esteem problems, lack of validation, depression, feelings of isolation, problems with anger, obesity, domestic violence, postpartum depression, suicidal ideation, cutting/self mutilation, and anorexia/bulimia. The highest percentage given to the mental health problem listed was stress (mean = 77.44), indicating that participants believe that the vast majority of their pregnant and parenting teen clients experience stress and that this is the most common type of mental health problem. As presented in Table 5 depression is the fifth on the list having a mean of 56.39, but it is not as common as stress, parenting stress or self esteem problems.
Table 5

Participant’s reports and percentage for pregnant and parenting teenager’s mental health problems

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>77.44</td>
<td>100</td>
</tr>
<tr>
<td>Parenting Stress</td>
<td>70.10</td>
<td>90</td>
</tr>
<tr>
<td>Self Esteem Problems</td>
<td>61.07</td>
<td>50</td>
</tr>
<tr>
<td>Lack of Validation</td>
<td>60.77</td>
<td>80</td>
</tr>
<tr>
<td>Depression</td>
<td>56.39</td>
<td>20</td>
</tr>
<tr>
<td>Feelings of Isolation</td>
<td>52.03</td>
<td>70</td>
</tr>
<tr>
<td>Problems with Anger</td>
<td>46.46</td>
<td>50</td>
</tr>
<tr>
<td>Obesity</td>
<td>30.70</td>
<td>0</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>29.37</td>
<td>20</td>
</tr>
<tr>
<td>Postpartum Depression</td>
<td>25.85</td>
<td>10</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>9.29</td>
<td>70</td>
</tr>
<tr>
<td>Cutting/Self Mutilation</td>
<td>7.22</td>
<td>10</td>
</tr>
<tr>
<td>Anorexia/Bulimia</td>
<td>6.87</td>
<td>0</td>
</tr>
</tbody>
</table>

*Figure 8. Client's experience with mental health problems*
Severity of Mental Health

Participants were asked to rate the severity of mental health problems that pregnant and parenting teens experience by using a Likert scale (1 = “no problem” to 5 = “a severe problem”). Parenting stress is what participants felt as the most severe form of mental health problem, while depression is fourth on the list.

Table 6

*Participant’s reports the severity of mental health problems for pregnant and parenting teenagers*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Stress</td>
<td>4.35</td>
<td>5</td>
</tr>
<tr>
<td>Stress</td>
<td>4.32</td>
<td>5</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>3.96</td>
<td>4</td>
</tr>
<tr>
<td>Depression</td>
<td>3.77</td>
<td>4</td>
</tr>
<tr>
<td>Lack of Validation</td>
<td>3.59</td>
<td>5</td>
</tr>
<tr>
<td>Problems with Anger</td>
<td>3.50</td>
<td>3</td>
</tr>
<tr>
<td>Feelings of Isolation</td>
<td>3.48</td>
<td>3</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>3.36</td>
<td>3</td>
</tr>
<tr>
<td>Postpartum Depression</td>
<td>2.96</td>
<td>3</td>
</tr>
<tr>
<td>Obesity</td>
<td>2.95</td>
<td>3</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>2.12</td>
<td>2</td>
</tr>
<tr>
<td>Cutting/Self Mutilation</td>
<td>2.00</td>
<td>2</td>
</tr>
<tr>
<td>Anorexia/Bulimia</td>
<td>1.92</td>
<td>2</td>
</tr>
</tbody>
</table>
Figure 9. Severity of client's experience with stress

Figure 10. Severity of client's experience with parenting stress
Figure 11. Severity of client's experience with self esteem problems

Figure 12. Severity of client's experience with depression
Figure 13. Severity of client's experience of problems with lack of validation

Figure 14. Severity of client's experience of problems with anger
Major Findings

This chapter discussed the findings from the study. This researcher has five research questions. The first research question was: What types of mental health problems do pregnant and parenting teenagers experience? The second question was: How severe are the mental health problems that pregnant and parenting teenagers experience? With regards to these two first research questions stress and parenting stress were the top two mental health problems that participants reported that their clients experience. Participants indicated that depression and postpartum depression were problems but not as common or severe as stress, parenting stress and self esteem problems.

The third research question was: What kind of social support pregnant and parenting teenagers receive from the father of their child, maternal family and the paternal families? According to participants, most social support comes from the maternal families with 40% of participants indicating that maternal families were either “extremely” or “very much supportive, only 8% indicated that paternal families were either “extremely” or “very much supportive,” and only 3% of participants indicated that fathers were either “extremely” or very much supportive.”

The fourth and fifth research questions were about the kinds of contraceptives that pregnant and parenting use and the extent of their knowledge of contraceptive use. In regards to these last two research questions the top contraceptive that participants stated their clients knew and used was condoms followed by Depo Provera and IUD’s.
Summary

This chapter explores the types of mental health problems that pregnant and parenting teenagers experience from the perspective of mental health service providers. The data found that participants did not feel that there were severe mental health problems such as depression and postpartum depression commonly found among pregnant and parenting teenagers. The following chapter will discuss the conclusions, implications for social workers, and recommendations for moving forward.
Introduction

This chapter will discuss the findings and address the research questions regarding the types of mental health problems pregnant and parenting teens experience. In addition, implications of the findings for social work practice and policy will be discussed as well as recommendations for future research.

Discussion

Previous research indicates that depression is a serious mental health problem that pregnant and parenting teenagers experience (Hodgkinson, 2010). The thirty-one participants who took the survey, however, rated other forms of mental health problems, mostly stress and parenting stress, as being more commonly experienced by their pregnant and parenting teenage clients. The top mental health problems that participants in this study stated that pregnant and parenting teenagers experience are stress, parenting stress, self esteem problems, and lack of validation. Depression appears fifth and then near the bottom of the list of mental health problems is postpartum depression (PPD). The highest mean for severity of mental health problems that participants ranked were for parenting stress, stress, and self esteem problems, and lack of validation. Depression appears fifth and then near the bottom of the list of mental health problems is postpartum depression (PPD).

It was interesting that depression and PPD were not the most common forms of mental health problems that pregnant and parenting teenagers experience according to the participants, nor were they considered to be among the most severe forms of mental
health problems. It is likely that stress and parenting stress are more common problems and thus were rated more of a concern both in frequency and severity. Depression and PPD were not rated as the top problems, however 52% of participants said that depression was “a problem” and 19% said it was a “severe problem,” 7% of participants rated PPD “a problem” and 14% said it was a “severe problem.”

This researcher believes that depression and PPD were ranked less severe and less common for pregnant and parenting teenagers than stress possibly because their symptoms could have been minimized. Perhaps they could not be open about the fact that they were experiencing depression since they are considered to have enough problems already, and there may not be a support team in place for them. This researcher thinks that pregnant and parenting teenagers may have been embarrassed by mental health problems, and the thought of possibly being stigmatized could be even more unbearable.

Previous studies and research have concluded that pregnant teenagers are at a higher risk for depression (Hodgkinson, 2010). As discussed in the literature review, Dr. Hodgkinson (2010) states that pregnant teenagers are at a higher risk of depression due to risk factors such as family history, childhood adversity, social isolation and exposure to life experience. Depression can also become more severe for pregnant and parenting teenagers if it goes untreated.

A severe form of depression, postpartum depression (PPD), can occur anytime after the first year of delivery. According to Reid and Meadows-Oliver (2007) PPD is a form of severe depression that requires some form of treatment. PPD can last anywhere from twelve to eighteen months after the child is delivered. Even though there are
services available, it does not necessarily mean that pregnant and parenting teenagers will
go to a facility and access those services.

When asked about the social support that pregnant and parenting teenagers
receive from their maternal family, the paternal family, and the father of their child,
practitioners rated them all as somewhat supportive. Maternal families were the most
supportive, 40% were “extremely” and “very much” supportive. Participants stated that
8% of paternal families were “extremely” and “very much” supportive, while 3% of
fathers were “extremely” or “very much” supportive. This researcher believes that there
may be a lack of support from the maternal family because they may be angry and upset
that their teenage daughter is now going to be a teenage mother, however, nevertheless
maternal families were still supportive. Maternal family were only 7% “slightly
supportive” and “not at all supportive,” 53% of parental family were “slightly
supportive” while 47% of fathers were “slightly supportive” and “not at all supportive.”
This potential anger and lack of unconditional support could certainly add to feelings of
stress. This researcher believes that more than half of parental families and the father of
the child were “slightly supportive” and “not at all supportive” due to perhaps they did
not care about the pregnancy and child, or some may even believe that they are not the
father of the child.

The best known and the most frequently used types of contraceptive according to
participants surveyed was condoms, followed by birth control pills, Depo Provera, IUD,
the birth control patch, Plan B, and then Nuvaring. This researcher was unable to locate
literature on the different types of contraceptive use among teenagers. This researcher can
only assume that the reason condoms are the most frequently used is because it is easy access to them as they are sold over the counter. Birth control pills are popular because they are discrete, they are something that you can carry with you, and they allow the girl to control the contraceptive. The reason that Depo Provera could be so popular is due to the fact that this birth control shot is good for three months.

Limitations

This study had several limitations. First the sample size was small because this researcher was not able to obtain a large number of participants who were willing to take the survey. Secondly, roughly a quarter of the participants did not accurately complete the surveys, and some chose not to answer all of the questions, resulting in missing data. Third, mental health service providers in only Sacramento County were targeted. In addition there was no standardized instrument used. An important limitation was that the findings in this study were based on the perspective of mental health service providers and their experience with pregnant and parenting teenagers. This researcher was not able to ask teens directly to participate in this study. Thus, the information that was obtained was through mental health service providers who were not experiencing the mental health problems themselves but only were interpreting what pregnant and parenting teenagers told them about experiencing symptoms of certain mental health problems. In addition, participants are not clinician and may not have been attuned to mental health problems that teens may have been experiencing.
Implications

This study is important to the field of social work as social workers frequently work with pregnant and parenting teenagers and this is a vulnerable population. The field of social work is very broad and there are special fields that will require social workers to have daily interactions with youths. When social workers are aware that pregnant and parenting teens experience high levels of stress, self esteem problems and their support system may be compromised this will help social workers pin point what services are needed.

Social workers should encourage all pregnant and parenting teenagers to take parenting classes. They should also be encouraged to take any other additional classes that will help them be more prepared to become a parent. In addition to the knowledge they will gain, these classes should help to alleviate the “parenting stress” that these teenagers are feeling. Other services that may help teens can come from community based agencies, parent child interaction activities, and basic living skill classes.

This study will help service providers and social workers see that pregnant and parenting teenagers are dealing with more stress than most assume. First of all they are experiencing pregnancy at a young age and their bodies and minds as changing and they may not fully understand all of the different emotions they are experiencing. Social workers can help pregnant and parenting teenagers identify who their support systems are and how to maintain strong bonds.
Recommendations

This researcher, based on a review of the literature on this topic, anticipated finding evidence of widespread depression and postpartum depression. The study found how levels of stress and parenting stress, however depression was at 56% which is still high but not as high as expected. Depression is a problem just not as common a concern as stress. Instead this researcher found that rather than being depressed these teenagers are overwhelmingly stressed about their pregnancies and their new role as parents. Both stress and depression have significant health consequences for both the teenagers and their babies. Future research should be done on the effects of stress on pregnant and parenting teenagers. Need to determine if there is a connection between stress levels, and the amount of support offered by the father and extended families. Are there other solutions to help resolve the stress and it should be explored. If teenage mother support group may help them share how stressful they are. It may be helpful for pregnant and parenting teenagers to define what is causing their stress. When practitioners work with pregnant and parenting teenagers they can ask questions should ask directly what is causing their stress.

It would also be beneficial to develop screening tools for pregnant and parenting teenagers. The screening can be done in a pre and post test way so that service providers will be able to see if pregnant teenagers are experiencing any mental health problems, and, if so, those can be monitored. The post test is essential to help service providers distinguish if the mental health problem is ongoing or in the early stages. Having done the screening, service providers can make appropriate referrals to help pregnant and
parenting teenagers overcome their mental health problems and also to gain support from their service providers.

If there are not any support groups in place for this specific population, one should be set up so that pregnant and parenting teenagers can go and share their frustrations and accomplishments and support each other in their efforts to overcome their situation. This support group can be the first step to achieving more self esteem for themselves and hopefully this will help motivate them to accomplish more in their life such as attaining higher levels of education and obtaining a good paying job.

Finally this researcher thinks that it would be good practice for parents to have the “sex talk” with their children at an earlier age, such as being in junior high. Parents should not be ashamed or scared to engage in this type of conversation with their children. It would also be beneficial for the parents and child if school actively taught sex health education every year starting at the junior high. But more importantly this researcher believes that open communication is the key to help reduce teenage pregnancy.
APPENDIX A

Human Subjects
TO: Somaly Kong

FROM: Committee for the Protection of Human Subjects

DATE: March 2, 2011

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "Mental Health Problems Amongst Pregnant and Parenting Teenagers."

X approved as EXEMPT  X NO RISK  ___ MINIMAL RISK.

Your human subjects approval number is: 10-11-086. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Jude Antonyappar, Maria Dinis, David Demetrul, Susan Eggman, Serge Lee, Kisun Nam, Maura O'Keefe, Sue Taylor, Santos Torres

CC: Dr. Maura O'Keefe
APPENDIX B

Consent/Informational Letter
Information Sheet/Consent Form

You are being asked to participate in a research which is conducted by Somaly Kong, a second year Masters of Social Work student at California State University, Sacramento. This research is being conducted in order to gain a better understanding of mental health problem that pregnant and parenting teenager’s experience.

You are being asked to participate in this study because you are a professional who has experience working with pregnant and parenting teenagers. If you agree to participate you will be asked to complete a survey about your knowledge and experience with mental health problems among pregnant and parenting teenagers. The survey will take between ten and fifteen minutes of your time. After completion, please place the survey in the manila envelope provided by this researcher. This informational sheet/consent form is for you to keep.

Your participation in this survey is entirely voluntary. You may refuse to participate with no negative consequences. You may also skip any questions you do not wish to answer.

Your answers are fully confidential.

You will not be receiving any kind of compensation for your participation. However, this researcher appreciates you participating. It is hoped that knowledge gained from you will help advance knowledge on teenage pregnancy.

If you have any questions you are more than welcome to contact this researcher. Somaly Kong can be contacted via telephone (916) xxx-xxxx or via email xxxxxxxx@gmail.com. My thesis advisor Maura O’Keefe can be contacted via telephone (916) 278-7067 or via email okeefem@saclink.csus.edu.

Your completion of the survey indicates that you are consenting to participation.

Thank you for your time and participation.

Somaly Kong, MSW II
APPENDIX C

Survey
Mental Health Problems Amongst Pregnant and Parenting Teenagers from the Perspective of Mental Health Service Providers

Section I: Demographics
Directions: Please mark that one that best applies to you.

1. Gender: Female Male
2. Ethnicity: Caucasian AfricanAmerican Pacific Islander Asian Indian Native American Decline to state
3. Highest level of Education: High School Diploma Associate Degree Bachelor’s Degree Master’s Degree Clinical License Degree Doctorate Degree

Please write in your answers.

4. Age:
5. Years in professional field:
6. Current position:
7. Working with population:

Section II: Pregnancy
Directions: Please write in your answer that best applies to most clients you work with.

1. How many children do your clients have? Include unborn child.
2. Using the Likert Scale, please indicate your clients knowledge on the following.
   1=None 2=Slight 3=Some 4= Knowledgeable 5=Very knowledgeable
   A. Condoms B. Depo Provera C. Birth Control Pills D. NuvaRing E. Birth Control Patch F. IUD G. Plan B

3. What percent of your clients use these forms of Birth Control? Please write your answers in percentage.
   A. Condoms B. Depo Provera C. Birth Control Pills D. NuvaRing E. Birth Control Patch F. IUD G. Plan B

Please fill in the answer with a percentage based on the clients you work with.
1. What percent of your clients thought about abortions for any of their pregnancies?
2. What percentage of your clients ever had an abortion?
3. What percent of your clients voluntary gave up her child for adoptions?
4. What percent of your clients ever had a CPS referral/case?
5. What percent of your clients were ever in the foster care system as a minor?

Section III: Support/Risk Factors
Directions: Please pick the answer that best applies to your clients you work with.

1. Using the Likert Scale, please indicate the answer that best fit your clients.
   1=Not at all 2= Slightly 3= Somewhat 4= Very much 5= Extremely
   A. How involved is the father with unborn/child?
   B. How involved is the maternal family with the mother and unborn/child?
   C. How often is the mother and unborn/child living with maternal family?
   D. How involved is the paternal family with the mother and unborn/child?
   E. How often is the mother and unborn/child living with paternal family?

2. Using the Likert Scale, please indicate the answer that best fit your clients.
   1=Not at all 2= Slightly 3= Somewhat 4= Very motivated 5= Extremely motivated
How motivated are your clients in:
A. Finishing school  B. Going to college  C. Getting a part time/full time job  D. Getting off welfare  E. Living on their own

Please fill in the answer with a percentage based on the clients you work with.
1. What percent of your clients live in lower economic areas? 
2. What percent of your clients live with extended family members? 
3. What percent of your clients come from two parent household? 
4. What percent of your clients come from single parent household? 
5. What percent of your clients have ever been homeless? 

Section IV: Mental Health/Disorders/Services
Directions: Please pick the answer that best applies to your clients you work with. The following are some common problems that pregnant and parenting teenagers may experience.

Please fill in the answer with a percentage based on the clients you work with.
1. What percent of your clients experience these following problems:

2. Using the Likert Scale, please indicate the severity of the problems pregnant and parenting teenagers experienced.
   1=No Problem 2=Slight 3=Somewhat 4=A Problem 5=Severe Problem

3. Please fill in the answer with a percentage based on the clients you work with.
   A. What percent of your clients are willing to participate in needed services such as parenting/co-parenting class? 
   B. What percent of your clients receive referrals to other programs/agencies? 
   C. What percent of your clients are participating in needed services such as parenting/co-parenting class? 
   D. What percent of your clients do you think benefits from services/programs?

What are some of the issues/challenges that pregnant and parenting teenagers face with mental health problems in terms of treatment?
__________________________________________________________________________________  
__________________________________________________________________________________  
__________________________________________________________________________________  
__________________________________________________________________________________  

Please note any other issues/concerns regarding pregnant and parenting teenagers with mental health problems.
__________________________________________________________________________________  
__________________________________________________________________________________  
__________________________________________________________________________________  
__________________________________________________________________________________  

This researcher would like to thank you for your time.
REFERENCES


