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ABSTRACT

This paper examines the problem of teenage women who, because of deep-rooted pathological, psychological reasons, become pregnant repeatedly. All too frequently after giving birth to a series of unwanted, uncared for children these women and their children become psychiatric casualties. Attempts by helping agencies to deal with these adolescents are often unsuccessful. In a large metropolitan hospital the Ob-Gyn and Psychiatric Departments established a group therapy program which utilized "advocacy" as a primary mode of treatment. The group was designed as a quasi-family with the therapists emphasizing their roles as mother surrogates. With the therapists as advocates, feelings of self-esteem were reinforced, and the ability to deal effectively with others was conveyed. Problems were dealt with in a dynamic context by way of the group therapy process and advocacy stance. As a result of this corrective emotional experience in the group, the members have taken good care of themselves and their children. They have been better able to negotiate systems, and have made better use of resources available to them. Group members have also requested continued treatment to deal with "our messes that got us in these troubles." The adoption of this therapeutic stance which emphasized social and psychological advocacy as an expression of good mothering has had many positive results in working with teenage mothers. Such a therapeutic stance has widespread applicability in terms of prevention and treatment. (Author)

WHEN CHILDREN BECOME MOTHERS - A GROUP THERAPY EXPERIENCE WITH TEENAGE SINGLE PARENTS

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INTRODUCTION

A first planned pregnancy for a married woman is generally a time of celebration and joyousness on the part of the pregnant woman herself, her husband, family and friends, as well as our society at large. The support, sanction, and hope for the future provided to the pregnant woman by those around her helps to mobilize her own maternal feelings in preparation for the newborn. A pregnant woman has intensified longings for nurturance, and when these needs are fulfilled she increases her capacity for assuming the responsibilities of parenthood.

The single adolescent faced with a pregnancy often has a very different, less comforting experience. Studies have differentiated class reactions to such a pregnancy. Middle class families have been depicted as trying to conceal it by sending the girls away to shelters or to relatives outside the community, and then urging that the baby be placed for adoption. Abortions or the push towards early marriage have also been described as middle class reactions. Lower class families without the same financial options or access to resources as the middle class, and often without the same adoption opportunities, have at times also been viewed as being disappointed by such a pregnancy. They have been seen in more instances, however, as accepting the newborn into the family group.

In our work with pregnant teenagers we have observed that adolescent single parenthood bears a stigma across class lines, and that this culture does not provide the nurturance needed by these mothers-to-be. As a result they have less chance of establishing a positive self-image as mothering figures, and their children suffer the consequences.

The burdens faced by the pregnant adolescent should be seen within the framework of her being an adolescent as well as an expectant mother, without the conventional support of marriage and the encouragement of others who will look with approval upon the experience. Such an environment imposes shame and guilt upon her. This is paradoxical in a society which encourages early dating, independence, and early sexual freedom, and yet reverses itself so completely if a child out of wedlock is born.

Often those people with whom the pregnant adolescent has contact do not separate her biological maturation from her psychological maturity. The fact that a teenager is about to give birth does not guarantee that she is sophisticated as an adult. The adolescent single parent must deal simultaneously with two developmental tasks that ordinarily would have occurred during a several year period. Not only must the young mother learn to cope with the biological stresses of pregnancy before she has learned fully to cope with the changes of puberty, but she must also adjust to parenthood while she is still immeshed in the problems of adolescence.

Thus she is in some ways still a dependent child who is uncomfortable in asserting what are soon to be her parental rights and responsibilities. While she may at times manifest adult-like strengths and independence, she may also become frightened by her attempts at emancipation, and may regress to child-like behavior and dependency upon adults. This is one of the normal phases of this period, and the adolescent mother, while protesting for independence may actually be more frightened and dependent than at any time since infancy.

Ideally, the pregnant adolescent could be helped to have a reconciliation between the roles of child and parent, by allowing her to express her needs as an adolescent while moving toward the responsibliities of mothering. Yet such a role transition becomes difficult and the self-esteem needed to parent successfully becomes undermined if she is continually faced with people angry with her for becoming pregnant, who do not provide any validation, direction, and support of her capability to mother successfully. Without such help her already vulnerable state deteriorates. When her psychological needs remain unmet this young mother will often give birth to uncared for or abandoned children, and she may become a psychiatric casualty herself. Frequently, this becomes an uninterrupted pattern of repeated pregnancies. Child abuse studies reveal that those mothers that physically or emotionally reject or abuse their children are the very mothers that felt rejected themselves.

Problem:

Often attempts by helping institutions to aid the pregnant adolescent may be well intended but superficial. Little recognition is given to the psychological motivations for becoming pregnant. These teenages are dealt with as if the pregnancy was consciously motivated, with little investigation of any underlying unconscious conflict.

Remaining angry with these girls will not help them. Treating them with contempt, ostracism, and punitiveness may only encourage uncooperative passivity in the pregnant teenager so that she reacts negatively to those facilities which could provide her with necessary services. The labels "unresponsive" and "unappreciative" become necessary only as the pregnant adolescent reacts to the attitudes of others towards her.

Often with the single, adolescent mother, hostility and jealousy towards her is masqueraded with great equanimity as being for her own good. Thus the New York City Board of Education has a high school in the Bronx for the pregnant adolescent which separates her from her community and peers. Another illustration is that as a rule pregnant teenagers in foster homes are not permitted to raise their children. Relocation or giving up their children are seen as the only alternatives.

As professionals from the disciplines of social work, psychiatry, and obstetrics, our concern and involvement has come from various sources:

The OBS-GYN Department at Bronx Municipal Hospital has noticed that teenage prenatal patients have great difficulties in receiving the care they need. The teenagers are inconsistent in keeping prenatal medical appointments and often avoid following medical advice altogether. Sometimes they avoid seeking help until the beginning hour of their labor period. This lack of care can add to the complications of a teenage pregnancy so that unnecessary toxemia, malnutrition, and premature deliveries occur.

Social workers in this department have noticed that these adolescents often demonstrate denial or lack of awareness of the needs of their unborn. Housing, child care supplies, financial support are sometimes left unattended. Often, too, these patients seem to have difficulties in considering the impact of having a child in their life.

The Inpatient Psychiatric Department at BMHC has had a substantial number of young women who are hospitalized with a history of repeated pregnancies as teenagers. A sampling of that populations shows that 50% of the women age 21-35 were pregnant as teenagers. Psychiatric evaluations have determined this to be usually related to hostile dependent feelings towards their mothers, with the pregnancies as attempts at conflict resolution.

Many of the children seen by the Child Psychiatry Department at BMHC reveal a history of having an adolescent mother and many childhood caretakers.

By the time the offspring were seen in the clinic for autism, hyperactivity, school problems, or delinquency, deteriorated situations were notoriously difficult to improve.

Pregnant teenagers and their children are thus an unnecessarily high risk population, medically and psychiatrically.

Therapeutic Stance:

We felt that it was important to examine the underlying conflicts which the adolescent may have been trying to resolve by way of her pregnancy in order to interrupt this ineffective attempt to resolve her conflicts.

Research on this subject has shown that adolescent parenthood is often a result of parent-child stress. We found that the young women we were working with had histories of maternal deprivation. They had difficulties around the issues of separation and individuation, were confused as to their own identity, and had hostile dependent feelings towards their own mothers. We understood their pregnancies to be unconscious attempts to resolve their conflicts with their own mothers, with the pregnancy representing a heterosexual acting out of the girl's traumatic fixation to the preoedipal mother.

To understand this fully, we must examine some of the dynamics of adolescent development. Blos[7] described this period of chaotic growth in which a second separation-individuation phase occurs. If the adolescent has not had the "good-enough" mothering described by Winnicott,[40] her earlier, unsatisfied longings for nurturance will be intensified. A regressive pull in the direction of a return to

the preoedipal mother occurs at this time. If the adolescent has not successfully mastered the past relationship to her own mother, the strength of this pull becomes all the more forceful. The adolescent may react against it by a display of excessive independence, hyperactivity, and a forceful turn toward the other sex.

Normally during this developmental phase the adolescent emerges from dependency upon childhood love objects. The process of reworking the relationships to these objects included oppositional or negativistic interactions with the persons who represent them. The rebelliousness which adolescents so prominently display is to facilitate adaption to reawakened sexual feelings and the recrudescence of the early dependent longings. It is also an attempt to achieve a new concept of self which is more in keeping with their contemporary life situation.

However, this process obviously shakes the family as well as the broader social scene. What often happens is the increasing appearance of parental abdications from phase-appropriate parenting. Empathic relatedness is difficult to maintain in the face of the adolescent's aggression and sexuality. Consequently the adolescent cannot satisfactorily work through or renegotiate relationships with her parents which would enable her to assume responsibility for her own behavior and to acquire the perception of parents and important others as real persons.

This whole process is particularly problematic when the relationship between the adolescent and her mother has been largely unsatisfactory. Unless a reconciliation occurs between them, the girl may have a need to redo this earlier period. The adolescent pregnancy may symbolize such a need to recreate the symbiotic unit of mother-child.

We saw with our teenagers that as they attempted to recreate this mother-child union by way of their pregnancy, a confusion often existed between the identity of mother and child. They have expressed feelings of frustrated dependence and resultant hostility towards mothering figures. The pregnancy can express the fantasy of revenge acted out by the girl, while at the same time punishing herself. And yet as Leontine Young [41] pointed out, these girls may unconsciously want to give their babies to their mothers, with the hope that they will receive reflected love in return from the mothers who never provided it before.

Methodology:

The teenagers seen in our Obstetrics Clinic were offered such services as individual counseling, educational approaches, and rap sessions, but these attempts to help were not always successful. We developed an approach which appears promising and helpful. Our approach was designed to take advantage of the meaningfulness of the peer group to the adolescent. We began a group therapy program setting up the group as a quasi-family, with the therapists as very active advocates for the girls.

Our basic premise was that any alternative to the young women being able to function as good mothers represented a grave failure that would have serious repercussions for their own well-being and certainly for the healthly development of their infants. Bowlby's[8,9,10] work was central to our understanding of the importance of the development of the infant's attachment to its mother and vice versa. A child that is wanted, with at least one person whom he can love and receive good enough love and care in return, has the optimal chance of growth and achievement. A consistent mothering experience is also vital for the healthy emotional development of the child. We also know that the younger the child and the more extended the period of uncertainty or separation, the more dangerous it will be for the child's subsequent functioning.[17]

We were keenly aware that the ordinary support systems - parents, boyfriend or husband, friends - were absent or not helpful. Certain staff members within the hospital, school, or social welfare agencies were clearly too provoked and angry to provide the needed service and support. Thus for the adolescent in our group faced with a major life crisis, there was little available to her to provide the safety, positive identity, caring and self-esteem needed for her to provide the good enough mothering.

Our therapeutic task was at first to provide this in some measure, and then eventually to explore and understand with the group members their own need for this, their attempts to achieve this for themselves, how they had failed in the past, and how better to succeed in the future.

Advocacy was central to our therapeutic technique. The term "advocacy" usually means the mobilization of community forces to deal with a limited need. A premise inherent in this concept is that a change in the system is indicated as an integral part of dealing with an individual or community problem. While adhering to this principle, we view advocacy from a different vantage point. We see it as an integral part of the parent-child experience. To have parents negotiating the system on behalf of their children becomes an essential developmental experience which is a reaffirmation and consistent expression of a healthy parent-child relationship.

From the moment of conception a parent can attempt to insure that the offspring receive maximum benefit from the system. How the child experiences these interventions becomes a critical component in her self-image and her effectiveness in dealing with the world. When this has been lacking or unsuccessful, feelings of competence and security in the child may be compromised.

With this kind of prior history our group members had developed the conviction that their environment could not be trusted. Their resulting negativistic approach to agencies and systems becomes a self-fulfilling prophesy insuring failure.

We thought that an effective treatment approach must emphatically use advocacy as an expression of mothering. It was our hypothesis that by helping members negotiate the system within the framework of a group psychotherapeutic relationship, we would help repair their developmental lag in the area of trusts vs. mistrust - competence vs. incompetence.

Afterall these expectant mothers were still children themselves. By our repeated demonstration of positive mothering behavior we would be specifically attending to their unmet nurturance needs, which would enable them to become better mothers themselves.

Our group began with eleven, expectant, first pregnancy single adolescents between the ages of 15 - 17. Group sessions were held once a week for á 1½ hour duration on the same day as the girl's prenatal appointment.

Clinical Material:

We would now like to present several clinical examples of our work to illustrate this use of the concept of advocacy.

Early in treatment we saw the presence of severe depression, isolation, and withdrawal in the group members. Our exploration as to the reasons for such behavior led to a denial of difficulties. Hints were provided, however, when some members mentioned the disapproval of their pregnancy expressed by others who were important to them. Often the adolescents proclaimed how they could manage on their own, but their statements of fierce independence were contradicted by the incidents they related in the group.

The group bond became much more firmly established as did their belief in us, as we became advocates during the crisis following Virginia's delivery. During the week prior to her delivery, we received a call from a caseworker at a foster care agency who told us that Virginia was in foster care with that agency. She stated that this adolescent had been very "unrealistic" throughout her pregnancy in regard to future planning for the child. Virginia would only express to the agency that she wanted to keep her child and remain at home with her foster mother. The caseworker informed us that such a plan was not possible, and she expressed frustration with Virginia's silence. The agency's plan was to separate the teenage parent from her child until she completed high school (which would not be for another two years!)

The child would be placed in another foster home in the interim.

Virginia had not told us that she was a foster child, and thus this call from the agency was our first knowledge of this. She had appeared depressed and was an especially quiet member of our group. We certainly could now understand some of the reasons why she had withdrawn into silence, when the reality that she faced after the delivery was so grim.

When we informed her of the call, and asked her what she wanted to do about the child, she stated that she wanted to remain with the baby in her family. The caseworker made it clear to us that this was not possible. The only exception that might be made, and there could be no guarantee of this, was that Virginia and her newborn could be placed together in another home apart from her foster family. The agency's possible alternative of separating Virginia from her psychological mother was not acceptable to us. As an adolescent, she also needed her mother.

As we attempted to control our outrage and indignation at such treatment, we explored the situation further. We then interviewed Virginia's foster mother. We learned that Virginia and her sister had lived there continuously since their respective ages of three and two years. The foster mother said that there was already a separate room and ample provisions for the newborn in her home. She said that she only wanted Virginia to be happy. She regarded herself as the grandmother, and wanted Virginia to be able to keep the child.

When Virginia delivered a week later, we visited her on the ward and learned that a representative from the foster agency had come to the hospital so that she would sign the authorization giving them jurisdiction over the child. Their plan was for Virginia to leave the child in the hospital nursery until a new foster home for the infant was found.

We therefore instructed her not to sign until she had legal clarification as to her rights. We obtained a lawyer for her, and began a series of interventions involving the Pediatrics Department of the hospital, the Bureau of Child Welfare, the Office of the Commissioner of Mental Health and Retardation at the local level, and several other agencies. We thus challenged the soundness of such inhumane policy by this massive intervention and we were able to successfully resolve the crisis so that Virginia was allowed to keep both her child and her mother.

In addition, our all-out advocacy in this matter cemented the group identity and feeling of concern and understanding among the members. Virginia was now able to share her feelings of prior hopelessness and as well as her new feeling of optimism based upon the commitment and help of the leaders. The members were very supportive of Virginia and she was now able to accept this support.

The information that she was a foster child also led to an outpouring from all of them about each member's childhood experience of maternal abandonment and subsequent series of caretakers. They recognized that they were now in a similar position as their own mothers had been and that the pressures they faced to separate from their children were enormous.

They realized that a great effort would be required to interrupt this pattern, but they were unanimous in their desires to remain with their children.

Another illustration of our advocacy position occurred in the obstetrics clinic where at times the feeling toward the single, pregnant adolescent is judgemental and punitive. This of course is not strikingly different from what the young woman is experienceing in school, on the street, or at home. Thus there is quickly established the kind of negative transference relationship that vividly portrays the adolescent's struggle to establish herself in the larger world, with much of the same ambivalence, love, hate, provocativeness, and need. The ability to provide needed services is compromised by feelings of anger and frustration on the part of those people providing the services. They may then condemn the adolescent's rebelliousness, lack of responsibility, badness, etc., without any recognition of their own contribution to this. As good, substitute parents we often had to challenge this.

There were multiple enactments of this process in the interactions between the group members and the hospital service staff. Beginning with entry to the clinic, some of the registration clerks and the clerks who dispensed transportation reimbursements treated the adolescent patients with special hostility and suspiciousness. This also occurred in their dealings with us in matters regarding the adolescents.

Some staff, while recognizing the needs of these patients for services, largely felt that the appropriate approach was an educative, coercive one. They offered grim reminders that failure to do as told would lead to bad trouble. For instance facing the chairs where the women waited for their examinations was a gruesome poster of a battered child. There seemed to be little awareness or recognition that the adolescent patient might require a different approach than older obstetric patients.

One striking example of this regarded the food that we provided in the group. We had cokes, cookies or potato chips, and sandwiches. We were told by several clinic personnel, who were experiencing varying degrees of horror at this menu, that this was very bad, and that our members could have retarded babies at that rate.

A hospital dietician offered to come into the therapy group, instruct the girls in the need for good nutritian, and then provide a nutritious lunch for our members. We refused this intrusive offer. That is not to say that we thought nutrition was unimportant, but rather that when the adolescents were eating improperly or not eating, or not taking their vitamins, it was clearly due to depression, and not lack of knowledge or carelessness.

Our meetings were held in a room in the obstetrics clinic which was used for various other functions. There were various supplies in the room including delivery gift packages and pampers. For a period of several weeks we were accused that the girls were stealing these supplies.

This seemed to come to a point of crisis when the accusation was that canned milk had been stolen. We defended our group, pointing out that everyone in the clinic had access to the room, that the supplies after all were for the patients, that it was provocative to leave supplies around that were in some instances desperately needed, and that the milk was in rusty cans and dangerous to have lying around anyway.

Therefore part of our work necessarily involved working with staff to convey some of our ideas. Our job with the staff was at times very difficult. For instance, after most of the deliveries had occurred, we were asked how long they were going to be hanging around, hadn't they been there long enough, and that they would just be getting pregnant again anyway. However, as the group continued and staff were able to see the patient's progress, we were also able to see a progress in staff interest, understanding, and attitudes.

Clearly the event of the delivery was a time in which a lot of support was needed, but not always forthcoming. The patients had not been familiarized with the labor and delivery room beforehand, the doctors who delivered their babies had not necessarily been involved with their prenatal care, and our presence there when they delivered was hardly welcomed by the staff.

We saw how family members failed them at this time. Inez turned to her own mother for comfort following her labor, and her mother's only response was, "You should have kept your legs closed". Another member, Mary, went into labor on group day and was abandoned at the labor room by her relatives. The group members found out about it and joined her. She had not delivered when it was time for the group session to begin.

The members expressed a desire for her to come to the group, yet did not take the initiative in asking her, because they were afraid of witnessing the labor. She was brought down from the delivery floor to the group, and physically held in a comforting way by one of the leaders. The leaders demonstrated their caring for her which further facilitated a positive transference to them as mother figures. This experience of togetherness, support, comfort, and concern was a very powerful one for all of us. We are reminded here of the many birth customs, described by Helene Deutsch,[14] that require the presence of a helpful and loving circle of women during labor and delivery.

Summary:

In this paper we have concentrated on the part of our work that dealt with the failure in the parent child relationship that was demonstrated in the abdication of the parenting role during the life crisis of pregnancy. We initiated a group therapy experience with single teenage mothers who had become pregnant for various psychopathological reasons. The experience of a parent intervening

for a child in dealing with various systems - school, medical, etc. - is a normal part of a healthy developmental experience whereby the child eventually develops these capacities with a feeling of effectiveness and self-esteem. Our patients, who represent a whole category of people, have not had this experience.

We demonstrated that through a corrective emotional experience in the group during this period of crisis - the single teenage pregnancy - that the unmet developmental need for advocacy could be satisfactorily resolved. The patients were able to incorporate this experience into their lives on an on-going basis. We believe this approach of demonstrating and living out a developmental gap can be useful with other problems when there is the proper emotional tone.

We have had the opportunity now to see the development and progress of our patients into more successful and responsible young women and mothers. Conflicts having to do with sexuality, self, mothering, object relations, have become group material. The group members have been better able to plan and manage their own lives, and are raising healthy, developmentally normal children. The group members are also more able to make use of the community systems such as health care centers, schools, and social service agencies. Finally, and most importantly, they have been able to change their relationship with their parents, thus getting help from them appropriate to their age and situation.

We want to make it clear that this is not a subtle method of birth control or racial genocide, but is instead a means of putting these women in touch with certain unconscious forces which had driven them because of psychological reasons to become pregnant. By the therapeutic use of advocacy as an expression of mothering these women were enabled to make conscious choices about the direction their lives were to take.

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