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ABSTRACT

Project TEAM (Team Education for Adolescent Mothers) is a support program designed to counteract the socioeconomic consequences of early childbearing, by developing a model for providing high-quality care services for pregnant adolescents, adolescent parents, their infants, and their extended families. The project has four site locations: Washington High School and the Area Vocational Center, Ogden, Utah; Washoe High School, Reno, Nevada; Shiprock Alternative High School, Shiprock, New Mexico; and Monument Valley, San Juan, and Whitehorse High School at the Southeastern Utah Navajo Reservation. The program's four intervention components include health care, structured group counseling, child development assessments and parenting instruction, and a volunteer role model component. The components are delivered in such a way that the adolescent mother receives intense services during her initial involvement with the program and then less intense services as the adolescent becomes more responsible and is able to function more independently. A program evaluation of the small number of subjects who have completed the program's posttests showed no significant differences between the treatment group and a control group on any of the assessment instruments. (JDD)

Team Education for Adolescent Mothers

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Team Education for Adolescent Mothers

Introduction

Teenage pregnancy continues to be a nationwide concern. Pregnancy and childbirth among young adolescents frequently results in severe adverse health, social and economic consequences, including: a higher percentage of pregnancy and childbirth complication, a higher incidence of low birthweight babies, a higher infant mortality and morbidity, a greater likelihood that an adolescent's marriage will end in divorce, a decreased likelihood of completing schooling, and higher risks of unemployment and welfare dependency. Education is a key factor in counteracting these socioeconomic consequences of early childbearing. Yet support programs to improve the outcomes for teens are often unavailable or narrowly focused with little demonstrated subsequent impact. Many programs are only for the pregnant teens and do not focus on the growing infant or the extended families. Others are school-based and offer no services for girls who have dropped out of school. There is an even greater need for high-quality care services for pregnant adolescents and their infants who live in rural areas. Typically, these adolescents receive limited health care services and not much else.

Some of the expected benefits and results from educational programming for pregnant and parenting teenagers are: improved care services for adolescent parents, improved care services for the infants born to adolescent parents, improved ability of pregnant adolescents to access resources and support services, increased opportunity for adolescents to finish high school or other training programs and find employment, increased awareness and concern for pregnant adolescents by the general public, decreasing referrals of teen mothers for child abuse and neglect and awareness of adoption as an alternative to child rearing.

Project TEAM (Team Education for Adolescent Mothers) is a national care service demonstration program funded by the Office of Adolescent Pregnancy Programs in its third year, and is demonstrating, evaluating, and disseminating a model for providing high-quality care services for pregnant adolescents, adolescent parents, their infants, and their extended families. The project has four site locations: Washington High School and the Area Vocational Center, Ogden, Utah; Washoe High School, Reno, Nevada; Shiprock Alternative High School, Shiprock, New Mexico; Monument Valley, San Juan, and Whitehorse High School at the Southeastern Utah Navajo Reservation which serves the four corners area of Utah, Colorado, Arizona, and New Mexico. TEAM serves pregnant adolescents (13-17 years of age), teen mothers whose

first child is under 10 months of age, and the adolescent's extended families. Measures are taken of various aspects of the history and current developmental functioning of the adolescents studied and of the development of their children.

The program's intervention consists of four components, including a health component, a structured group counseling component, an infant component, and a volunteer role model component.

The components are delivered in such a way that the adolescent receives intense services during her initial involvement with the program and then less intense services as the adolescent becomes more responsible and is able to function more independently. For example, during the first several months of the program, the adolescent receives all the program services. During the second year of the program, the services are less intense. Finally, upon completion of the program, the adolescent may be asked to volunteer as a role model for individuals just entering the program. The program components are described below.

The first component is the health component. When a pregnant adolescent enters the program, she is questioned as to whether or not she is currently seeing a physician on a regular basis. If she is not, she is given assistance in finding a suitable doctor and also applying for financial aid if necessary. Following delivery, the doctor is contacted and asked to fill out a questionnaire regarding the adolescent's general health and the details of her delivery.

The second component of intervention is the group counseling program. This program consists of weekly group sessions for the adolescent mothers. The group sessions are structured to focus on encouraging the completion of educational plans and job training, and opportunities to learn appropriate social skills. The one-hour sessions are also utilized to develop support systems among the mothers themselves as the adolescents report progress toward goals and share significant experiences. Each session is conducted by a trained school counselor at each site to insure that the adolescents from the four sites receive similar programs.

A third component of the intervention is the infant component. All of the pregnant adolescents and young mothers are required to attend a child development class where various aspects of child development, discipline, nutrition, safety, etc., are discussed. Following each class discussion, the adolescents are given an opportunity to observe and interact with babies in a nursery. Supervision is provided to encourage the adolescents to respond positively to the babies and toddlers.

In addition, all of the babies receive extensive testing at 3, 12, and 24 months of age. If the testing indicates a developmental delay, an individual program is written for the child. The adolescent mother, father, or someone from the extended family is then trained to carry out the program on a daily basis at home. Staff members meet with the adolescents weekly to insure that they are completing the home program as directed and to make any necessary changes in the child's program.

The fourth component of the intervention is the role model advocacy program. This component is available to all the adolescent girls who wish

to receive this service. When possible, the role models are selected from a population of women who were adolescent mothers who have received prior services from participating agencies, have succeeded in completing their education, and are either gainfully employed or successful mothers and housewives. These women will have experienced the same problems being faced by the pregnant adolescents, but will have solved these problems in a constructive fashion. When it is not possible to find enough role models who were themselves adolescent mothers, other women from the community are asked to participate in the program. Once identified, the role models receive training with materials developed by the project. Following this training, each role model is paired with an adolescent and the two of them will then have at least one contact, either by phone or visit, each week.

The project has developed the following products to aid in accomplishing project goals:

1. The Adolescent Development Group Manual, which outlines weekly group sessions structured to focus on encouraging the completion of educational plans and job training, and opportunities to learn appropriate social skills.

2. The Role Model Advocates for Adolescent Mothers Manual, which outlines a program for utilizing "successful performers" to serve as role models for pregnant adolescents and adolescent parents.

3. A Parent Intervention Manual, which includes assessing the child, training the parents in infant stimulation techniques,and educating the parents in the area of child development.

4. Documentation Forms for Health-Related Services, which provide a method for collecting health-related data received during pregnancy and after the birth of the adolescent parent's child.

One of our four sites, the Utah Navajo Reservation site, represents a unique rural setting and is a part of the Utah Navajo Development Council, a private, non-profit corporation with programs in education, health, housing, and natural resources. The UNDC programs benefit approximately 5,300 Navajos living in the Utah portion of the Navajo reservation. This area is comprised of 1.3 million acres of arid, rugged land within the Colorado and Green River Plateau regions. It is recorded that the Navajo comprise the largest, wealthiest, and most energetic tribe in America, and the achievements of the Navajo people throughout their long history have been many and outstanding. In spite of this, the Navajo reservations still exist with unemployment, isolation, language barriers, poverty, and some poor living conditions. Traveling is difficult, and distances are measured not in miles, but according to the conditions of the road to be traveled. These factors aid in preventing the Navajo from giving their children the attention they need. In addition to these factors they are generally excluded from the mainstream of American life.

Today, although Navajo school attendance has more than tripled since 1950, the quality of education offered on the reservation continues to lag behind the national standard. The language barrier is one of the most important contributors to academic failure among Navajos because it affects the student's entire progress throughout the White dominated school system.

According to the 1974 Bureau of Indian Affairs figures, 70% of Navajo children entering school cannot function in English on a first-grade level, yet they are expected to learn in a system where English predominates. The problem is further compounded for the Navajo child because of the vast differences in thought and expression that make communication between the Navajo and the American cultures difficult. A large number of Navajo Indian students are faced with educational failure because of difficulties resulting from multiple causative factors. Included in this group are the expecting and parenting teens.

However, the Navajo people are unique and special because of their language, culture, and religion which are truly their own. Educators and site coordinators at the reservation schools are committed to the present and future wellbeing of the expectant and parenting adolescents, and provide project program components in harmony with cultural values. Services are offered to teens at home who have dropped out of school or are provided in the various high schools in coordination with school personnel. A special effort is made by the project coordinator to involve the parents of the pregnant or parenting teen in:

- Promoting parent/teen communication
- Discussing values and beliefs
- Expressing interest in their child's continuing education
- Maintaining emotional support and empathetic understanding
- Strengthening positive emotions such as love, compassion, respect, pride, and thankfulness
- Knowing and respecting the value of companionship and friendship as learned in traditional Navajo teachings and studies.

Data is collected from each client at entry (during pregnancy or with child under 10 months), at childbirth, three months, twelve months, and twenty-four months after birth. Data is managed locally at TEAM and analyzed at Utah State University.

Evaluation Model

The evaluation design requires each site to enroll adolescents and provide treatment for everyone program resources will cover. The remaining adolescents serve as a no-treatment comparison group. It is expected that 120 adolescents will have been part of the treatment group at the end of Year 3, and data will have been collected on 60 members of a comparison group. The design used is a pre-post design with data being collected upon program entrance and yearly thereafter. Although limited numbers of subjects have completed the posttesting currently, it is expected that complete data will be available for analysis on 90% of program entrants at the end of Year 3. Table 1, on the following page, presents a summary of the instrumentation, together with an administration schedule.

A total of 100 treatment and 42 control subjects have been recruited. However, data collection is ongoing, and complete data has been gathered on very few subjects. Therefore, the results of this evaluation must be interpreted with caution due to the small sample size. Another limitation of this evaluation is the higher proportion of non-White participants in the

Table 1

Summary of the Number of Administrations of Each Instrument Collected by Group

Data	Treatment	Control	Total
Demographic Data			
Entry	100	42	142
12 Months from entry	36	19	55
24 Months from entry	1	0	1
Attitude Scale			
Entry	99	41	140
12 Months from entry	33	18	51
24 Months from entry	1	0	1
Personal Feelings Scale (Rosenberg Self-Esteem & Locus of Control)			
Entry	99	39	138
12 Months from entry	32	19	51
24 Months from entry	1	0	1
Father's Questionnaire			
Entry	82	39	121
12 Months from entry	27	15	42
24 Months from entry	1	0	1
Prenatal Information and Infant Risk Index			
Birth	51	27	78
Carey Infant Temperament Scale			
6 to 8 months of age	40	22	62
Grandparent Questionnaire			
3 Months	69	36	62
12 Months	13	12	25
24 Months	1	1	2
Battelle Developmental Inventory			
Entry or 3 Months	60	29	89
12 Months	30	15	45
24 Months	2	2	4
Vineland Behavior Inventory			
12 Months	23	16	39
24 Months	1	1	2
My Baby's Day			
3 Months	48	25	73
12 Months	32	13	45
24 Months	2	2	4

treatment group, and the higher proportion of married participants in the control group.

The purpose of this evaluation was to determine if participation in the Project TEAM program significantly increased the well-being of the treatment group members and their offspring when compared to the control group. Specifically, the following null hypotheses were put forth:

1. There will be no significant difference between the mean scores of the treatment group and the control group on the second administration of the Grandparent Questionnaire.

2. There will be no significant difference between the mean scores of the treatment group and the control group on the second administration of the Locus of Control Scale.

3. There will be no significant difference between the mean scores of the treatment group and the control group on the second administration of the Rosenberg Self-Esteem Scale.

4. There will be no significant difference between the mean developmental quotient difference scores between the first and second administrations of the Battelle Developmental Inventory for the treatment group and the control group.

The average age of the fathers in the treatment group was 19.4 (range 15 to 29). The average age of the fathers at the birth of their first child was 18.20 years (range 13 to 26). The average age of the fathers in the control group was 18.92 years (range 15 to 23). The average of the fathers at the birth of their first child was 18.66 (range 15 to 22).

Prenatal data was also gathered at birth by group. The average weight of treatment group offspring at birth was 3235.09 g (range 2268 to 4564 g). The average weight at birth for control group offspring was 2935.22 g (range 2240 to 3864 g). Child care data was also collected. The average age of treatment group offspring when this data was collected was 5.02 months (range 2 to 12 months). The average age of control group offspring was 4.48 months (range 2 to 10 months). For all subjects, 17% of the grandparents report that they babysit their grandchildren once per month, 22% twice per month, 23% once per week, 12% every other day, and 26% report babysitting their child daily.

Results and Discussion

Total scores from the first and second administrations of the Grandparent Questionnaire are presented in Table 2. There were no significant differences between the treatment group and the control on either the first or the second administration of this instrument. Data from the first and second administrations of the Locus of Control Scale and the Rosenberg Self-Esteem Scale are summarized in Table 3. There are no significant differences between the treatment group and the control group on either the first or second administration of the Locus of Control Scale or Self-Esteem Scale.

Table 2

Means and Standard Deviations for the First and Second Administrations of the Grandparent Questionnaire by Group

	Control Group (n = 8)				Experimental Group (n = 10)			
	1st Adm.		2nd Adm.		1st Adm.		2nd Adm.	
Instrume'	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Grandparent Questionnaire	102 13	6.69	97.00	9.46	100.50	9.35	104.50	7.59

Table 3

Means and Standard Deviations for the First and Second Administrations of the Locus of Control Scale and Rosenberg Self-Esteem Scale by Group

	Control Group (n = 14)				Experimental Group (n = 29)			
	1st Adm.		2nd Adm.		1st Adm.		2nd Adm.	
Instrument	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Locus of Control Scale	28.21	4.69	31.07	4.16	28.17	5.31	29.38	4.87
Rosenberg Self-Esteem Scale	38.14	4.67	41.00	4.17	39.86	7.68	41.07	7.67

Data from the first administration of the Battelle Developmental Inventory was analyzed. Developmental quotients were obtained by dividing the subject's age equivalent score by the subject's chronological age. There were no significant differences between the treatment group and the control group on any domain of this assessment instrument. Table 4 summarizes data from the second administration of the Battelle Developmental Inventory. There was no significant difference between the treatment group and the control group. Difference scores were calculated for each group by subtracting the mean score obtained from the first administration from the mean score obtained from the second administrations for each domain. T-tests performed upon these difference scores failed to reveal any significant difference between the treatment group and the control group.

In summary, there were no significant differences between the treatment group and the control group on any of the assessment instruments. Therefore, all of the null hypotheses were accepted. It is hypothesized that the failure to find any significant differences between the two groups is due to the small number of subjects that could be included in the statistical analyses.

Table 4

Developmental Quotient Means and Standard Deviations for the Second Battelle Administration by Group

	Control Group (n = 10)		Exp. Group (n = 25)		t-test Probability
Domain	Mean	SD	Mean	SD	
Personal-Social Total	101.67	18.76	89.24	12.17	.08
Adaptive Total	120.00	15.8	108.81	24.78	.12
Gross Motor	105.83	26.07	105.49	29.89	97
Fine Motor	102.50	16.69	101.70	19.33	.90
Motor Total	105.00	20.86	102.43	24.55	.76
Receptive Communication	109.17	32.74	104.09	28.25	.67
Expressive Communication	101.67	17.92	98.48	16.16	.63
Communication Total	100.83	23.06	99.04	19.80	.83
Cognitive Total	115.83	14.93	112.64	21.50	.62
BDI Total	114.17	18.02	104.61	17.48	.17