

RUNNING HEAD: Adolescent mothers

Parenting Behaviors among Adolescent Mothers in the National Early Head Start Program: The
Role of Teenage Motherhood, Maternal Depression, and Parenting Stress

Diana Mejias, M.S.Ed

A Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor
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PREVIEW

ABSTRACT

This doctoral project examines the relationships between teenage motherhood, mental health, and maternal parenting behaviors, using data from approximately 3,000 families who participated in a nationwide evaluation of Early Head Start. Outcome data were collected when the children were 36 months old. Measures included the Center for Epidemiologic Studies Depression Scale-Short Form (CESD-SF), Parenting Stress Index-Short Form (PSI-SF), the Parent-Child Semi-Structured Play Task, the Puzzle Challenge Task, and a modified version of the Preschool version of the Home Observation Measurement of the Environment – Short Form (HOME-SF). Maternal mental health problems included depression and parenting stress. Adolescent mothers were defined as being less than 20 years of age when the target child was born. Parenting behaviors included positive (warmth, supportiveness, stimulation of language and learning) and negative (detachment, intrusiveness, negative regard, harshness) aspects of mother-child interactions. It was hypothesized that teenage motherhood and maternal mental health would predict maternal parenting behaviors above and beyond established risk factors. Independent t-tests, Chi-square analysis, Pearsons correlations and hierarchical multiple regressions examined these relationships. Contrary to the hypothesis teenage mothers did not differ significantly from adult mothers in their levels of mental health. The theoretical model was generally supported as associations between age, mental health and parenting behaviors were established. However, many relationships were weak: for example, relationships between teenage motherhood, mental health, and maternal parenting behaviors tended to be significant but small. Nevertheless, these associations persisted above and beyond the effects of established risk for a good portion of the parenting behaviors examined. The best fitting regression model combined the following variables: program status, established risk factors, teenage motherhood, and maternal stress,

predicting almost 22% of the variance in parenting behavior scores. The most unexpected finding was the lack of support for maternal depression and parental distress in predicting emotionally supportive mother-child interaction scores. Lastly, some risk factors demonstrated predictive ability even when teenage motherhood and maternal mental health variables were included in the regressions, augmenting the model's fit. Further research is indicated to refine understanding of the relationships tested, and to examine them in the context of Rafferty's (2006) larger theoretical model.

Parenting Behaviors among Adolescent Mothers in the National Early Head Start Program: The
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CHAPTER I: INTRODUCTION

Overview

Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. They are child-focused programs and have the overall goal of increasing the school readiness of young children in low-income families. Early Head Start (EHS) is a federally funded, comprehensive, community-based program, designed by the Administration on Children, Youth, and Families (ACYF) to provide intensive services to low-income families with pregnant women, infants, or toddlers (ACYF, 2002a). Its mission is simple: to promote healthy prenatal outcomes for pregnant women, enhance the development of very young children, and promote healthy family functioning (ACYF, 2002a). Enacted by Congress in 1994, following the recommendations of the Secretary's Advisory Committee on Services for Families with Infants and Toddlers, EHS is the only federal program specifically aimed toward improving early developmental and educational experiences among infants and toddlers (ACYF, 2002a; Zero to Three, 2005).

Over the next two years, ACYF revised the Head Start Program Performance Standards to bring EHS under the Head Start umbrella, began a continual national system for providing training and technical assistance (through the Early Head Start National Resource Center, in coordination with ACYF's regional offices and training centers), and initiated regular program monitoring to ensure maintenance of program standards (ACYF, 2002a). Through an initial pool of 143 programs funded by ACYF, as of 2002 there were 708 communities being served by EHS, embracing over 63,000 low-income families (ACYF, 2002a; Zero to Three, 2005). Each Early

Head Start program is responsible for determining its' own eligibility criteria and family income is one key factor in determining eligibility as the federal poverty guidelines are used to evaluate family income (ACYF, 2002). Early Head Start programs may elect to target their services to a particular population to best meet the unique needs of families and children in their community.

The National Early Head Start Research and Evaluation Project (NEHSRE) is a rigorous, large scale, longitudinal random assignment evaluation under the direction of the Child Outcomes Research and Evaluation Division, Office of Planning, Research and Evaluation, in the Administration for Children and Families, U.S. Department of Health and Human Services. It was conducted by Mathematica Policy Research, Inc., Columbia University Center for Children and Families, and the Early Head Start Research Consortium of researchers in 15 universities (ACYF, 2002a; Paulsell, Kisker, Love, & Raikes, 2002). Overall, 3001 and families in 17 research sites throughout the United States¹ were involved in the research; the study began in 1996, at the same time Early Head Start began. NEHSRE was designed to provide a comprehensive, comprehensible, and constructive assessment of the quality and impacts of services provided by a representative sample of program sites, with respect to geographic region, demographic characteristics, and type of program approach (ACYF, 2002a; Paulsell et al., 2002). In order to achieve multiple purposes, the Early Head Start Research and Evaluation project was funded in two waves. The Congressionally-mandated Birth to Three Phase (1996-2001) included an Implementation Study, an Impact Evaluation that investigated program impacts on children and families through the children's second and third birthday, and local research projects. In 2001, the Administration for Children and Families (ACF) funded the Pre-Kindergarten Follow-up Phase (2001-2004) to build upon the earlier research and follow the children and families who were in the original study from the time they left the Early Head Start program until they entered

¹ The 17 nationwide sites were located in Russellville, Arkansas; Venice, California; Denver, Colorado (2 programs); Marshalltown, Iowa; Kansas City, Kansas; Jackson, Michigan; New York City, New York; Kansas City, Missouri; Pittsburgh, Pennsylvania; Sumter, South Carolina; McKenzie, Tennessee; Logan, Utah; Alexandria, Virginia; Kent, Washington; Sunnyside, Washington; Brattleboro, Vermont.

kindergarten. The results of this evaluation were published by the ACYF (2002b) in an extensive, three-volume technical report. The source data were made available for public use in 2004, and call for more in-depth research in the area of early childhood development, parenting, and prevention efforts.

Paulsell et al. (2002) describe the various degrees to which specific program sites implemented EHS services. Paulsell et al. (2002) defined the extent to which individual programs offer services meeting the requirements of certain key elements of the revised Head Start Performance Standards as the “Degree of Implementation”. In order for a site to be considered “fully implemented” it needed to substantially implement the relevant program element, or to have exceeded expectations for the relevant element. All other sites were deemed “partially implemented,” which included sites with moderate, low-level, or minimal implementation (Paulsell et al., 2002). Moderate implementation was defined as programs that have implemented some aspects of the relevant element, while low-level implementation are programs that have made some effort to implement the element, and minimal implementation sites showed little or no evidence of efforts to implement the relevant element (Paulsell et al., 2002). In addition, researchers utilized three major areas of programming to develop these implementation ratings. The areas of programming utilized include 1) early childhood development and health services, 2) family and community partnerships and 3) program design and management (Paulsell et al., 2002). These areas of programming were assessed by the Infant-Toddler Environment Rating Scale (Harms, Cryer, & Clifford, 1990), and the Family Day Care Rating Scale (Harms & Clifford, 1989), and also observations of children during classroom and home visits (Paulsell et al., 2002).

As aforementioned site visits occurred in two waves in order to achieve multiple purposes. During the time of the first visits, in the fall of 1997, six of the 17 EHS sites were already fully implemented. During the next two years, all of the EHS research sites made substantial efforts and gains in implementing relevant program elements and by the second visit

in the fall of 1999, 12 EHS sites met the criteria for full implementation. However, Paulsell et al. (2002) clarifies that due to the significant differences in the amount of time it took sites to become full implementers and other relevant disparities, the programs were divided into three general groups.

The first group consisted of the six EHS sites that were already fully implemented at the time of the first site visit in the fall of 1997 and remained so through second site visit in the fall of 1999, and therefore were labeled “early implementers”. These six sites continually worked on improving and/or expanding their services to better meet the needs of the families in their local communities. Paulsell et al. (2002) note that the “early implementers” were strong in that they started with a reasonably strong focus on child development, benefited from past experiences, and did not have substantial leadership changes or frequent staff turnover. Furthermore, these sites tended to have stronger “accountability features”, i.e. internal monitoring, supervision, etc. (Paulsell et al., 2002).

The second group was labeled “later implementers” and consisted of the six EHS sites that were not fully implemented during the first site visit in 1997, but met criteria for full implementation by the second site visit in 1999. In their article, Paulsell et al. (2002) described these sites as programs those who not only received continual feedback from the Head Start Bureau (HSB) monitors, but also were rapid in acting upon the recommendations of the HSB in order to improve the services they provided and to be in compliance with the HSB standards. The other significant differences between this second group and the first group of “early implementers” is that the “later implementer” programs initially were more family support focused rather than child development focused (something that progressively changed as a result HSB monitoring) and that they experienced more leadership turnovers (Paulsell et al., 2002).

The final group was termed the “incomplete implementers” and is composed of the remaining five of the 17 EHS research sites. Paulsell et al. (2002) commented that these five programs also received continual feedback from HSB monitors, and while they also had made

some gains (i.e. improving their “accountability practices”), they experienced even greater difficulty in responding to and complying with HSB standards. The “incomplete implementers” were noted to have difficulty with community partners and high rates of leadership changes and staff turnovers all of which posed as obstacles to obtaining complete implementation (Paulsell et al., 2002).

As aforementioned the implementation ratings developed were based on three major areas of programming, and Paulsell et al. (2002) explain that the degree of implementation was strongly linked to the quality of services provided as determined by quality of care ratings. Quality of care ratings were determined by the number of visits children received per month, educational objectives (i.e. appropriateness of the curriculum), staffing (i.e. staff training, staff development, and staff turnover rates), and parent education and support opportunities (Paulsell et al., 2002).

According to both EHS website, (<http://www.ehsnrc.org/AboutUs/ehs.htm>) and the Administration for Children and Families (ACF) website (<http://www.acf.hhs.gov>), EHS programs are aimed at providing quality education both in and outside of the home, parent education, comprehensive health and mental health services, nutrition education, and family support services (ACF, 2003). The program’s mission continues today to encourage healthy prenatal outcomes, enhance the overall developmental progress of the young child, increase parents’ skills and knowledge of child development, strengthen the family unit, and promote community building and staff development. EHS programs are designed to be in partnerships with families, ensuring that the developmental needs of individual children can be met, in the best possible supportive and collaborative environment. In addition to receiving parenting skills training and other educational services, parents have opportunities to provide feedback on services, staffing, development of curricula, etcetera. (ACF, 2003).

EHS programs were implemented in three different ways: center-based programs, home-based programs, and mixed programs (ACF, 2003). According to ACF (2003) when the

NEHSRE began in the fall of 1997, seven of the 17 study sites were home-based, four were center-based, and six were mixed. A program is considered “center-based” when comprehensive services are provided in an EHS center, which are then supplemented with a minimum of two home visits per year by teachers and staff. Conversely, through “home-based” programs EHS services are delivered chiefly through weekly visits to families’ homes, which are then enhanced with a minimum of bi-monthly group socialization experiences via EHS centers. The final medium through which EHS programs were implemented was via “mixed” programs which involve both “home based” and “center based” service provision. “Mixed” programs are defined as by allowing individual families to select either “home-” or “center based” program services, or by providing families with a combination of service types, either at the same or different times (ACF, 2003). Regardless of service format, the majority of EHS research programs describe enhancing early-parent child relationship as a key goal.

The over-arching design of the NEHSRE consisted of a randomized design with two conditions: an EHS program group and a control group of eligible families who applied for EHS at one of the 17 research sites (ACF, 2003). Between February 1996 and October 1998 intake interviews were conducted to determine family eligibility and collect demographic information. At the time of intake, more than 99% of these applicants were the biological mothers of the target child and 26% of the applicants were pregnant. The mean age of the children already born at intake was 5.24 months (SD = 3.31) (ACF, 2003). EHS services began between the third trimester of pregnancy and the target child’s 12th month of age and then continued through the child’s third birthday. The control group did not receive an offer of EHS services but was eligible to receive any other community services (ACF, 2003).

Eligibility criteria for the project included the following: 1) family income at or below the federal poverty level (EHS programs can only accept a maximum 10% of families whose incomes are above the federal poverty level); 2) a child under one year born between September 1, 1995 and September 30, 1998; 3) an understanding of random assignment procedures (described to

many parents as a “lottery”), and an expressed willingness to participate in either the program or control group, and 4) no participation for three months or longer in a similar early childhood intervention program (i.e. Head Start, the Comprehensive Child Development Program, a Parent and Child Center) (ACF, 2003).

The study of poverty is an unfortunate, yet critical necessity, as there continues to be an overwhelming growing discrepancy between the distribution of wealth and basic resources throughout the world. Research has continually shown that living in poverty negatively affects children’s development in a multitude of ways, which include direct pathways (i.e. children living in poverty generally have inadequate healthcare and nutrition, are more likely to be exposed to infectious diseases and environmental toxins, etc.), and indirect pathways (i.e. exposure to discrimination, lack of successful role models, etc.) (Richter, 2003). Furthermore, research has demonstrated that poverty is associated with psychosocial risk. It has been repeatedly shown that children living in poverty have an increased likelihood of living in unsafe, economically depressed communities, with fewer high quality resources and supportive services accessible to their families (Evans, 2004; McLoyd, 1998; Richter, 2003). Home life is often cluttered with instability, over-crowding, transience, and various forms chaos (i.e. frequent exposure to domestic, community, and media violence) (Evans, 2004). Further adding to this dismal picture it that impoverished parents are more likely to utilize severe discipline techniques and are less likely able to provide their children with an environment that provides optimal opportunities for cognitive development and learning (i.e. encouraging their children to learn basic knowledge like the alphabet or numbers, having books and other educational material in the home, etc.) (Evans, 2004).

Research has demonstrated that the best predictor of competence during early childhood is strongly linked to the number of previous years the family spent in poverty, otherwise known as persistent or chronic poverty (Duncan, Brooks-Gunn, & Klebanov, 1994.) EHS programs are vital to the healthy development of society, especially the impoverished, as the work of EHS

focuses on prevention and early intervention among one of the neediest populations: poor young children and their families. The majority of past psychological research is based on white-middle class samples of people, specifically in the United States and Western Europe. Contemporary research calls for a renewed, more diverse, representative body of psychological literature to further assist in the continued improvement of generalizable and appropriate interventions (McLoyd, 1994; Mowbray, Oyserman, Bybee & MacFarlane, 2002). A striking point of the EHS body of research is that it encloses upon an ethnically diverse sample of families who are low-income, and living in high-risk settings. Conversely, the majority of past psychological research has included participants who are far less likely to be in such a dire need of intervention services, thus limiting the generalizability of those research findings.

The present paper will attempt to further examine the role of teenage motherhood and maternal mental health variables, specifically maternal depression and parenting stress, and the potential associated impact these factors have on adolescent maternal parenting behaviors. Through exploration of existing research (both within and external to the NEHSRE) and analysis of EHS data for new information, a theoretical model of association developed by Rafferty (2006) will guide the present doctoral project, incorporating maternal age, with associated maternal mental health variables, and their impacts on maternal parenting behaviors.

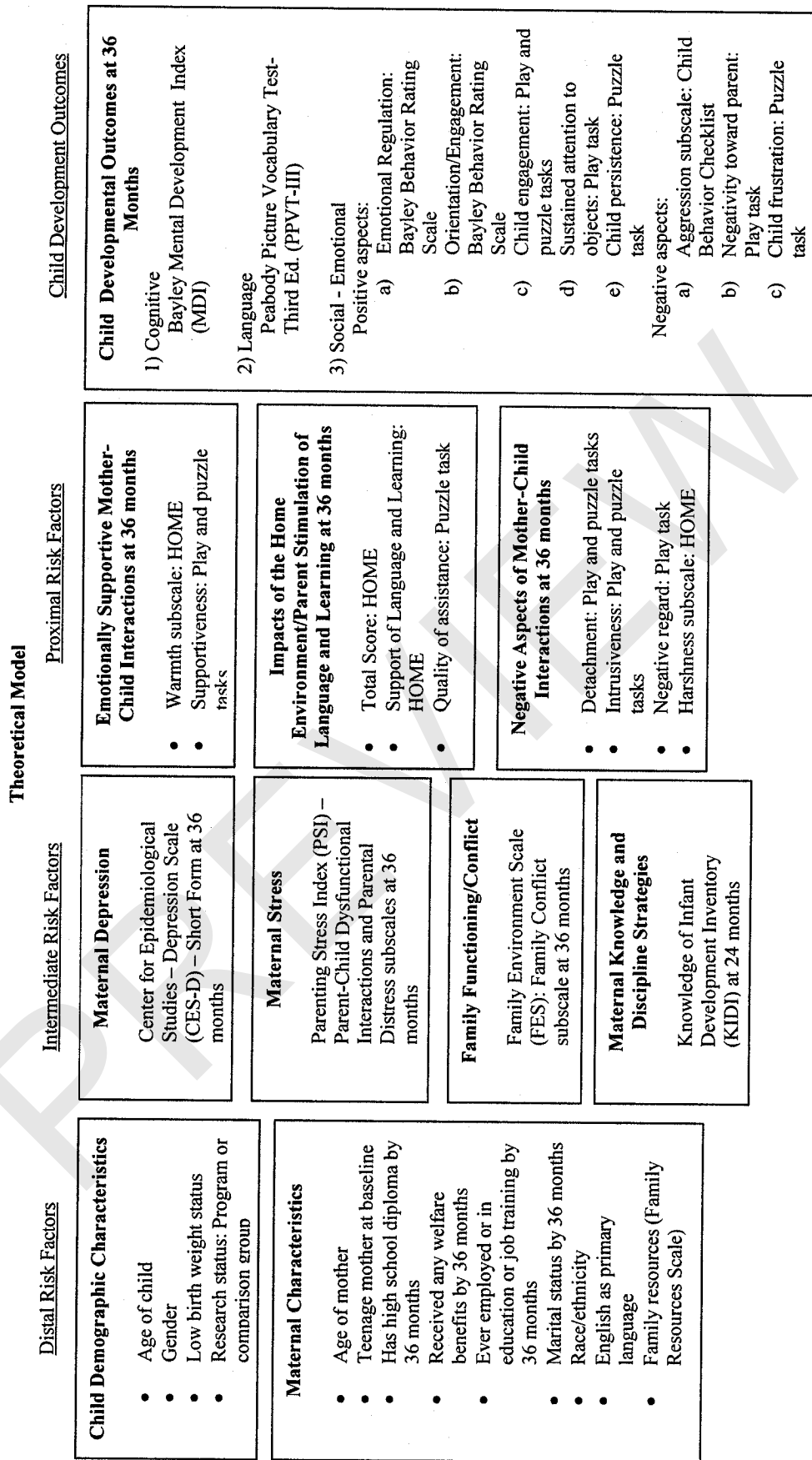


Fig. 1: Theoretical model of the relationship between risk factors, maternal mental health variables, and child behavioral outcomes (Rafferty, 2006). The present doctoral project will not examine all of these relationships, but only those delineated in the above paragraph.

CHAPTER II: LITERATURE REVIEW

Adolescent Motherhood

Approximately one million adolescents in the United States become pregnant every year, resulting in almost half a million births to school-aged mothers (Martin, Hamilton, Sutton, Ventura, Menacker & Munson, 2003). Although this number has declined since the early 1990's, it is still significantly higher than in all other developed countries (Clemmens, 2002; Coley & Chase-Lansdale, 1998; The National Campaign to Prevent Teen Pregnancy, 2005). Between 1991-2003, the U.S. birth rate for teens aged 15-19 declined 33 percent to 41.6 births per 1000 teen girls in 2003, after reaching its highest point in two decades (61.8 births per 1000 teen girls aged 15-19 in 1991) (The National Campaign to Prevent Teen Pregnancy, 2005).

Examining and improving adolescent maternal mental health was not a specific goal of EHS, although some EHS sites attempted to account for maternal mental health symptoms, particularly among groups considered to be at elevated risk (e.g., Beeber, Holditch-Davis, Belyea, Funk, & Canuso, 2004; Coley & Chase-Lansdale, 1998; Robinson & Emde, 2004). EHS results indicate that teenage mothers (defined as being < 20 years of age when the target child was born) were more likely enroll with a first born child and were more likely to be African American and less likely to be Hispanic (ACYF, 2002b). Adolescent mothers were much less likely to have completed the 12th grade and much more likely to be in school or training when they enrolled (ACFY, 2002b). The most striking and relevant to the current doctoral projects is the fact that teenage mothers were more likely to be in high-risk families (ACYF, 2002b); this finding will discussed throughout the current doctoral project. The risk factors considered by EHS include a constellation of interrelated issues, as follows: (1) being a single parent; (2) receiving

public assistance; (3) being neither employed nor in school or job training; (4) being a teenage parent; and (5) lacking a high school diploma or GED (ACYF, 2002b). For analysis purposes, the researchers also divided families into three groups based on the number of risk factors they featured at the time of enrollment: (1) families who had zero, one, or two risk factors; (2) families who had three risk factors; and (3) families who had four or five risk factors (ACYF, 2002b). EHS results indicate that it may be beneficial to improve mothers' mental health by assisting them to gain better access to community mental health services, engaging at-risk mothers in intensive services, and thereby having a greater affect on parenting and children's socioemotional behavior (ACYF, 2002b; Beeber et al., 2004).

The aforementioned adolescent birth rate is alarming for several reasons. Concern about teenage parenthood centers on its potential to compromise the physical, social, emotional well-being and future prospects of these young mothers and their children (Coley & Chase-Lansdale, 1998). Overall, the existing literature on adolescent motherhood is limited and inconclusive. Specifically, the majority of existing research on adolescent motherhood and its correlates are significantly outdated. Teenage parenthood became a prevalent research topic during the late 1980's and early 1990's when adolescent motherhood reached an all-time high in the United States. Since that time researchers have focused their attention on other areas of parenting, with less detailed attention to adolescent motherhood. Contemporary psychological literature has once again begun to shift its attention back to the unique phenomena of adolescent motherhood and its associated effects on maternal and child well-being. While the existing literature is limited and outdated, it is not entirely obsolete. Existing literature provides an excellent framework for contemporary research; especially the current doctoral project. Basic findings demonstrate that adolescent mothers are more likely to report depressive symptoms, substance abuse, and domestic violence than women who postpone childbirth (Fergusson & Woodward, 1999). Furthermore, studies have shown that the adolescent mother and her children