THE ART OF SOCIAL SUPPORT GROUP INTERVENTION WITH SINGLE ADOLESCENT MOTHERS

A Practicum Report

Submitted to

The Faculty of Graduate Studies

University of Manitoba

In Partial Fulfillment

of the Requirements for the Degree of

Masters of Social Work

BY

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THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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ABSTRACT

A review of the literature suggests that social support systems assist an individual to adapt to major life changes, such as parenting. Social support can positively affect parental behavior by increasing knowledge, promoting maternal self-esteem, reducing stress and providing practical assistance. The overall goal of the practicum was to implement a social support group intervention with single adolescent mothers. Two 8-session long groups were designed. The focus of the groups was to empower, educate, connect, network, and provide support to teen mothers. Intervention methods included network mapping, education on the role of social support, journal writing, and skill building. The evaluation instruments utilized to assess change were the Perceived Social Support Friend/ Family Scales and the Social Support Appraisals Scale. The findings did not indicate statistical significance per se, however, some clinically significant changes were identified. The feedback from the teen mothers indicated groups provided them with the knowledge and support to enhance their ability to choose options that could improve the quality and quantity of the relationships in their lives. Consequently, social support group intervention was found to be most beneficial in assisting single adolescent mothers in their adaptation to parenthood.

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INTRODUCTION

Introduction to the Problem Area

An increasing number of adolescents become pregnant and choose to keep their babies each year (Morris, 1991; Whitman, Nath, Borkowski & Schellenbach, 1991; Bergman, 1989). This phenomenon has severe consequences for the adolescent, her child, her family of origin, the community and society as a whole.

> "Pregnancy is a challenge in any female's life regardless of the circumstances. However, for the adolescent the crisis is greatly intensified because it adds another level of complexity to an already complex period of physical and emotional change" (Turner, Grindstaff & Phillips, 1990, p.46).

Parenthood is considered a crisis in the transitional stage of the life cycle, especially when unanticipated (Carter & McGoldrick, 1980). Furthermore, raising a child without the assistance of a partner amplifies the difficulties in performing the tasks of parenthood. An unexpected pregnancy forces an adolescent to abandon suddenly the tasks of adolescence and instantly assume the adult responsibilities of a parent; this further magnifies the complexity of the situation. In most cases, the adolescent does not have the psychological, cognitive, emotional or social attributes necessary for effective parenting. The single adolescent mother (SAM), therefore, constitutes a "high risk" group within the adolescent population. In turn, the offspring of the adolescent parent is considered a "high risk" group within the child population.

The stressful life events of pregnancy and childbirth may present the adolescent mother with a cycle of interrelated problems which have both direct and indirect consequences for her personally, her child, her family and society. The SAM may face medical risks, poverty, depression, stress, stigmatization and isolation (Lockhart & Wodarski, 1990; Turner et al., 1990; Unger & Wandersman, 1988). The child may encounter medical complications, developmental risks, and environmentally induced poverty and isolation (Lockhart & Wodarski, 1990; Turner et al., 1990; Unger & Wandersman, 1988). The extended family often shoulders emotional and financial burdens (Barth & Schinke, 1984), while society harbors economic and social costs (Morris, 1991).

Research indicates that SAM's with social support are markedly less prone to dropping out of school, unemployment, impaired health, and abuse or neglect of their children (Baldwin & Cain, 1980; Barth & Schinke, 1984; Unger & Wandersman, 1988). Moreover, the literature suggests that social support systems may help an individual adapt to major life changes (Gottlieb, 1981), such as parenting. Social support has been found positively to affect parental behavior by increasing knowledge, promoting maternal self-esteem, reducing stress and providing practical assistance (Dormire, Strauss & Clarke, 1988), while lack of adequate coping skills and social support further aggravates the stressful situation of adolescent parenting (Barrera Jr., 1981).

Objectives of the Practicum

The purpose of this practicum was to plan, implement and evaluate a social support group intervention for SAM's at the Adolescent Parent Centre, a school for pregnant and

parenting teens. The critical focus for this group was to assist SAM's in their adaptation to parenthood through empowerment, connecting, provision of networks, and education about the important role social support could play in their lives.

The primary goals and objectives for this practicum included:

GOAL 1: to develop and implement a social support group intervention at the Adolescent Parent Centre.

- Objective A: to work with teachers and staff to create a model based on social support group intervention which may be considered for inclusion in the Adolescent Parent Centre curriculum.
- Objective B: for the social support group intervention to be a model for other schools within the Winnipeg School Division #1 that have an adolescent parent population.

GOAL 2: to educate the SAM's on the important role social support plays in their lives.

- Objective A: to teach prosocial attitudes and interpersonal skills to SAM's using a social support group intervention model.

GOAL 3: to increase the social network skills that SAM's need to adapt to parenting their children.

- Objective A: to teach SAM's to independently connect to their current social support networks.
- Objective B: to assist SAM's to enhance their supportive personal networks and possibly improve their daily lives and ability to parent.
- Objective C: to assist SAM's link up with people in similar circumstances and to provide them with the opportunity to share resources.
- Objective D: to assist group members to identify or strengthen a minimum of one external reliable and supportive linkage.

GOAL 4: to evaluate the delivery, impact and outcome of this group intervention.

GOAL 5: to expand the writer's knowledge and skill in group facilitation.

GOAL 6: to further develop the writer's knowledge and understanding in the areas of adolescent parenting and social support as it relates to teen pregnancy, through a review of the literature and practical experience.

The practicum comprises a major part of the requirements of the Masters of Social Work degree. In accordance, student learning is one of the primary goals of the practicum. Four learning goals for the practicum were established. First, through the practicum, the writer planned to explore the use of social network interventions with SAM's. A second goal was to develop skills in the preparation and delivery of an intervention. Third, the writer hoped to increase group facilitation skills. Finally, the practicum provided an opportunity to develop skills in the evaluation of an intervention.

Organization of this Practicum Report

The introductory chapter of this report describes the focus, as well as the objectives of this practicum. The second chapter contains a review of the literature relevant to the practicum intervention. A thorough discussion of adolescence, parenthood, and SAM's in relation to social support is explored. The role of groupwork, as it relates to adolescents in general and SAM's in specific, is reviewed. The third chapter focuses on the planning of the intervention, including the setting in which the practicum operated and recruitment. The role of the practicum committee, in addition to the standardized and subjective tools for evaluation are also described in this chapter. The fourth chapter reviews the outcome of the intervention and discusses the implications related to the group as a whole, as well as individual case examples are shared. The fifth chapter explores common trends that were found to be present during the group interventions. The sixth and final chapter concludes with a summary of student learning and recommendations for future planning.

CHAPTER 1

LITERATURE REVIEW

1.1 Operational Definition

Adolescent parenthood is "an event whose impact of one's well-being could be influenced by the presence or absence of social support" (Barrera Jr., 1981, p.78). An assumption that underlies this practicum is that social support networks are helpful in meeting some of the postpartum needs of SAM's and in reducing the possible negative consequences of single adolescent motherhood.

There is a lack of agreement about the operational and conceptual definitions in regard to the nature and meaning of social support (Turner, Frankel & Levin, 1983; Gottlieb, 1981). An all-inclusive definition of social support is provided by Erikson (1984):

> the set of relationships contained in a personal network [includes] a focal person, everyone the focal person knows or interacts with, the set of relationships between those individuals and the focal person, and the set of relationships that exist independently of the focal person... the network is, in effect, the social universe of the person (p.188).

Furthermore, the function of social support networks is explained by Garbarino (In Whittaker & Garbarino, 1983):

> a social support network is a set of interconnected relationships among a group of people that provides enduring patterns of nurturance... and provides contingent reinforcement for efforts to cope with life on a day-to-day basis (p.5).

For the purpose of this practicum, social support is defined as:

> "support accessible to an individual through social ties to other individuals, groups and the larger community (Lin, Simeone, Ensel & Kuo, 1979, p.109)... the degree to which individuals have access to social resources, in the form of relationships, on which they can rely" (Johnson & Sarason, 1979, p.155).

A social network, therefore, is comprised of the people with whom we live, work, and interact on a regular basis. A social network refers to the ties one has with a group of people and the links within that group. The concept provides a useful conceptual tool to examine the structure of a person's social resources and examine how the structure changes across a range of settings (Leavy, 1983). Social support, then, is the assistance offered to individuals by the members of their social networks.

Caplan (1974) proposes that natural support systems generally consist of three basic elements: they assist one to deal with emotional problems, share advice, burdens and tasks, and provide tangible resources such as money, tools, or living space. Leavy (1983) identifies four types of social support behaviors: emotional support which includes caring, trust, and empathy, instrumental support which involves tangible forms of assistance, informational support which entails the provision of knowledge or skills, and appraisal support which aids in the measuring of personal performance. Both of the preceding conceptualizations are to be viewed as interrelated components of social support as opposed to separate entities of themselves.

1.2 Conceptual Framework

The stress of an unanticipated pregnancy can be overwhelming. Social support has been found to positively influence an adolescent's perception of the stressor, as well as decision-making in the adaptation process (Dormire et al., 1988). In fact, positive social support may act as a buffering factor, reducing heightened stress levels of families in high stress situations (Dormire et al., 1988). It is well documented in the literature that an individual with social supports is healthier, happier, more successful at maintaining economic and familial stability (Gottlieb, 1981; Whittaker & Garbarino, 1983) and better able to handle stress (Maguire, 1991)... that a positively oriented social support system provides one with feedback that s/he has worth and is valued (Maguire, 1991).

Whitman et al. (1991) propose a conceptual model that describes the factors that operate uniquely in the life of the adolescent mother and her child (Appendix A). They emphasize that the extent to which the adolescent mother is at risk for biological and psychological problems, and her infant at risk for developmental delays, is in large part a function of the degree of social supports she receives. To be an effective parent, the adolescent mother must be cognitively and emotionally prepared. Her cognitive readiness depends on the formal and informal education she receives within her social support systems and her ability to assimilate and utilize this information in specific parenting situations. Moreover, her capacity to parent effectively depends upon the number and type of stressors she encounters, the type of physical and emotional assistance she receives from her social support systems, and her own personal coping resources. This model, therefore, suggests

a dynamic relationship between social support and adaptation to the parent role in adolescent mothers.

1.3 Adolescence and Social Support

Five of the major issues involving adolescence and social support will be reviewed. They include the concept of adolescence, adolescent development, developmental tasks of adolescence, adolescence in the family life cycle, and the sources and nature of social support in adolescence.

1.3.1 *The Concept of Adolescence*

Adolescence as a definitive concept remains controversial; the general consensus is that it begins with the onset of puberty (de Anda, 1987; Shannon, 1972). Although it is agreed that adolescence is the period between childhood and adulthood, the age range is vast and spans between 11 and 25 years (de Anda, 1987, p.5). One explanation for the ambiguity of onset is that "children of a given age vary quite markedly in their physical and emotional development and it is, therefore, impossible to define an age at which it is 'normal' for a child to become an adolescent" (Clegg, 1980, p.3).

Whether adolescence is dependent on one's particular culture and society (Lambert, Rothschild, Altland & Green, 1972; Manaster, 1977; Conger, 1984; Twiford & Carson, 1980) or is a universal and inevitable phase in the life cycle characterized by 'storm and stress' (de Anda, 1987; Erikson, 1982) continues to be debated by theorists. Factors that impact a society's emphasis include the culture's attitudes toward adolescence as a critical

stage in the life cycle, the length of the adolescent period, the importance the society weighs on patterns, ceremonies, rites and rituals, and the value the culture places on emotional and intellectual preparation for adulthood (Bloch & Neiderhoffer, 1958, p.17). Since adolescents are required to effectively adapt to the norms of their particular culture, which vary from society to society, adolescence can be viewed as a process rather than a specific period (Lambert et al., 1972).

Adolescence can also be viewed as a transitional period in human development. According to Erikson (1982), it is the fifth of eight stages in the individual life cycle, marked by rapid physical and behavioral changes and by the normative crisis of identity formation versus identity diffusion. To overcome this crisis, several tasks that involve independence and autonomy, ideal and values, and interpersonal skills must be accomplished.

1.3.2 *Adolescent Development*

Adolescence is derived from the Latin word "adolescere" which means "to grow into maturity" (Twiford & Carson, 1980, p.5). This stage is generally characterized by marked physical, psychological, social, cognitive, moral and sexual maturation.

In terms of physical development, the onset of adolescence is typically paired with the commencement of puberty, which is defined as "the biological and physiological changes associated with sexual maturation" (de Anda, 1987, p.52). Although these changes are continuous throughout the life cycle, the magnitude and rate of change are more

significant during adolescence and the recipient also more cognizant of the transformations (de Anda, 1987).

The three major theories about psychological development during adolescence are the psychoanalytic, psychosocial, and social learning theories. Psychoanalytic theorists purport that individuals develop their id, ego, and superego prior to adolescence. Individual psychological development is viewed as a result of the reenacted Oedipal conflict between these intrapsychic components (Freud, 1973). Psychosocial theorists stress identity formation (personal, occupational, and ideological) as the basis for psychological development (Erikson, 1982). de Anda (1987) theorized that the formation of the adolescent's identity is influenced by his/her psychological integration and the social environment. Social learning theorists further emphasize the environment as an influential source for individual development (Bandura & Walters, 1963). The movement from childhood to adulthood is seen as a gradual socialization toward independence, which requires reinforcement from significant others, conformity to the norms of peer groups, modeling, and self-regulatory behaviors such as self-evaluation and self-reinforcement (Bandura & Walters, 1963).

"The adolescent's social development is closely related to his/her psychological development, particularly identity formation and need for intimacy" (de Anda, 1987, p.57). Intimacy is achieved through the establishment of interpersonal relations, which is the crucial factor in the social development of adolescents. The family is no longer the only source of social interaction; one's school, community, and particularly peer group

play major roles which influence the acquisition of social skills (Bandura & Walters, 1963). Developing interpersonal skills and relations is a process which occurs during all three stages of adolescence. In preadolescence, same sex relationships predominate. In early adolescence, however, the need for intimate relations with the opposite sex is the focus for most youths. During late adolescence, adolescents continue to develop and expand their interpersonal skills, modeling and practicing behavior they can ultimately use in a long term committed relationship (de Anda, 1987).

Cognitive development is primarily viewed as a "progression through stages of quantitatively and qualitatively more complex thought processes and structures" (de Anda, 1987, p.55); a leap from concrete to formal operations (Piaget, 1972). According to Elkind (1978), "cognitive egocentrism", the perception of constant scrutiny by others, is a primary characteristic of adolescent cognitive development, which may lead to feelings of self-consciousness, especially pertaining to physical appearance. "Personal Fables", the other notable feature of cognitive development (Elkind, 1978), occurs when adolescents perceive their thoughts and feelings as universally unique and their lives as invulnerable.

According to the psychoanalytic theory, childhood moral development occurs with the development of one's conscience, the superego (Freud, 1973). Subsequently, the superego is 're-externalized' during adolescence (Freud, 1973), when one retains or discards values and ideals internalized during childhood. Psychosocial theorists propose that moral development is part of the identity formation process (Erikson, 1982), which involves "moving from the specific moral learning of childhood to the pursuit of a moral

ideology" in adolescence (de Anda, 1987, p.56). Similarly, Piaget (1972) stated a shift from moral realism to subjectivism occurs during adolescence, which culminates in the attainment of moral development.

Adolescent sexual development is the result of an interaction between intrapsychic, sociocultural, and biological factors (de Anda, 1987). Psychoanalytic theorists view sexual development as the successful resolution of adolescent sexual Oedipal urges (Freud, 1973). Consequently, individuals can begin to establish effective heterosexual relationships in adolescence. Social learning and psychosocial theorists emphasize the external social and cultural environment; modeling and conformity to the norms of peers and society prominently influence the process of adolescent sexual development (Bandura & Walters, 1963).

1.3.3 *Tasks of Adolescence*

According to Erikson (1982), each stage in the developmental life cycle is characterized by a distinct crisis. For adolescents, identity formation verses identity diffusion is the specific normative crisis where physical and cognitive development and social expectations coincide enabling adolescents to prepare for their future (Preto & Travis, 1985). Although identity formation is continuous throughout the life cycle, it is at its peak during adolescence. Adolescents must also achieve maturational and normative tasks related to areas of social responsibility, independence, morality, and emotional stability. These tasks relate to the development of socially approved masculine or feminine roles, the establishment of effective relationships with peers of both genders, and the acquisition of

values to guide socially acceptable behavior (Conger, 1984; Erikson, 1982; de Anda, 1987). In accomplishing these tasks, the adolescent becomes a competent, autonomous, and responsible adult. Consequently, Erikson theorizes that each individual progresses through a series of underlying steps from birth to death; responsibility for growth, or lack thereof, is placed upon the individual.

In contrast to Erikson's psychosocial approach, Garbarino (1983) describes human development from an ecological perspective. He views "individuals and their environments as mutually shaping systems" (Garbarino, 1983, p.16). Unlike Erikson's theory which focuses on the individual and considers the environment as the arena in which all growth occurs, Garbarino views the setting as an active force to be considered when explaining why people develop as they do. Garbarino states that the "individual organism and the environment engage in reciprocal interaction; each influences the other in an ever-changing interplay of biology and society" (Garbarino, 1983, p.16).

If one were to integrate both Erikson's and Garbarino's theories, a more complete understanding of the normal course of adolescent development could be achieved. Drawing on Erikson's view, the adolescent is seen as a powerful force in determining his/her own growth; this approach is counter-balanced by Garbarino's view which emphasizes the systems, focusing on the adolescent as growing within the context of various systems which present as powerful determinants of individual development. These two theories have major implications for social work practice with adolescents;

interventions must impact on both, the broader systems and the individual, to create a balanced picture.

1.3.4 *Adolescence in the Family Life Cycle*

The family life cycle consists of six stages, each with specific tasks to accomplish. The family, with adolescent children, is the fourth stage in the family life cycle (Carter & McGoldrick, 1980), and it "extends from the oldest child's entry into adolescence through the last adolescent's initiation into adulthood" (Preto & Travis, 1985, p.23). The crises and tasks of adolescence in the individual and the family life cycles coincide. As the adolescent faces an "identity crisis", his/her parents face a "mid-life crisis" as mid-life, marital and career issues resurface (Erikson, 1982). Hence, both parents and adolescents are struggling with personal goals, relationships, and issues of autonomy and individuation during this period (Preto & Travis, 1985, p.24).

Adolescence inevitably has an impact on the changes within one's family, as the adolescents' tasks impose new demands and expectations on the family (Preto & Travis, 1985). The most predominant task of autonomy and individuation create confusion for both teens and their parents (Conger, 1977); the adolescent ambivalently seeks independence within the conflicts of parental protection and nurturance, while his/her parents attempt to promote independence, while simultaneously, supporting their child.

"A sense of safety and acceptance within the family contributes
to the emergence of a strong sense of self... the family that meets

> most of their needs for protection, nurturance, and guidance will provide strength by enabling them to refuel with sufficient supplies of self-esteem" (Preto & Travis, 1985, p.26).

1.3.5 *Adolescence and Social Support*

An adolescent has a vast array of social influences impacting his/her daily life. These various agents can either serve to enhance or impede his/her successful development. Most significant are the family, peer group, school system, media and community (Conger, 1984). Research has indicated that the two most predominant sources of social support for the adolescent are his/her family and peer group (Erikson, 1982).

The power of the family, specifically their practices, attitudes, and socioeconomic class, structure and function, immensely impact the development of the adolescent (Lambert et al., 1972). The major functions of the family assist the adolescent to develop the basis for identity formation (Carter & McGoldrick, 1980). The family strives to be a model of socially acceptable behavior, exemplifying moral standards and values. In addition, the goal of a healthy family unit is to promote individual independence and autonomy through flexible guidelines, limitations, protection and nurturance (Preto & Travis, 1985).

Although the adolescent requires the stability of his/her family, he/she also needs the guidance and support of his/her peers (Conger, 1984). Over time, the influence of the peer group progressively overtakes the importance of the family in some areas. In fact, a

major function of the peer group is to assist the adolescent to achieve autonomy through emancipation from the family (Carter & McGoldrick, 1980). As well, the peer group aids in the development of interpersonal skills and relations. Therefore, the evolution from family membership to peer group involvement reflects a continuum that facilitates the overall development of the adolescent.

1.3.6 *Summary*

Adolescence is a unique stage in the human developmental life cycle. It is characterized by rapid developmental changes, namely physical, psychological, social, cognitive, moral, and sexual growth. The stage of adolescence as well causes changes in the family structure and function. The crisis of identity formation verses identity diffusion is a major cause of turbulence in adolescents. To overcome this crisis, several tasks must be performed. These are to gain independence and autonomy, to establish a set of ideals and values, and to develop interpersonal skills and relations.

Environmental sources aid the adolescent throughout this difficult stage. Familial support provides nurturance and protection, while peer support promotes separation and autonomy. Environmental factors, therefore, ease the successful accomplishment of identity formation; in turn, a smooth transition to succeeding stages is facilitated. In summary, developmental processes and factors interact with environmental and cultural elements so that normal adolescent growth and development can reach its maximum potential. These processes may become chaotic and add developmental delays when teenage pregnancy and parenthood occur.

1.4 Parenthood and Social Support

The concept and development of parenthood and their effect on the individual and familial life cycles will be explored, in addition to, the specific dynamics of single motherhood. The sources and nature of social support in parenthood will also be reviewed.

1.4.1 *The Concept of Parenthood*

Conventional theories recognize parenthood as the predominant task in adult life, and a normative crisis in the developmental cycle. Regardless of age, stage of development, or marital status, pregnancy and parenthood are considered life crises (Erikson, 1982). It is widely believed that the birth of the first child is the greatest developmental crisis a woman encounters during her lifetime.

> "When a woman becomes a mother, she must adjust to significant changes in her view of herself, her role in her marriage, her body and her place in the larger context of the outside world. She must also adjust and react to a newly created intimate relationship with her child" (Walter, 1986, p.186).

Societal and cultural norms, values and expectations also play important roles in the new mother's development. These forces define motherhood as an important symbol of maturity, responsibility and adult status, which the new mother feels pressured to fulfill (Walter, 1986).

1.4.2 *Parenthood and Tasks in the Family Life Cycle*

The family with infants and young children is the third of six stages in the family life cycle (Carter & McGoldrick, 1980). This transitional phase demands changes in the couple's relationship, their individual adult functioning, and their immediate environment (ie. work, extended families, friends, and other sources of support)" (Cox, 1985; Erikson, 1982). Relationships with the extended family must also be realigned to include parenting and grandparenting roles (Carter & McGoldrick, 1980).

1.4.3 *Single Parenthood*

The crisis of parenthood is further complicated in families with only one parent, which according to Statistics Canada (1981) is the most profound change in family formation during the last fifty years. Of paramount concern is that the single parent family is rapidly increasing (Department of Family Services, 1994) and the average age of the single female parent is decreasing (Manitoba Health, 1993).

Single parenthood dramatically affects the whole family system; it alters the family's emotional processes, its functioning and its task performance (Carter & McGoldrick, 1980). The presence of poverty further complicates the life of the single mother. Both middle and working class single mothers earn significantly less than their married counterparts (Carter & McGoldrick, 1980), with many of the former living below the poverty line and requiring social assistance to support their families. This has dramatic short term and long term consequences for the single mother, her children and society.

Another common pattern of single motherhood is isolation. Due to financial insecurity, many single mothers have minimal opportunity for socialization, and consequently, spend the majority of their time with their children (Thompson, 1986). This is exacerbated when the single mother lacks or loses social and familial supports, "single parents frequently find themselves emotionally cut off from extended family relationships and social networks" (Carter & McGoldrick, 1980, p.257). Consequently, loss of social and familial support combined with low financial income exacerbates the social deprivation commonly experienced by single mothers. In turn, "social isolation, anxiety, depression, and loneliness may serve to foster decreased functioning in a single parent" (Carter & McGoldrick, 1980, p.257). This is especially relevant when the major task of childrearing is performed by a young single parent with young children (Coleman, Ghodsian & Wolkind, 1986).

Task overload is a major difficulty for single mothers with young children. The deterioration of task performance is inevitable if the family has a low level of organization, economic problems, high levels of stress, and inappropriate support systems. As a consequence, maternal malfunctioning and family disorganization develop (Carter & McGoldrick, 1980).

1.4.4 *Parenthood and Social Support*

To overcome the difficulties during parenthood and to accommodate the new member into the family system, several tasks must be performed, patterns and lifestyles altered, family roles renegotiated, and generational boundaries realigned (Carter & McGoldrick, 1980).

One's internal coping ability and external sources of support such as family, neighbors, friends, and self-help groups, may aid in the transition to parenthood. Some functions of these external support agents are to aid the new parent in coping with stress, and to assist with the transition to parenthood (Walter, 1986). The familial relationship typically provides the most social support and is based on love and duty. The main function of kin is to provide financial, emotional and instrumental aid, for example, childcare and advice on childrearing. When kin are not available, the importance of other social supports increase (Wearing, 1984); for example, neighbors and friends may provide reciprocity based support. The ideal function of neighbors and friends is to provide an informal source of emotional and instrumental support which serves to decrease isolation and loneliness, for example, through discussions about childrearing (Wearing, 1984). Finally, formal self-help groups provide companionship, as well as social and psychological support (Walter, 1983; Wearing, 1984).

1.4.5 *Summary*

Parenthood is a major crisis in the human developmental life cycle. It is normally associated with maturity and adulthood. A smooth transition to parenthood is dependent on societal and cultural norms and expectations. Parenthood creates several changes in the individual, marital, and family systems; the structural and functional components of the relationship are altered significantly during this phase which at times leads to stress and conflict within and between these systems.

To overcome the crisis of parenthood, several tasks must be performed including altering old patterns and lifestyles in order to accommodate a new member into the family system. Roles must be renegotiated, as well as generational boundaries realigned. The crisis of parenthood is further complicated if the family is headed by one parent only, for economic and social deprivation usually characterize single parenthood.

Internal sources such as coping ability, are essential elements to facilitate the transition to parenthood. External sources, such as family, friends, neighbors, and formal mothers' groups, as well can aid the individual in coping with the stress of parenthood, providing emotional, instrumental, and financial support for new mothers. Both developmental processes and environmental elements appear to be necessary for a successful transition and adaptation to parenthood. Unfortunately, social supports are typically absent for most single adolescent mothers, which further aggravate an already chaotic situation.

1.5 SAM's and Social Support

The needs and experiences of SAM's will be reviewed, in addition to, the role of social support at the three critical levels, namely micro, mezzo, and macro.

1.5.1 *The Needs and Experiences of SAM's*

The SAM faces a host of psychological and emotional challenges in six major areas, which include housing, childcare, education/ employment, income, mental health, and physical health (MacKay & Austin, 1983).

Due to limited finances and generally young ages, SAM's greatest unmet need is affordable and suitable housing. To assist with housing, the SAM generally relies on informal or micro resources, such as family or friends (MacKay & Austin, 1983), or on more formal or macro resources, such as provincial housing departments or residential facilities. Extended family, financial assistance and childcare support appear to be more available to the SAM who resides with her family of origin (Sacks, Macdonald, Schlesinger & Lambert, 1982); in fact, the majority of SAM's depend on informal childcare provided by family, friends, and neighbors (MacKay & Austin, 1983). The SAM's who live with their extended family are more likely to return to high school, graduate, and become employed (Barth & Schinke, 1984); those who live independently or are alienated from their families generally are forced to utilize formal daycare services which are costly and difficult to access (MacKay & Austin, 1983) and which reduces their chance to complete their education, find suitable employment, or pursue leisure activities enjoyed by both other families and by other adolescents (MacKay & Austin, 1983).

Although education and training programs generally increase the employability of the SAM, child-rearing responsibilities and suitable childcare impede and block the adolescent's attendance (MacKay & Austin, 1983). SAM's consequently turn to formal or macro services such as Resources for Adolescent Parents/ Resources for Women (New Directions) or Taking Charge (Employment and Income Security), to assist with educational and occupational needs. Unfortunately, these are often found to be limited due to age restrictions or inadequate schooling (MacKay & Austin, 1983). This may result in feelings of loneliness, isolation or frustration (Sacks et al., 1982). The public

school systems have attempted to respond to the growing adolescent parent population during the past decade by developing childcare labs, programming, and academic courses geared to SAM's on site. This will hopefully serve to lessen the barriers to educational advancement, increase employability and reduce the poverty status of the SAM, as research continues to illustrate that the more education a young mother has, the more favorable her overall well-being tends to be (Thompson, 1986); in general, young mothers with less than a high school diploma have less job security, less financial security, less information on community medical resources, as well as fewer supports, which further weaken their coping ability (Thompson, 1986).

The SAM often struggles to manage on a limited income, which primarily stems from public assistance or private income, such as child support or assistance from family and/ or friends. These resources rarely meet the basic needs of food, clothing or safe shelter (MacKay & Austin, 1983).

Emotional and mental health needs must also be addressed. Adolescent pregnancy often results in social ostracism, isolation and alienation from the family of origin. The more unfavorable the conditions surrounding the crises of teenage pregnancy and motherhood, the more emotional stress the adolescent experiences (MacKay & Austin, 1983). Limited social support, task overload, stigmatization, isolation and poverty may lead to reduced coping ability which may aggravate the SAM's already fragile mental status (MacKay & Austin, 1983), as she attempts to deal with the tasks of separation and individuation from her family of origin and with the tensions and stressors of parenthood (Erikson, 1982). The SAM is also more likely to experience depression, stress and frustration than her older

counterparts (Simkins, 1984). She is often more ineffective at solving parenting problems due to insufficient maturity and lack of the necessary coping skills (Simkins, 1984). The SAM's positive mental health status is a function of the emotional support and closeness she experiences with her family and friends (MacKay & Austin, 1983). "Successful support systems seem to foster good health, encourage health-related behaviors, provide useful resources in stressful situations, and give participants helpful feedback for maintaining sound behavioral practice" (Gottlieb, 1981). Ironically, the SAM who generally utilizes formal services is alienated from her informal familial support systems (MacKay & Austin, 1983).

The difficulties the SAM faces may also affect her baby's emotional status and mental health. Research illustrates that the risk factors for the baby of the SAM, such as cerebral palsy, epilepsy, mental retardation (Osofsky, Osofsky, Kendall & Ranjan, 1973) neonatal mortality (Baldwin & Cain, 1980) and delayed social and emotional development are compounded by the youth of the mother (MacKay & Austin, 1983). The young mother also tends to create a strong mother-child unit as she typically parents alone. Consequently, generational boundaries between the parent and the child may be breached and inappropriate mutual dependency fostered as they attempt to fulfill each other's needs. "For the adolescent who has been deprived of the support, affection and warmth of her parents, a baby of her own may be a savior" (Cashmore, 1985, pp. 156-157); for the adolescent, the burden of parenthood may be balanced by the comfort, fulfillment and emotional gratification experienced (Cashmore, 1985). The presence or absence of adequate coping skills can enhance or aggravate the SAM's adaptation and the role she

assumes in childrearing (Barrera Jr., 1981). Social support, either formal or informal enables the SAM "to function adequately as a parent, to mature, and to become self-supporting and self-sufficient" (Zittner & Miller, 1980, p.4).

Young parenthood may affect the SAM's physical health, as she commonly delays seeking prenatal care until after the most critical period of fetal development, the first trimester (Lockhart & Wodarski, 1990). This delay of care combined with marginal nutritional status further jeopardize her medical status. Substance abuse is also generally increased during adolescence, and therefore, the SAM who smokes, drinks or abuses drugs places her child at increased risk of low birth weight, prematurity or delayed development (Osofsky et al., 1973; Anderson & Grant, 1984).

The SAM's age and the medical risks she faces during pregnancy and childbirth are also inversely related (Morris, 1991). Additionally, the lack of family planning has detrimental long term consequences for the SAM and her child; the earlier a woman begins her family, the more unplanned births she is likely to have in a shorter time span (Baldwin, 1977; Ralph & Thomas, 1984). This may reduce her resources and ability to cope (Hardy, Welcher, Stanley & Dallas, 1978). Recurring pregnancies are also characteristic of adolescent parents (Ralph & Thomas, 1984).

1.5.2 *The Role of Social Support*

Anxiety and stress are inevitable emotions in the developmental life cycle. Early and unexpected pregnancy, childbirth and motherhood are considered high sources of stress;

their effects vary according to one's coping skills (Belkin & Nass, 1984) and the availability and use of social support (Thoits, 1982).

The transition to and through single adolescent motherhood can be moderated by the presence of a positive natural support system (Barrera Jr., 1981). Caplan (1974) described the social support network as assisting to mobilize psychological resources, mastering emotional burdens, sharing tasks, and supplying extra supplies of money, materials, tools, skills, and cognitive guidance.

The structural features of social networks relate to the positive adjustment of SAM's (Barrera Jr., 1981). These structural characteristics consist of size, number of confidants, proportion of kin, proximity of network members, and frequency of contact (O'Hara, Rehm & Campbell, 1983, p.336). The quality of social support may also be as important as the quantity or frequency of support contacts in the adaptive functioning of SAM's to their stressful situation (Cutrona, 1984; Andrews, Tennant, Hewson & Vaillant, 1978).

1.5.3 SAM's *and Social Support*

There are three essential levels of social support that play important roles in providing the SAM with instrumental, emotional, and financial support (Gottlieb, 1981). The first level, the micro, refers to the relationship between the individual and the social environment. It is defined as:

> People's access to intimate relationships, and seeks to identify the resources available in such confiding social ties. These tend to be more qualitative than quantitative and more processually oriented than structurally oriented (Gottlieb, 1981, p.33).

Studies indicate that the family, putative father/ boyfriend and peers provide instrumental, emotional and financial support to the SAM (Sacks et al., 1982; MacKay & Austin, 1983). The age of the SAM is inversely related to the amount of support and reliance on her family of origin. Research indicates that the younger the mother, the more reliant she is on her family of origin (Sacks et al., 1982; MacKay & Austin, 1983).

Social support from grandparents may be viewed as a mixed blessing. It is positive in the sense that heightened family contact can positively affect the child's development and allow the teenage parent to continue school, attend job training programs or find stable employment (Baldwin & Cain, 1980). However, it remains negative in the sense that generational boundaries may be breached; if the grandmother adopts the role of mother, separation and autonomous development for the adolescent parent may be impeded as she depends extensively on her mother to meet her needs and those of her child (Barth & Schinke, 1984). Moreover, the child might experience the same child-rearing practices from the grandmother that contributed to the situation of adolescent motherhood.

Peer groups typically play a major role and are a principle source of influence and support during adolescence. de Anda and Becerra (1984), however, found limited peer support for pregnant teens. This may have been partly due to stigmatization from the peer group during and after pregnancy, and/or reduced opportunity to maintain peer contacts following birth. SAM's appear, therefore, to be isolated from their peers at a point in their development when peer contact is particularly critical.

The second level of social support, the mezzo level, refers to:

> a network which narrows the interactional focus to the pattern of relations that people maintain within a distinct social aggregate... it centers on structural differences among people's social worlds and the ways these differences determine differential access to resources needed in the process of coping and adaptation (Gottlieb, 1981, p.32).

Research indicates that neighbors and community activities, such as informal mothers' groups, are the most important resource for SAM's at this level and supplement the lack of kin or peer contact (Walter, 1986). They also become the basis for friendship development, meet childcare and mental health needs and provide instrumental and emotional support on a reciprocal basis.

The third level of social support, the macro level, refers to one's involvement with formal community institutions, voluntary associations and informal social gatherings (Gottlieb, 1981). Studies indicate that formal services are approached only after the family, peers and neighbors are deemed unable or unavailable to provide support for the SAM (Bergman, 1989). Emotional, financial and instrumental support in the areas of housing, income, education, employment, physical, mental health and childcare are provided through classes on effective parenting, daily living skills, coping and adjustment skills. Unfortunately, the cycle of social difficulties continues since the majority of SAM's do not attend the programs nor reach out to the community and social agencies (Bergman, 1989).

1.5.4 *Summary*

The stressful life events of pregnancy and childbirth present SAM's with a cycle of interrelated problems, including housing, education/ employment, childcare, income, mental health, and physical health. Inaccessibility, unavailability, and unaffordability of resources are common barriers to having their needs met. As a result, a combination of single parenthood, low education and occupation achievement, and little, if any, social support contribute to the crisis of single adolescent motherhood.

Social support has a direct and positive impact on the well-being of the individual. Furthermore, research indicates that social support plays an adaptive role in the crisis of single adolescent motherhood for it serves as a buffering agent with respect to stress. In addition, social support on the micro, mezzo, and macro levels play an important role in providing SAM's with the instrumental, emotional, and financial support required. Thus, knowledge of the various levels of social support systems is necessary for effective social work practice with adolescent mothers. For example, since the extended family is a central source of emotional, financial, and instrumental support, social workers should focus on family intervention; this would allow for family bonds and support to be developed, strengthened, and maintained, while simultaneously, assisting appropriate separation and individuation for the adolescent and her child. Consequently, a positive social support system combined with an effective coping style is essential for the effective adaptation to single adolescent motherhood.

CHAPTER 2

GROUPWORK WITH ADOLESCENTS

2.1 Introduction

Several authors have pointed out significant differences in the process and technique of adolescent group treatment when contrasted with adult group treatment. These include the adolescent's focus on developmental phase tasks, higher anxiety level, difficulty in accepting direct interpretation of behavior, lower expectancies for self-analysis, difficulty in relating to authority figures, and greater tendency to use activity as a mechanism for handling anxiety (Corder, Haizlip & Walker, 1980).

Group treatment has been found to be very appropriate for adolescents. It provides a place in which adolescents can express and experience their conflicting feelings, discover that they are not unique in their struggles, openly question their values, learn to communicate with peers and adults, learn from modeling provided by the facilitator, and learn how to accept what others offer and, in return, give of themselves (Corey & Corey, 1987). Groups tend to provide a place in which adolescents can safely experiment with reality and test their limits. Moreover, group treatment allows adolescents to be instrumental in one another's growth; group members assist one another in the struggle for self-understanding. Most important, however, a group setting provides adolescents with an opportunity to express themselves and to interact with their peers.

To do effective group treatment with adolescents, it is important for the facilitator to be cognizant of the fact that each individual member is at a different stage of personal development (Corder et al., 1980). Very rapid and dramatic psychological, cognitive, and physical growth occurs throughout adolescence, and thus, the abilities, personal issues, and expectations placed upon the adolescent may change quite alot within only a few years of development. Group therapists generally separate adolescents into three categories: early adolescence (13 and 14 year olds), middle adolescence (15 and 16 year olds), and late adolescence (17 year olds and up); this tends to ensure greater commonality of abilities and concerns (Corder et al., 1980).

Group treatment has been found to be very beneficial for adolescents who cannot verbalize their own feelings. In working with the adolescent population, the average teenager can understand, accept, and assimilate teachings of her/his own peers with greater ease than s/he can from those in authority (Kraft, 1961). "Many adolescents in a group wish to defend, detach, and possibly isolate her/himself from the threatening adult authority system" (Weisberg, 1980). Group therapy can be extremely therapeutic in dealing with adolescent adjustment issues; the group milieu can facilitate the adolescents to support, assist, and confront one another in a safe environment.

Although the adolescent tends to rebel against adult authority, s/he simultaneously is seeking to learn, expand, and even conform to model roles which are available to her/him from the adult community (Weisberg, 1980). The facilitator of the adolescent group is the single most influential "member" (Hurst & Gladieux, 1980). The facilitator is responsible for establishing a tone of comfort, safety, and relaxation, which secondly creates a learning

environment (Hurst & Gladieux, 1980). An effective group therapist provides structure and sets firm limits without being domineering; s/he conveys affirmation, acceptance, understanding and caring for group members and their concerns (Hurst & Gladieux, 1980).

It is also important for the facilitator to have a clear understanding of normal adolescent developmental phases. Modeling self-disclosure of thoughts and information, especially in the area of her/his own adolescence, can serve to demonstrate that s/he does understand, at least to some degree, the experience of the adolescence. Furthermore, research indicates that affective expression by the facilitator contributes to the development of group cohesion (Hurst & Gladieux, 1980).

There are certain group dynamics which play an important role in adolescent group treatment. The first is the reaction of regression. Almost always, members of the group will regress. Regression tends to occur as adolescents work through painful memories or life experiences and often is encouraged.

Resistance is, as well, frequently encountered in group treatment with adolescents. Resistance in adolescent groups encompasses many forms. Absenteeism, leaving the room, changing the topic, or remaining silent are some examples. Resistance allows group members to avoid experiencing negative feelings such as anxiety, depression, fear, and hopelessness (Schaeffer, Johnson & Wherry, 1982).

A third group dynamic in adolescent treatment groups is transference and counter-transference. It is essential for the group facilitator to recognize the presence of

transference and countertransference in group members and within him/herself. Transference commonly occurs when the facilitator symbolically represents a significant person from the adolescent's life, for example an authoritative or domineering parent, and the adolescent angrily acts on his/her subconscious feelings. It is the facilitator's responsibility to assist group members in recognizing such distorted perceptions and to help them work through the feelings that have been triggered by these distortions. As well, it is critically important for the facilitator to fully understand her/his own adolescence to prevent counter-transference from occurring during group treatment. Typical counter-transference issues include the urge to act out parental authority conflicts through the group (Kraft, 1961), feelings of omnipotence, fear of self-disclosure, and overidentification with the adolescent (Schaeffer et al., 1982). A great deal of self-awareness is needed for the leader to recognize the dynamics if they occur and work through the issues. With both, transference and counter-transference, it is important to maintain a critical awareness and sensitivity to all that is happening both with group and with yourself as group leader.

2.2 Groupwork With SAM's

Social work practitioners develop specialized knowledge and skill with regard to the needs of the adolescent parent population, and are able to identify those SAM's who are at risk for maladjustment to parenthood. The SAM with limited support may lack the opportunities for contact or the interpersonal skills needed for initiating and maintaining affirmative social contact (Barth & Schinke, 1984). In addition, the SAM with few social supports may lack the assertiveness required to initiate network membership or request

assistance, especially in the areas of financial support, transportation and childcare; an inability to ask for assistance due to cognitive or interpersonal constraints may result in parental difficulties (Barth & Schinke, 1984).

Epstein (1980) found that the teenage parent who was coping well with teenage pregnancy attributed her success to the information and services she was taught to access. It is essential to teach the SAM social and cognitive skills to strengthen her capacity to maintain harmonious family and social relationships. One approach is through group work.

Group work can exist in many shapes and forms. The focus of this practicum was on the benefit of educational treatment groups in enhancing the social support networks of SAM's in general, and in supporting and educating members in the acquisition and application of new skills and personal growth in specific.

Group treatment goals for the SAM included empowerment, connection through informal supports, networking, education and provision of support. A primary focus of the group was on skill building and pertinent SAM issues; research indicates that groups that fail to offer basic training only make people more dependent on professional help for their support needs (Lovell, 1991).

Educating the SAM on the important role social support plays in her life, as well as teaching the SAM a variety of pro-social attitudes and interpersonal skills, may improve the quality of the relationships in her life, as well as personal growth. Furthermore, teaching the SAM to create and independently link up to social support networks may

improve her daily life and parenting skills. Finally, teaching the SAM to connect with people in similar circumstances may expand her resources and friendships. Consequently, didactic group intervention may increase the SAM's social networks and assist her adaptation to parenthood.

Group work was selected as the treatment of choice because of the opportunity it presented to capitalize on the natural momentum of the adolescent stage of social development. Erikson (1980) observed the peer group as an opportunity for teens to support each other as they tested out new concepts, roles, patterns of behaving and relationships (Garbarino, 1985). In addition, a group experience offered the adolescents an opportunity to meet many of the needs related to psychological growth within a social setting appropriate to their developmental stage.

2.3 Social Groupwork

For the purpose of this practicum, group work was defined as:

> "Goal-directed activity with small groups of people aimed at meeting socio-emotional needs and accomplishing tasks. This activity was directed to individual members of a group and to the group as a whole within a system of service delivery" (Toseland & Rivas, 1995).

Klein (1972) defined group work as:

> "a method of helping people through a group experience... a form of social helping directed toward giving people a constructive experience of membership in a group so that

> they are able to develop as persons and be better able to contribute to the life of the community... a group is a social system consisting of two or more people who are in face-to-face interaction at both the cognitive and psychic levels within which the people perceive that they belong to the group" (p.26).

The above definitions highlighted several important aspects of group work. Labeling group work as 'a method' and 'a form' of social helping implied that this type of social work practice involved purpose, planning, and direction, based on some identifiable body of theory.

2.4 Theoretical Orientation

Several factors historically contribute to the success of group intervention (Yalom, 1985) for the SAM. These factors, not in any ranking order of importance, are as follows:

1. Universality

Universality aids the SAM in realizing that she is not alone in her situation through sharing and discussion. "Universalizing issues and needs facilitates group bonding and breaks down the barriers of social isolation... as a result, new behaviors, and new modes of communication can be mastered in a reliable setting" (Cervera, 1989).

2. Installation of Hope

Group treatment allows the SAM to help others by being supportive, offering peer feedback from her personal experiences, providing useful information and learning about herself through the experiences of others (Toseland & Rivas, 1995).

3. Imparting of Information

Group treatment serves an educative role. The group provides members with various opportunities to test new skills and rehearse new behaviors in a "safe" environment (Toseland & Rivas, 1995). Information may come in the form of advice, suggestions or direct guidance offered by either the facilitator or other group members.

4. Development of Socializing Techniques

For the SAM who lacks intimate social relationships, the group may serve as her first opportunity for interpersonal feedback. This process provides each member with the opportunity to learn empathy, patience, and interaction skills.

5. Altruism

A member beginning treatment often has low self-esteem, believing she has nothing of importance to offer the group. By learning she is capable of helping others, her self-esteem and sense of empowerment increases. Members can assist one another by offering support, suggestions, reassurance, insights or sharing similar problems.

6. Corrective Recapitulation of the Primary Family Group

Members often enter therapy groups with unresolved histories and issues from their familial group. In such situations, the therapy group can help correct the maladaptive growth-inhibiting relationships from previous family life, to enable the individual to continue growing and learning from intimate relationships.

7. Imitative Behavior

Members may model themselves after group members or the group facilitator. This may function to assist the individual in experimenting with new behaviors and roles.

8. Interpersonal Learning

Group treatment fosters the opportunity for SAM's to develop healthy interpersonal relationships. By connecting with other young women in similar situations, as well as the facilitator, SAM's may be able to develop more appropriate social skills.

9. Group Cohesiveness

Groups promote a sense of solidarity, "we-ness" or "groupness" (Toseland & Rivas, 1995). Group membership, acceptance and approval are of the utmost importance in the development of the individual (Yalom, 1985).

2.5 Summary

Adolescence is a time of searching for an identity and developing a system of values that will influence the course of one's life. One of the most important needs of this period is to

experience successes that will lead to a sense of self-confidence and self-respect. Adolescents need to recognize and accept the wide range of their feelings, and they need to learn how to communicate with significant others. Group experiences can be very useful in dealing with these feelings, as well as in assisting adolescents make constructive life choices. Moreover, it provides a forum in which adolescents can express and experience their conflicting feelings, discover they are not unique in their struggles, openly question their values, learn to communicate with peers and adults, and learn how to accept what others offer and give of themselves in return. Groups provide a place in which adolescents can safely experiment with reality and test their limits, help one another in the struggle for self-understanding, and express themselves both verbally, as well as through interaction with their peers.

CHAPTER 3

CONTEXT, INTERVENTIVE METHODS, AND EVALUATION PROCEDURES

3.1 Setting

The mission of the Adolescent Parent Centre is the overall improvement in the quality of life for the adolescent mother and her child, academic achievement, and graduation. Promoting parental competence is the objective of the program. The school fulfills its mission by providing compulsory parenting and nutrition courses, offering academic courses, creating a nurturing environment, establishing goal setting for future independence, fostering responsible decision-making and having on-site community services, such as Child Guidance Clinic, Child and Family Services, Public Health and Social Assistance. The program operates out of the Winnipeg School Division #1. Enrollment is approximately 135 young women whose age ranges from 12-21, plus 70 babies. Approximately three hundred young women utilize the program each year. The school provides laboratories for the young women to learn hands-on parenting skills, and provides childcare while the young women are in class. Students can remain in the program until age 21 or until their child is two years old; once their child reaches age 2, younger students can continue to attend until age 21 if they find alternate childcare. The program is designed as a holistic approach to the problems facing adolescent pregnancy/ parenthood. Although the current program is comprehensive in nature, a void exists in the area of teaching students the skills necessary to independently access social support networks.

3.2 Group Recruitment

The writer posted a memo (Appendix B) and interviewed all interested participants to explain the nature, purpose, and time commitment of the group. Students were then requested to complete a consent form (Appendix C), a prescreening interview questionnaire (Appendix D), and two measures the Perceived Social Support- Friend Scale (PSS-Fr)/ The Perceived Social Support- Family Scale (PSS-Fa) (Procidano & Heller, 1983) (Appendix E) and the Social Support Appraisal Scale (SSA) (Vaux, Phillips, Holley, Thompson, Williams & Stewart, 1986) (Appendix F). The administration and purpose of the standardized measures are discussed in subsection 3.4.

The pre-group interview process involved defining the purpose of the group, a discussion on previous group experience, feelings about participation in this group, and expectations of the group. Moreover, during this process, more detail was provided on the role of the facilitator and confidentiality.

The following were the inclusion criteria listed on the posted memo:

1. First-time mother with an uncomplicated perinatal experience who delivered a healthy, term newborn baby.
2. Age range of 16-19 years inclusive.
3. Children less than 1 year at the commencement of group.
4. Student at the Adolescent Parent Centre.

3.3 Practicum Committee and Supervision

The practicum committee consisted of Dr. Don Fuchs, Dean of the Faculty of Social Work, Ms. Kim Clare and Mr. Don Lugtig from the Faculty of Social Work and Ms. Thelma Wood from the Adolescent Parent Centre.

Clinical supervision was provided primarily by Dr. Fuchs on a bi-weekly basis. File recordings and a video tape of each session were supplied to Dr. Fuchs and were thoroughly reviewed during supervision sessions throughout the intervention phase of the practicum.

3.4 Evaluation

The group was evaluated by a group record form which allowed the writer to monitor the group's progress from session to session, and by client logs which allowed individuals in the group to monitor their feelings and behaviors throughout the group process.

To measure social support, the PSS- Fr/ PSS- Fa and the SSA were utilized. The PSS- Fr and PSS- Fa are two 20- item scales designed to measure the extent that one perceives his/her need for support, information , and feedback are fulfilled by friends and/ or family (Procidano et al., 1983). The SSA is a 23 item pre-test/ post-test scale designed to measure subjective appraisal of support. Participants completed the pre-test measures at the end of the initial interview, and the post-test measures during the final group session, to determine the effect group intervention had on the SAM's perception of support from friends and family. The PSS- Fr and PSS- Fa are found to be internally consistent

(Cornbach's alpha- .90); alphas for the PSS- Fa range from .88 to .91 and .84 to .90 for the PSS- Fr. The test-retest reliability also is reported to be high (r=.83 over a one month interval); as well, the PSS measurement is found to be valid (Procidano & Heller,1983). The SSA is said to be internally consistent, with alpha coefficients ranging from .81-.90 and is, as well found to be valid (Vaux et al., 1986).

Actual social support was measured using the Network Diagram and the Personal Networking Assessment Instrument (Maguire, 1991) (Appendix G). These instruments involved three activities in the networking process: identifying, mapping, and linking (Fuchs & Lugtig, 1992). Identifying is described as the process whereby persons recognize the potential for networking in their social networks. This is an information gathering phase where the potential network members are named, their willingness to provide support is discussed, their resources and personal capabilities are listed, and their willingness to provide help or support in deferent situations is determined (Fuchs & Lugtig, 1992, p.51). Mapping is described as a process of charting network ties, including strength of ties, type of relationship and the frequency, duration and intensity of the connections (Fuchs & Lugtig, 1992, p.51). Linking is the goal setting step. Once the network is mapped, one needs to determine if it requires alteration to produce different or better sources of social support (Fuchs & Lugtig, 1992, p.51).

A final method of evaluation was a form on group satisfaction (Appendix H) completed by all group participants at the end of the last session. This form included closed and open-ended questions. The closed-ended questions required group members to record their opinions on a Likert-type scale. This allowed for comparison between members due to

the same scale values being used for all group members. The open-ended questions allowed each group member to reply in a unique manner. The group satisfaction form served as a useful method of evaluation for it provided this writer with written feedback about the group.

CHAPTER 4

PRACTICUM EXPERIENCE AND FINDINGS

4.1 Introduction

This chapter begins with a description of the practicum participants. Following these descriptions is an overview of the two groups which describe in detail the structure, content and process of the interventions.

4.2 Group #1: Overview of Participants and Group Sessions

Thirteen young women were pre-screened for the first social support group. Six of the thirteen adolescents completed the group; seven were unable to complete group due to hospitalization, ongoing personal crises, and truancy. The mean age of participants was 18 years old with a range in ages of 16-19 inclusive. All participants were first-time parents with a child under the age of one year. Four participants lived with extended family, one lived on her own, and one lived in a foster home situation (Table 1).

TABLE 1

GROUP #1: DESCRIPTION OF PARTICIPANTS

Participants	Mother's Age	Baby's Age	Living Sit.
1	18	2 Mths.	Family
2	16	3 Mths.	In Care
3	19	2 Mths.	Family
4	17	2 Mths.	Family
5	19	1 Yr.	On Own
6	19	5½ Mths.	Family

Group sessions occurred weekly for eight weeks with a two week winter holiday break midway through group. The sessions occurred at the Adolescent Parent Centre in one of the classrooms where space, lighting, and seating created a climate of comfort. At the commencement of the group, the length of the sessions were approximately 2 hours with a midway 15 minute nutritional break. By session four, both the writer and the participants decided to extend the group to 2 1/2 hours each session since all were enjoying the opportunity group afforded to share experiences. Consequently, the amount of time initially assessed to adequately cover the topic areas might have been underestimated. Nevertheless, the desire to increase the length of group demonstrated a high degree of motivation and commitment to the group.

A variety of techniques were utilized over the course of the eight sessions. In the earlier sessions, in order to initiate members into the group process and to assist in building group cohesiveness, a variety of "warm-ups" or icebreaker exercises were used. These exercises enhanced the development of trust among the participants and between the participants and the writer. The members seemed to enjoy the warm-ups and the exercises served to reduce tension, increase energy, set a positive tone for the group, and most importantly include everyone. An example of a warm-up exercise was the didactic introduction of members to the group. During the first session, it provided the opportunity for members to share factual information without the discomfort of presenting oneself or disclosing personal data. More structure was used in the earlier sessions to facilitate interaction between members; less structure was required as the group progressed and members' comfort level increased.

Another technique involved subdividing into smaller groups. Generally, group members enjoyed interacting in a dyad or triad, especially during the beginning stages of group when some members perhaps felt threatened to participate. Dividing into smaller groups was an attempt to encourage more interaction between members. This technique presented as very useful during the first half of group where members appeared to be quieter and more reluctant to share in the larger group. Toward the second half of group, members seemed to prefer to discuss issues as one group; this was most likely due to the increased comfort level between members.

Brainstorming was another technique used to generate thoughts and feelings about the meaning of social support, the positive and negative qualities of relationships, and strengthening one's personal network. This technique was very useful in 'normalizing' some of the concepts related to social support, and served to promote discussion and member to member interaction.

Handouts were also utilized to stimulate discussion. Handouts either focused on exercises or provided general information on the sessional topic. One example is the Relationship Roadmap (Lovell, 1991) (Appendix I) that was introduced in session four. This handout prompted an intense discussion about the stages of relationships and the result when stages are omitted. Members reported that the handouts were useful in providing a visual understanding of the concepts and stated they would use them as reference material in the future.

In terms of didactic content, healthy/ unhealthy relationships and positive social support networks were the major focus of group intervention. Mapping support networks using both, the Social Support Map (adapted from Fuchs & Lugtig, 1992) and the Personal Network Assessment Instrument (adapted from Fuchs & Lugtig, 1992) allowed members to visually observe and then share their actual support networks with the group. Group discussion also included the involvement (or lack thereof) of boyfriends or baby's father, abusive relationships, control in one's life, the responsibilities of being a parent, age versus maturity as a parent, and increasing one's social support network.

The content of discussions reflected a series of non-normative events that impacted each member's life. Examples of non-normative life changes were balancing the competing demands of a family with young children (ie. family, school) and shifting dramatically from adolescence to adulthood. Not all of the content, however, reflected negative situations. Some of the SAM's believed that having a child at such a young age was a positive shift in their lives', refocusing them from negative peer groups and habits, such as alcohol and drug use, to greater responsibility such as academic achievement and future goal attainment.

As with most groups, the process changed and developed over the life span of the group. During the first few sessions, the focus was on the joining of members, group expectations/ responsibilities, and the goals and objectives of the group. Although information was shared during the initial meetings, it was narrative in form with mutual aid processes not yet apparent. Group resistance was not evident, however, members presented as extremely cautious about active participation which is common during the

initial stages of group development. Session four seemed to be the turning point, when supportive interaction, intimate sharing, and universality began to occur. For example, a discussion about the qualities of a healthy relationship led to disclosure about personal past and present unhealthy relationships, such as cheating boyfriends and disloyal friends. Session four through six /seven were the working phase of this group, whereby alot of active participation and sharing occurred. For example, members presented as very comfortable to map and share their personal networks, and through sharing, the realization of stronger or weaker supports became obvious. Session seven through eight were the ending phase of this group; members completed sharing their personal networks and discussion focused on ways to increase or strengthen one's network. Session seven included a presentation by the Young Parent's Community Centre, a resource that can serve to increase one's network. Each member was also requested to complete a resource sharing assignment to hopefully increase their awareness of external resources (Appendix J). Session eight involved completion of the post-test questionnaire, as well as the group satisfaction survey. The group terminated with a planned party at the Discovery Zone play centre where the SAM's had the opportunity to interact with each others' children, as well as 'play'.

Although mutual support was evident throughout the group, cohesion seemed low to moderate and a strong bond did not develop between group members. Other than two SAM's who knew each other prior to the group commencement, it does not appear likely that members would continue to connect and provide support following the group's termination.

Participants were requested to journal at the completion of each session, which gave the writer ongoing feedback about members' needs. The feedback and benefit of the social support group was generally positive; the adolescents wrote of the importance for opportunities to meet and listen to peer in similar situations, share feelings and experiences in a relaxed and trusting environment, and develop new friendships. Some of the comments included "the group seems positive and friendly", "it's nice to really know these people in the hallway each day", "it feels good to know I am not the only one with these thoughts and feelings".

4.3 Group #2: Overview of Participants and Group Sessions

Eleven adolescents were pre-screened for the second social support group. Of the eleven, seven young mothers completed the group, two withdrew from the Adolescent Parent Centre, and two withdrew from the group. The mean age of participants was 17 years old with a range in ages of 16-19 inclusive. Similar to group one, all participants were first-time parents with a young child under the age of one. Four of the participants lived with parents, two lived on their own, and one lived on the upper floor of her parents' duplex home (Table 2).

TABLE 2

GROUP #2: DESCRIPTION OF PARTICIPANTS

Participants	Mother's Age	Baby's Age	Living Sit.
1	18	2 Mths.	Family
2	17	11 Mths.	Family
3	17	2 Mths.	Family
4	18	6 Wks.	Family
5	18	1 yr.	On Own
6	18	8 1/2 Mths.	On Own
7	16	7 Mths.	Family

Group sessions occurred weekly for eight weeks, with a one week break midway in group. The group was conducted at the Adolescent Parent Centre in the same classroom as group one. Once again, this environment proved conducive to group learning. All sessions were approximately 2 1/2 hours in duration with a midway 15 minute nutritional break.

Similar techniques from group one were used in group two, with the addition of a felt board to assist the adolescents in mapping and understanding their social networks. Each SAM was given the opportunity to describe her network using felt people to represent positive or negative relationships. SAM's were able to map their actual networks and their ideal networks. The categories used were the same as those outlined in the social network mapping exercise (refer to Appendix G). This tool proved beneficial, as it allowed for creativity and a visual display of one's personal network. The feltboard mapping also served to assist the facilitator and group members to better understand the network of their peers.

Group two presented as an extremely cohesive and verbal group, willing and able to interact and discuss highly sensitive and personal issues throughout all 8 sessions. Common resurfacing issues included controlling and unsupportive mothers, absent fathers, and abusive relationships.

Similar to group one, group two's process changed and developed as the session progressed. Unlike group one, group two's cohesion and bonding formed early and was strong. The beginning phase of group focused on the joining of members, group expectations/ responsibilities, and the goals and objectives of the group. During session

one, all members seemed interested and open to sharing and learning from one another. Group cohesion began to develop as early as session one with minor personal disclosure and a high level of participation. The group began to assume group responsibility as early as session two, for example, when they decided to share in snack duty. Member to member connections began to form, and mutual support increase. For example, when a SAM was asked to care for her fussy baby during group, another SAM was quick to assist in the calming process. By session three, the group seemed cohesive and there were many interactions between members. The working phase, sessions three to seven, involved discussions about positive and negative personal experiences. The group responded well to the Relationship Roadmap (Lovell, 1991), outlining how their relationships fit on the map. For example, some SAM's learned that healthy relationships need time to develop and that transition from an acquaintance to a partner in a matter of days or weeks is not healthy. Like group one, group two completed the network mapping exercises and began to understand their network more fully. Group two also enjoyed the presentation by Mary Ann, from the Young Parents Community Centre during session seven; the adolescents thought the resource was a good introduction to their personally lacking external supports. Session eight once again involved the completion of the post-test questionnaire and the group satisfaction survey. The group, as well, ended with a planned visit to the Discovery Zone play centre which was once again enjoyed by all.

All sessional feedback from group two was extremely positive. Once again, the SAM's thought the group was a supportive environment where they could share their experiences and feelings. Some comments from group two included "thanks for listening to my story",

"the group has introduced me to new friends", "it's nice to know I'm not alone", "I'm so glad I decided to join group... I was unsure at first".

4.4 Overview of the Social Support Group Interventions

Shulman and Gitterman (1986, p.9) defined a group as "an enterprise in mutual aid, an alliance of individuals who need each other, in varying degrees, to work on certain common problems". Rosenberg (1984, p.181) added that "the main thrust of the support group constitutes the development of cohesion and the enhancement of self-esteem, which in turn produce better coping patterns in society". In both groups, although all members were different chronological and maturational, various educational backgrounds, and with different life experiences, they "were all in the same boat"; SAM's with young children trying to further their skill level and education and make the best for both themselves and their offspring. Homogeneity of purpose and certain personal characteristics helped facilitate communication, for members could identify with each others' concerns, problems, and tasks of parenthood (Toseland & Rivas, 1995). In terms of heterogeneity, members' ages, their childrens' ages, their educational levels, and living situations all varied. This allowed for the younger parents to learn from the experiences of the older members. Furthermore, this facilitated mutual aid because there was a range of experiences and coping skills from which members drew from. It also allowed members to compare their situations and skills which although was slightly threatening, also facilitated learning (Toseland & Rivas, 1995). For example, several group discussions focused on baby's father or boyfriends which allowed the SAM's to learn more about healthy relationships.

Both of the social support groups were closed groups which according to Toseland & Rivas (1995), created greater cohesion and sense of stability. Both groups were also voluntary in nature, allowing participants the option of terminating from the group at any time. Pre-screening group members and reviewing the group purpose and goals with potential participants was also an important process; "recognizing the reasons members join a group is a powerful way of building strong healthy groups" (Dimock, 1983, p.21).

Shulman and Gitterman (1986) note that it is often difficult for a group to engage in change and growth without a group facilitator. The writer served as the group facilitator for both social support group interventions. In terms of leadership style, the writer assumed a 'democratic style' (Posthuma, 1989) where a safe environment was created within which group members felt free to express their views, thoughts, and feelings without fear of rejection or ridicule. Members were encouraged to be themselves, deal with their issues through problem solving, and assume responsibility for the direction and functioning of the group.

To be an effective group facilitator, it is necessary to emulate certain qualities, such as genuineness, honesty, trust, acceptance, and empathy. This writer feels she conveyed affirmation, understanding, and caring for all group members and their concerns without becoming enmeshed in their issues or problems. For example, if a SAM did not show for group, a follow-up phone call would be attempted to ensure all was well. Awareness of strengths, weaknesses, and fears and having an internalized personal belief system about helping and using groups as a medium for change also prove to be positive skills in a facilitator (Anderson & Robertson, 1988). Throughout both groups, this writer learned to

follow an agenda, as well as abandon it and go with the 'here and now' issues; moreover, being herself and self-disclosing where appropriate allowed the SAM's to connect with the writer on an individual level. Understanding one's role as a group leader, role modeling positive behavior, and promoting communication also assists positive group functioning (Garvin, 1987; Rosenberg, 1984). Personal sharing further allowed the SAM's to identify with and develop insight into the personality and behavior of an important adult model; following the group responsibilities and simply enjoying the group were other behaviors this writer modeled.

Throughout both groups, several linkages were observed. The first link was 'the member-to-facilitator' connection. From the initial pre-screening meeting, members attempted to connect with the writer and the writer to each member. The writer served to encourage members to exercise their own power and take responsibility for themselves and for the functioning of the group as a whole. The writer facilitated group and individual efforts to achieve desired goals. The mapping exercises allowed the facilitator to connect on an individual basis with each member.

The second link was 'the member-to-member' connection. At both groups' commencement, the primary facilitator role was to assist members identify themselves as a collectivity of supportive partners working toward a common goal (Toseland & Rivas, 1995). Members in both groups seemed to be comforted by the familiar; they all soon realized through group sharing that they were not alone with their concerns or issues. Overtime, both groups were able to share commonalties, and respect individual differences.

The third and final link was the member-to community connection. For both groups, the SAM had poor linkages to community resources. The consequent link to Mary Ann from the Young Parents Community Centre was then established and each group member was also given a copy of a resource handbook specifically designed for young single parents.

4.5 Analysis of Test Scores

An important concept in social networks is perceived support, which is the extent one subjectively expects support from relationships with network members (Thompson, 1995). Cobb (1976) defines perceived social support as "information leading the subject *to believe* that he/she is cared for and loved, esteemed, and a member of a network of mutual obligations". Subjective perceptions of support are critical for psychological well-being and assist in appraisals and coping with stress (Procidano & Heller, 1983). Perceived support may be more significant than actual support in predicting the extent that contact with network members buffers stress (Barrera, 1986; Whitman et al., 1991); coping with stress may depend more on one's expectations that support is available and accessible than on the past instrumental actions of social network members or the individual's actual utilization of network resources (Barrera, 1981; Procidano & Heller, 1983; Vaux et al., 1986). In fact, "knowledge of people's subjective appraisals of the adequacy of support is more critical to the prediction of their well-being than simply collecting information about the number of supporters or the quantity of supportive behaviors to which they have access" (Barrera, 1981). Consequently, it is important to analyze one's perception of support as well as one's actual supports during social support

group intervention, for both types of support seem to play a critical role in one's well-being.

An individual's perception of support of others may not always accord with the helpers' efforts or actions. For example, the mother who urges her pregnant daughter to quit smoking and eat nutritiously to advance her and her offspring's well-being may be perceived as unsupportive by the pregnant daughter. This example identifies that one's perception of social support may not always be a valuable index of the intended or actual support of network members.

The Perceived Social Support-Friend Scale (PSS-Fr)/ Perceived Social Support-Family Scale (PSS-Fa), as well as the Social Support Appraisals Scale (SSA) were utilized to evaluate change in the perceived social networks of the participants over the course of both group interventions. Participants completed the pre-test during the pre-screening interview and again during the last group session. To ensure the interventions were responsible for change, comparison SAM's completed the pre and post test measures, but were not part of the intervention groups.

After review of the pre and post test data from both groups and comparison SAM's, it appears that most SAM's perceptions of social support of friends were high and family were moderate (Tables 3-8). This is consistent with normal adolescent development where adolescents perceive their peers as more dominant and supportive in their lives than family. Ironically, most of the SAM's indicated in group that their friendships decreased when they became pregnant and subsequent parents, which seems to contradict their

moderately high response scores of perceived support. Similarly, although SAM's scored their familial support as generally moderate, their verbal accounts of familial support during group were quite low.

In analyzing the pre and post test scores on both the PSS-Fr/ PSS-Fa and the SSA for both social support groups, as well as the control group, marginal differences between pre and post scores were noted. This writer believes this may be due to several factors. First, although the groups provided the SAM's with new information and skills with respect to social support, internalizing these new cognitive skills into practical behavior is a long-term conscious commitment that extends beyond the course of the group intervention. For example, it takes approximately 3-4 months to develop a friendship and approximately another 6 months to a year to increase that relationship into a personal friend or partner (Lovell, 1991). Consequently, the group experience exposed members to basic information that increased their knowledge about social networks, however, it may take months or perhaps years of conscious self-awareness for SAM's to develop or increase healthy relationships, terminate unhealthy connections, or strengthen personal networks to the desired level.

Second, several limitations exist with the PSS-Fr/ PSS-Fa and SSA measurement scales. Since neither scale clearly defines the term 'friend' or 'family', each subject may have had a different personal definition of the terms. Moreover, cultural differences may have affected the results; for example, the aboriginal culture strongly values the extended family in everyday life. Furthermore, the language of the PSS-Fr/ PSS-Fa and the SSA scales may have been too complex for the SAM's since they were tested by the authors on

college students. The intellectual, comprehension, and educational levels of the SAM's may also have affected the study's results although all subjects were assessed for literacy during the prescreening interview. Finally, the limited response categories of the scales, specifically, the lack of a 'sometimes' category on the PSS-Fr/ PSS-Fa questionnaire, and a lack of a 'neutral' column on the SSA measurement, may have restricted response choices and led to responses that did not reflect actual beliefs.

In reviewing the pre and post test data on both measurements, no trends were observed, however, some changes were noted on individual scores which deserve mention.

In group one, participants 1, 2, 5, and 6 reported a decrease in scores on the PSS- Fr scale, and participants 1, 4, and 5, and 6 reported a decrease in scores on the PSS- Fa measurement when comparing the pre and post test results (Table 3). Experiencing a decrease in perceived social support at the termination of group could be due to the increased awareness of poor support from families and friends. Moreover, many of the SAM's described wanting changes in their personal networks, such as seeking friends with more life issues in common; the decrease in scores may be attributed to SAM's beginning this process of change. Participant 2 reported an increase in perceived family support which may be due to her move from her foster home placement to her biological family home during group and attempts to rekindle more intense connections. Participant 4 reported an increase in perceived friend support and participant 3, an increase in both scores, perhaps due to group intervention; both participants may have sought more supportive relationships once they acquired further skills and knowledge through the group intervention.

In reviewing the individual scores on the SSA measurement for group one, only data for participants 3 and 5 seemed consistent with the above findings (Table 4). Consequently, although the reliability and validity of the tools were found to be fair, as mentioned in the literature review, the variability of data when comparing the two scales to each other, may lead one to rethink and reanalyze.

In group two, participants 1, 2, 6, and 7 reported an increase in scores on both the PSS-Fr and PSS- Fa post test measurement; perhaps their perception of overall support increased from informal knowledge about social supports. Participant 4 demonstrated a marginal decrease in both post test scores perhaps distinguishing positive support from her situation after repeated exposure and education during group. Participant 3 showed an increase in her perceived friend score perhaps due to new friends she met through group and a significant decrease in her perceived family score perhaps due to her comparing the support she received with that of her group members. Participant 5 reported a dramatic decrease in her perceived friend score perhaps due to a move into a new neighborhood during group and no change in her perceived family score (Table 5). All participants, except for participant 5, reported a decrease in their SSA post test scores (Table 6) indicating a greater subjective appraisal of social support. This writer believes this may be due to various reasons. First, as reported in the practicum, group two was more cohesive than group one, with each member assuming a responsibility for overall group functioning and learning. The facilitator-to-member connection and member-to-member bond were also both stronger in group two; building new friendships may have contributed to a stronger perception of social support. Second, the facilitator gained skills about

groups by running the first group and was able to utilize these skills to create a better group atmosphere during the second group. Finally, different techniques used during group two, such as the feltboard, may have played a greater role in members' perception of supports. The added feltboard tool was a strong tool in visually mapping out actual supports which may have contributed to participants' positive beliefs about the supports in their lives', thereby leading to post test scores in the desired direction.

TABLE 3

GROUP 1

PERCEIVED SOCIAL SUPPORT FRIEND/ FAMILY SCALE: PRE/ POST TEST

	Perceived Social Support - Friends		Perceived Social Support - Family	
Participant	Pre-test	Post-test	Pre-test	Post-test
1	14	8	12	7
2	14	12	5	8
3	13	14	12	15
4	12	13	16	12
5	8	6	18	16
6	19	17	20	19
*7	5	17	10	17
*8	19	16	12	12
**9	1	0	6	7
**10	15	12	12	7
**11	8	7	3	6
***12	9	-	6	-
***13	3	-	14	-

* completed more than 1/2 of group

** completed less than 1/2 of group

*** truant

TABLE 4

GROUP 1

SOCIAL SUPPORT APPRAISALS SCALE: PRE /POST TEST

Participants	SSA Pre-test			SSA Post-test		
	total sc.	fr. score	fam. sc.	total sc.	fr. score	fam. sc.
1	46	14	17	46	14	16
2	48	11	19	54	16	21
3	41	14	12	33	7	12
4	36	10	14	41	13	14
5	52	21	11	54	22	15
6	38	11	12	38	13	9
*7	57	26	12	36	12	11
*8	44	13	16	43	12	15
**9	51	20	17	51	19	14
**10	37	10	13	52	16	20
**11	58	19	19	50	16	17
***12	55	14	22	-	-	-
***13	55	20	12	-	-	-

* completed more than 1/2 of group

** completed less than 1/2 of group

*** truant

TABLE 5

GROUP 2

PERCEIVED SOCIAL SUPPORT FRIEND /FAMILY SCALE: PRE /POST TEST

	Perceived Social Support - Friends		Perceived Social Support - Family	
	Pre-test	Post-test	Pre-test	Post-test
1	10	16	1	1
2	17	18	18	19
3	16	19	17	4
4	15	14	14	13
5	14	4	1	1
6	9	14	12	15
7	14	15	1	2
*8	16	-	18	-
**9	13	-	3	-
***10	8	-	16	-
***11	7	-	7	-

* completed less than 1/2 of group

** withdrew from school program

*** truant

TABLE 6

GROUP 2

SOCIAL SUPPORT APPRAISALS SCALE: PRE POST TEST

Participants	SSA Pre-test			SSA Post-test		
	total sc.	fr. score	fam. sc.	total sc.	fr. score	fam. sc.
1	59	17	22	52	14	21
2	27	7	9	26	7	8
3	40	13	13	37	10	13
4	47	14	16	45	14	15
5	45	8	20	69	22	20
6	46	13	16	43	11	15
7	64	16	27	57	9	28
*8	41	-	-	-	-	-
**9	58	-	-	-	-	-
***10	36	-	-	-	-	-
***11	47	-	-	-	-	-

* completed less than 1/2 of group

** withdrew from school

*** truant

TABLE 7

CONTROL GROUP

PERCEIVED SOCIAL SUPPORT FRIEND /FAMILY SCALE: PRE /POST TEST

	Perceived Social Support - Friend		Perceived Social Support - Family	
	Pre-test	Post-test	Pre-test	Post-test
1	12	17	12	12
2	7	8	13	7
3	18	17	3	3
4	15	18	18	19
5	17	20	19	20
6	11	13	11	18
7	14	18	11	18
8	10	13	7	5

TABLE 8

CONTROL GROUP

SOCIAL SUPPORT APPRAISALS SCALE: PRE /POST TEST

Participant	SSA Pre-test			SSA Post-test		
	total sc.	fr. score	fam. sc.	total sc.	fr. score	fam. sc.
1	37	11	12	38	11	13
2	41	14	15	46	14	16
3	39	7	24	35	8	17
4	45	14	13	47	13	15
5	36	12	10	33	12	10
6	41	10	14	36	12	11
7	40	13	14	29	7	11
8	62	16	24	58	16	22

4.5.1 *Statistical Analysis*

A repeated measures multivariate analysis of variance (repeated measures manova) was performed on the SSA family, SSA friends, PSS- Fa, and PSS- Fr. Additionally, a total score on the SSA was calculated, combining family and friends measures.

The group means for pre and post test measures are depicted in figures 1 through 5. There were no significant differences found between the group means (Table 9).

In referring to the PSS- Fr graph (Figure 1), group means represented an increase in social support for group two, as compared to group one and the control group. Once again, these findings are suggestive of the effectiveness of group intervention perhaps due to the high group cohesion, an increase in group facilitation skills, and overall learning with respect to healthy relationships and the important role of social support. In contrast, the PSS- Fa group means indicated a decrease in perceived social support for both group one and two when compared to the control group (Figure 2). These findings may suggest, once again, that the group experience heightened members' awareness of the lack of supportive relationships within their families.

Significant and subtle decreases were noted in the means of group two on the SSA family/ friends graphs respectively (Figures 3 & 4) when the member's score were compared to the control group. This may perhaps be due to the highly positive response of group two to group treatment; raising members' level of consciousness during group about social support using both visual and written methods seemed to be very effective. Moreover, perhaps group provided members with a greater understanding of the terms utilized in the

FIGURE 1

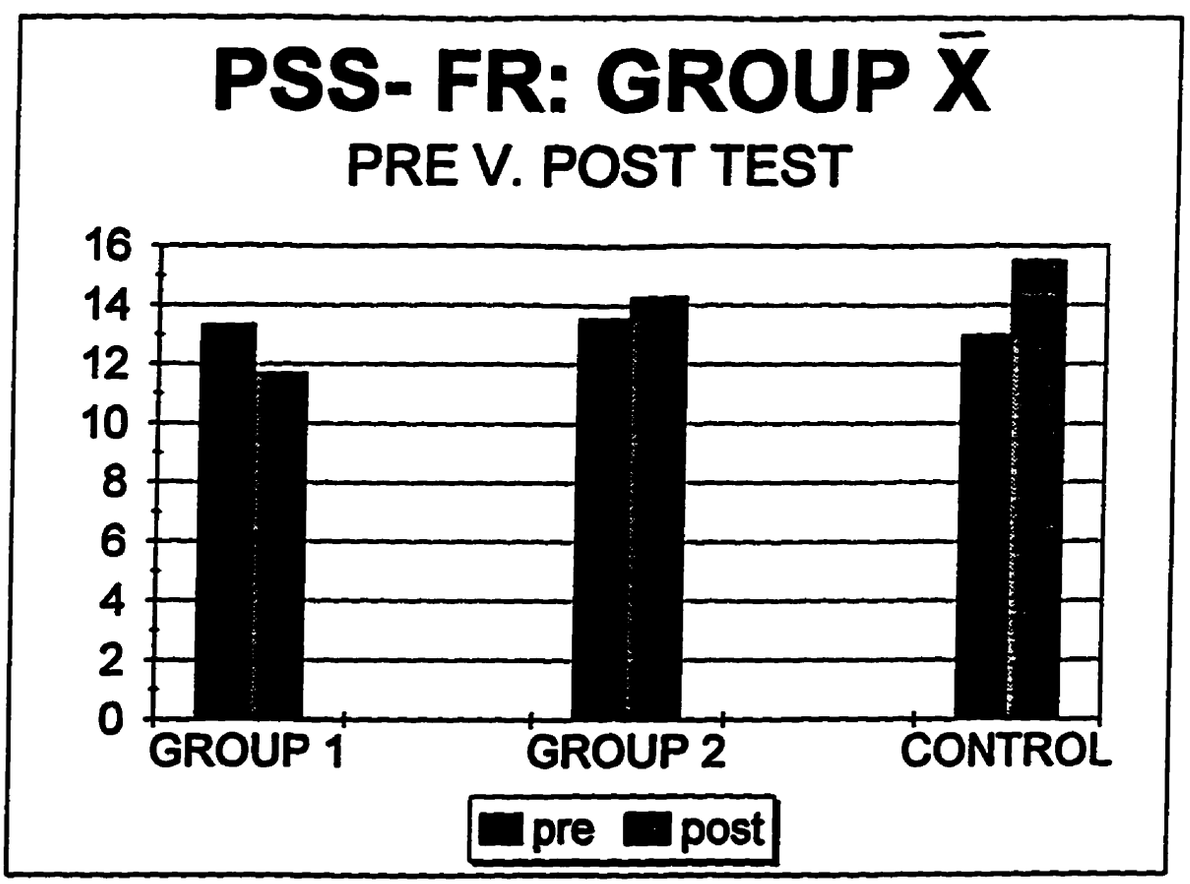

PSS- FR: GROUP X̄
PRE V. POST TEST
16
14
12
10
8
6
4
2
0
GROUP 1
GROUP 2
CONTROL
pre
post

FIGURE 2

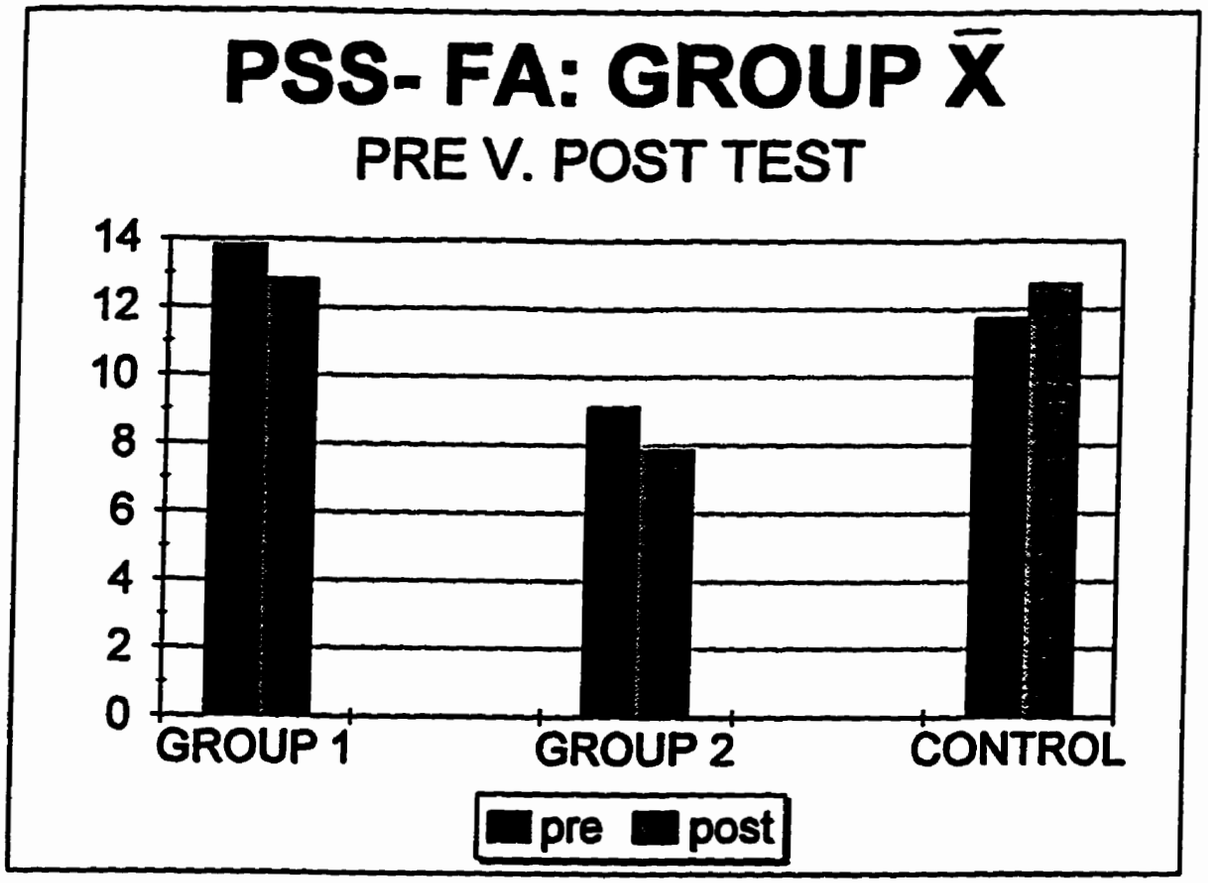

PSS- FA: GROUP X̄
PRE V. POST TEST
14
12
10
8
6
4
2
0
GROUP 1
GROUP 2
CONTROL
pre
post

FIGURE 3

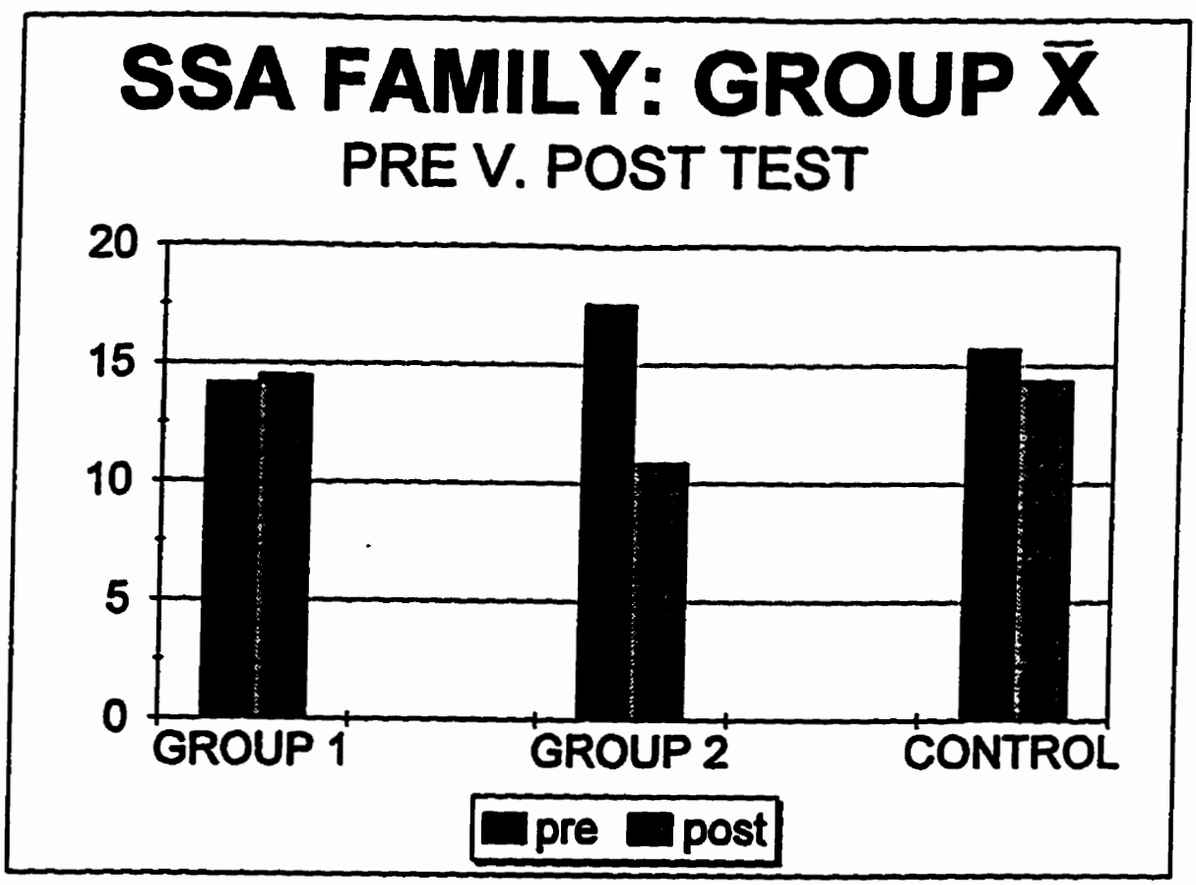

SSA FAMILY: GROUP X̄
PRE V. POST TEST
20
15
10
5
0
GROUP 1
GROUP 2
CONTROL
pre
post

FIGURE 4

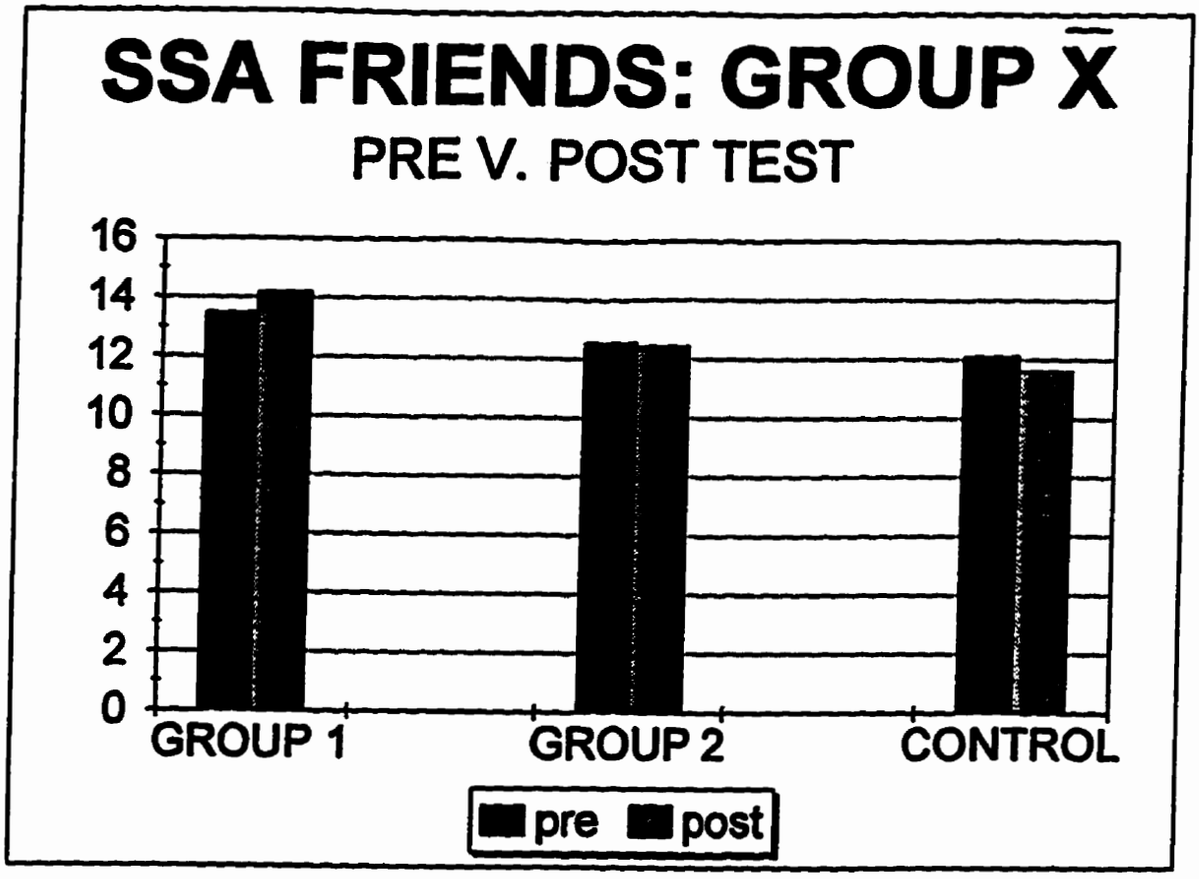

SSA FRIENDS: GROUP X̄
PRE V. POST TEST
16
14
12
10
8
6
4
2
0
GROUP 1
GROUP 2
CONTROL
pre
post

FIGURE 5

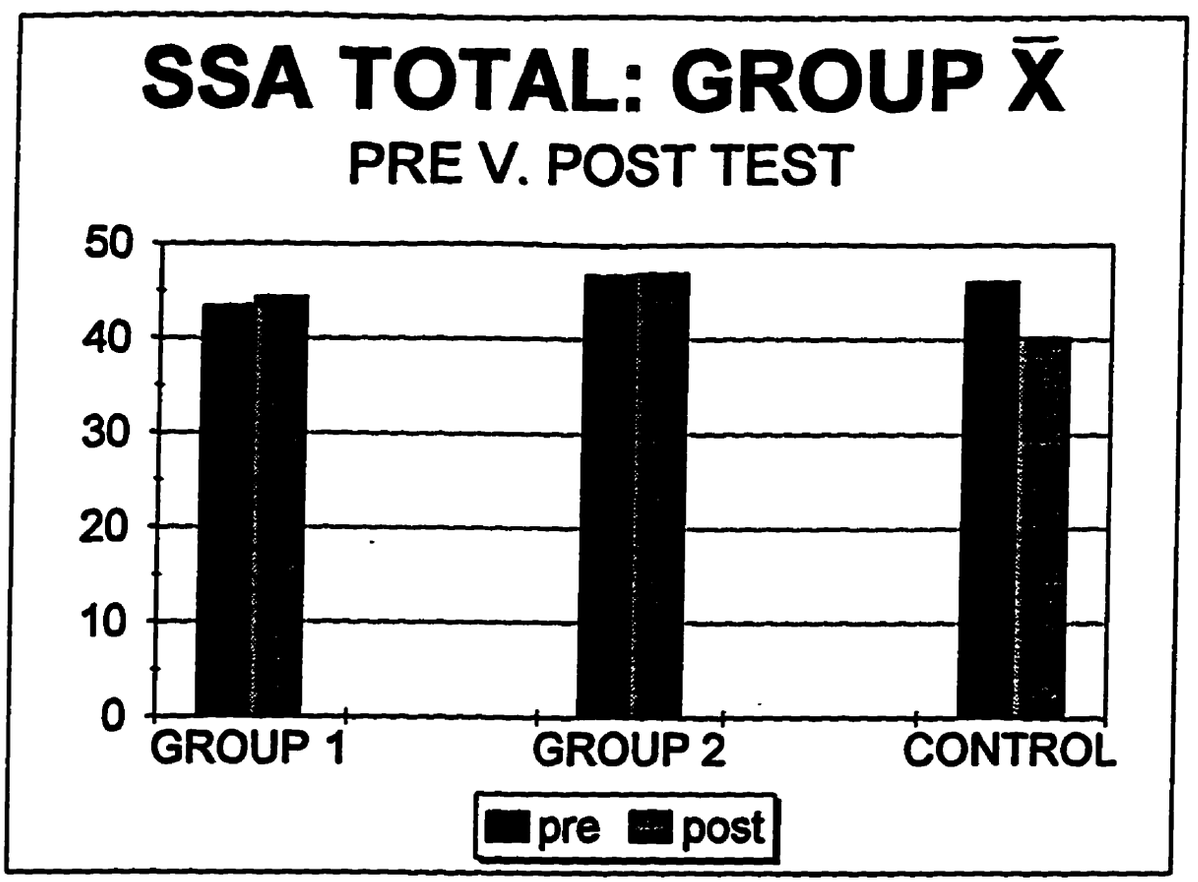

SSA TOTAL: GROUP X̄
PRE V. POST TEST
50
40
30
20
10
0
GROUP 1
GROUP 2
CONTROL
pre
post

TABLE 9 REPEATED MEASURES MANOVA

GROUP	F	DF	PROB. SCORE
SSA Family pre v. post	2.25	2, 18	P ≤ .134
SSA Friend pre v. post	.11	2, 18	P ≤ .897
SSA Total pre v. post	.37	2, 18	P ≤ .693
PSS- Fr pre v. post	2.36	2, 18	P ≤ .123
PSS- Fa pre v. post	.58	2, 18	P ≤ .569

SSA measurement, allowing for a more accurate response during the post test. A weaker subjective appraisal of social support characterized group one's post test data for family, friends, and total group means (Figure 5). This may be due to group one being the first group to undergo the social support group intervention; as well, as previously mentioned, group one did not seem to have a strong member-member or facilitator-member connection as was evident in group two.

4.6 Personal Networking

Personal networking or mapping was utilized to assess the group members' actual supports. The process involved three phases: identification, analysis, and linking (Maguire, 1983).

The primary purpose of the first stage, identification was to create a list of network members and categorize it on the basis of their relationship. There were five important factors to consider, which included: the personal network *size* or number of possible connections which was a tally of those 'willing to help'; *basis of relationship* which involved identifying possible network supports in the spheres of family, friends, neighbors, colleagues, and helpers; *capabilities* which included the network members' ability to provide resources; *resources* such as personal contacts, information, or access to professionals; and *level of willingness* to assist (Maguire, 1983).

In both social support intervention groups, verbal discussions and written exercises such as visual mapping (Fuchs & Lugtig, 1992) were used to identify potential network members. Although a valuable stage in networking, one limitation identified was that little

information with respect to the functioning and closeness of the network relationships was ascertained.

The second and most time consuming phase of personal networking, network analysis, quantitatively and qualitatively assessed the ties in the network to maximize their effectiveness and efficiency (Maguire, 1983). Frequency of contact, in person or by telephone, duration of the relationship, and intensity or the degree of potential helpfulness were the factors considered during this stage. The Personal Assessment Network Instrument (Fuchs & Lugtig, 1992) was utilized to assist each group member to analyze their own social support network and record the supportive (and nonsupportive) functions of their network relationships, such as the types of supports, the reciprocity of relationships, and degree of satisfaction in the relationship. In group two, an exercise was also utilized whereby members were offered the opportunity to map out their support networks using a feltboard.

Linking, the final phase of the personal network process, involved discussions about connecting with a primary network member that was listed in the Personal Network Assessment Instrument (Fuchs & Lugtig, 1992).

Overall, Personal Networking was extremely helpful with both social support intervention groups, for it allowed group members to identify and assess stressors, strains, and current or new resources within their social environment. The process revealed unexpected information for many SAM's, outlining more supportive resources than initially perceived. For example, one SAM in group two believed she had no childcare supports; in the

process of completing her social network map, she was able to identify two people that could assist her with baby-sitting. As well, two SAM's from group two and one SAM from group one connected to the Young Parents Community Centre as a result of the presentations.

Networking also enabled discussion of other pertinent issues during groups, which were helpful in understanding current stressors experienced by the SAM's, such as abusive or controlling relationships. The personal networking exercises served to be empowering activities as they allowed many SAM's to recognize the critical importance of reciprocity within their social support relationships and the steps needed to assure their needs would be met.

Several limitations of personal networking existed, which include the recall bias of self-reported data, data adjustments due to social desirability (Tracy & Whittaker, 1990), and reliability and validity of data (Tracy & Whittaker, 1990). For example, it was difficult to determine "true" network size, for time or the phrasing of questions may have influenced the numbers and types of people potentially included. Another limitation of personal networking was that the process involved the individual as opposed to the total family unit. The map served to provide information about one's personal social network, and omitted the collective impact of personal social networks within the family or group (Tracy & Whittaker, 1990). The overlap or lack of overlap in network maps among different family members may prove to be significant (Tracy & Whittaker, 1990).

4.6.1 *Examples of the Benefits of Personal Networking: The Experiences of 3 Practicum Participants*

The following are experiences of three practicum participants, Brenda (group #1, participant #6), Michele (group #2, participant #1), and Naomi (group #2, participant #4) to highlight common issues in both groups.

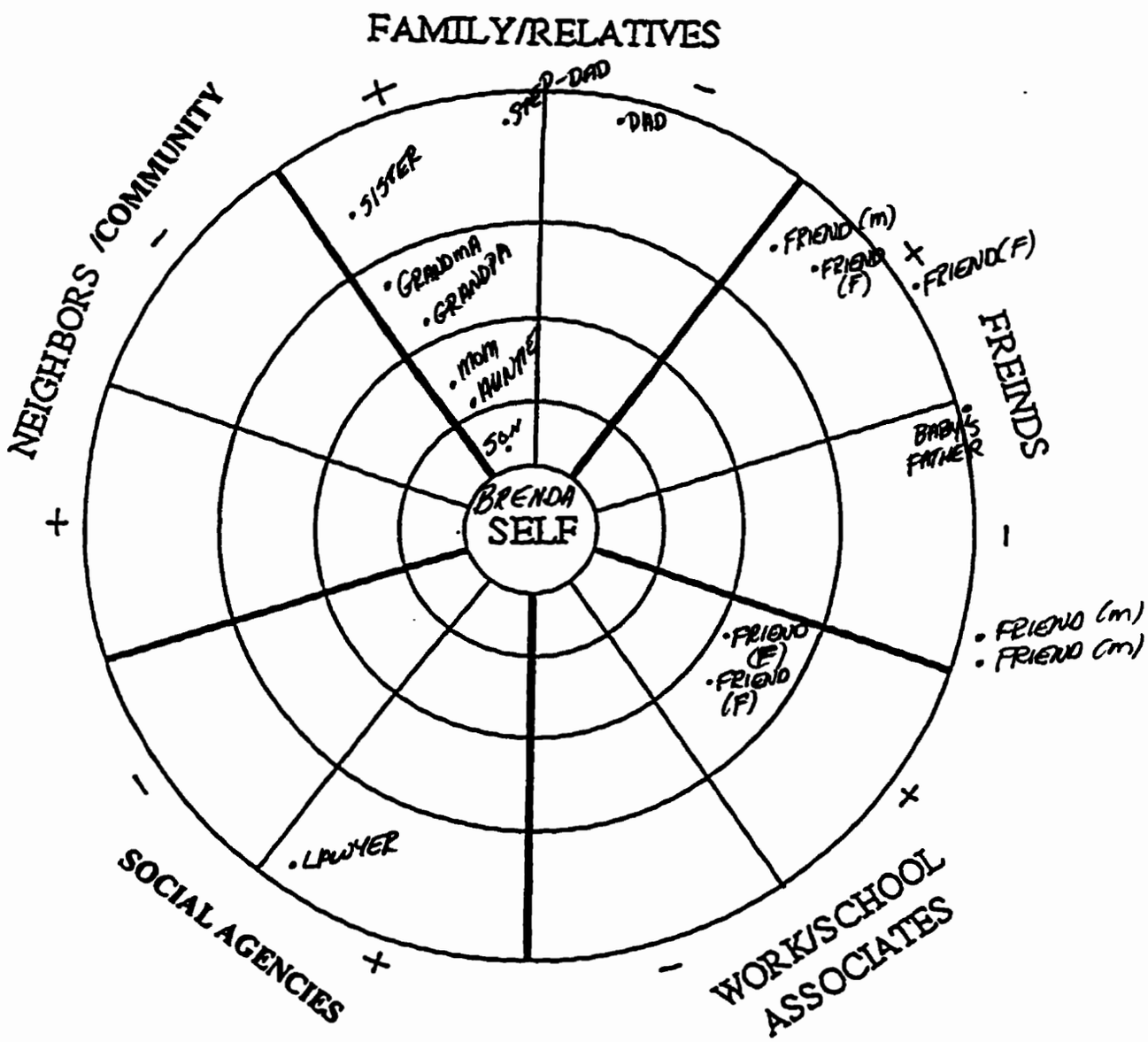
Brenda

Brenda described a moderately sized social network map (Figure 6) comprised predominantly of family members and friends. Brenda expressed dissatisfaction with her network and perceived it as rarely helpful and quite disconnected. She felt her family was instrumentally and emotionally unsupportive, describing a critical, unencouraging and negative mother, particularly about her parenting role and skills, and a tenuous relationship with her father, step-father, and baby's father. Brenda reported losing friends as a result of her pregnancy and included 5 friends in her network with whom she either had no contact for years of wished to sever ties. Developing new friendships was a goal Brenda set for herself during group and was accomplished by attending the Young Parent's Community Centre with a fellow SAM following a group presentation. This plan appeared to be a positive start for Brenda in increasing her peer network.

FIGURE 6: BRENDA

SOCIAL NETWORK MAP

(adapted from Fuchs & Lugtig, 1992)



PERSONAL NETWORK ASSESSMENT INSTRUMENT

(Adapted from Fuchs & Lugtig, 1992)

Parents need help and support from others. Please list 5 people who have assisted you in being a parent in the past six months.

a. initials of helpers					
b. relationships of helpers to you	Mom				
c. where does the helper live? (ie. your household, your street, same neighborhood, outside city)	Same place as my son & I				
d. kinds of support/help you get from each helper 1. listens to your concerns about parenting	No				
2. gives you information and advice about raising and caring for your children	Yes				
3. tells you how you are doing as a parent- both positive and negative	Mostly Negative				
4. babysits your children when you have an appointment or emergency	Sometimes				
5. babysits your children to give you a break	Sometimes				
6. gives you praise and encouragement for your parenting	No				
7. provides you with a model of a good parent	No				
8. lends or gives you food, money, clothes, or transportation	Sometimes				

e. Which helpers know each other? (initials under appropriate column)					
f. Which helpers do you see at least once a week? (place "x" under appropriate column)	X				
g. Which of the above helpers do you help? (place "x" under appropriate column)	X				
h. Which of the above helpers do you count on the most? (list 1-5)					
I. How long have you known each helper?	19yrs.				
J. Degree of satisfaction. How satisfied are you with the help you have received? 1) Very Satisfied V.S. 2) Satisfied S 3) Dissatisfied D	D				

Michelle

Michelle mapped a small network map (figure 7) that she perceived as moderately helpful. Michelle included her baby, parents, 2 friends, and a Child and Family Services worker in her network, with her baby and friends as her positive supports. Michelle reported losing touch with friends as a result of her pregnancy, and explained past friends would be unable to understand her experience, responsibilities at home, current sobriety, and lifestyle choices. Michelle's parents recently separated and although she perceived them as emotionally unsupportive toward her in her map, she listed them in her personal network assessment (figure 8) as the only instrumentally supportive individuals during the past six months.

Michelle's low pre and post test reports of perceived family support were fairly consistent with her report of actual supports. The results of the SSA measure of social support represented a realistic picture of her situation; high pre and post test scores which indicated a weak subjective appraisal of social support from friends and family. Michelle's low-to-moderate score on the PSS-Fr pre-test and moderate-to-high score on the PSS-Fr post-test for perceived friend support seemed inconsistent and unrealistic with her reports of actual friends (two on the personal network map and none on the personal network assessment instrument). Perhaps the increase in the post test score was due to Michelle including friends she had met in group.

On review of her personal network, Michelle expressed an interest in improving her supports, specifically, her relationship with her parents, older brother, and friends.

Improving conversational skills and understanding healthy relationships were two of the goals Michelle set to increase her ties.

FIGURE 7: MICHELLE

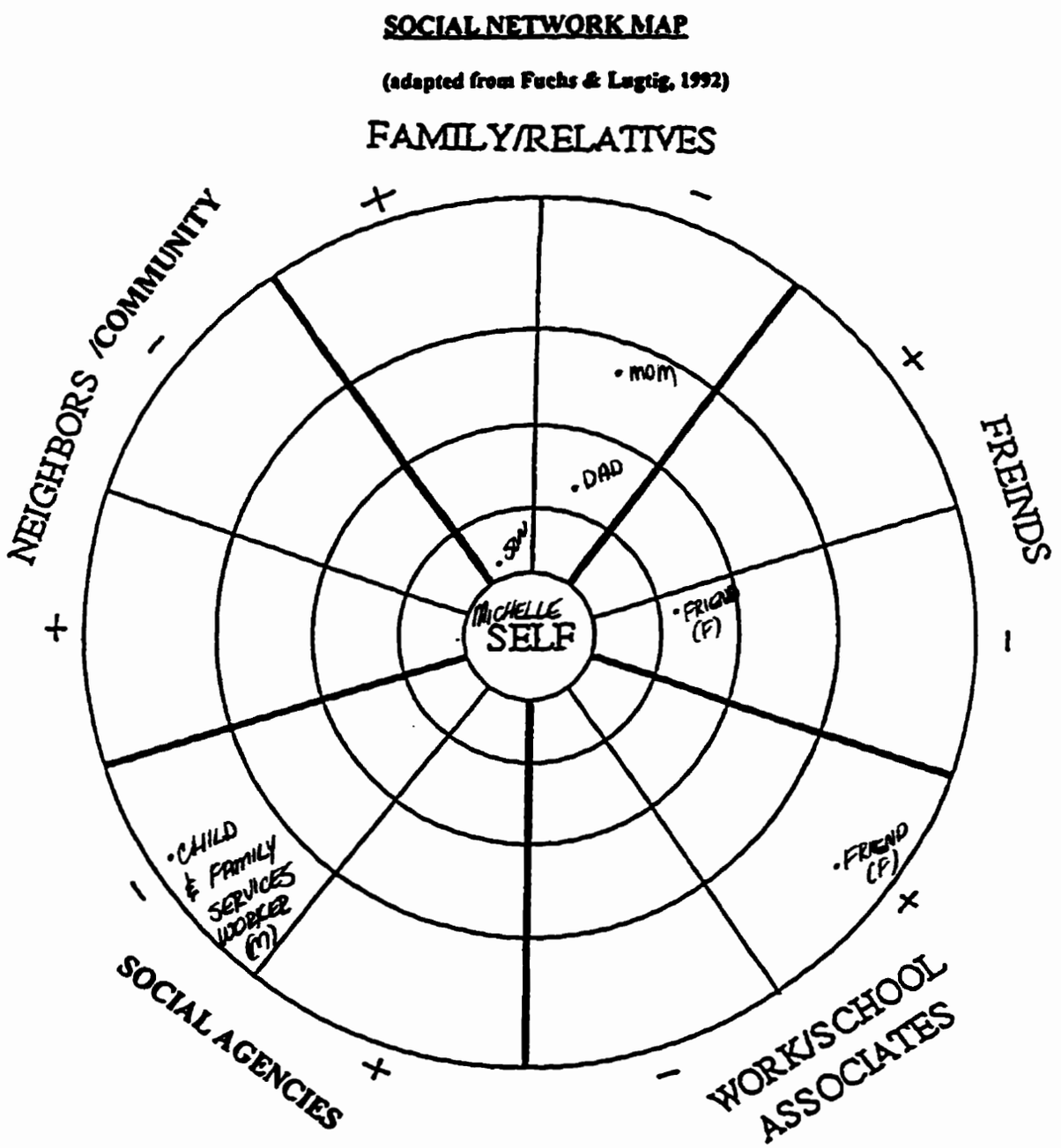


FIGURE 8

PERSONAL NETWORK ASSESSMENT INSTRUMENT

(Adapted from Fuchs & Lugtig, 1992)

Parents need help and support from others. Please list 5 people who have assisted you in being a parent in the past six months.

a. initials of helpers					
b. relationships of helpers to you	Mom	Dad			
c. where does the helper live? (ie. your household, your street, same neighborhood, outside city)	In My House	Outside of city			
d. kinds of support/help you get from each helper 1. listens to your concerns about parenting	No	No			
2. gives you information and advice about raising and caring for your children	Yes	Yes			
3. tells you how you are doing as a parent- both positive and negative	Yes	Yes			
4. babysits your children when you have an appointment or emergency	Once in awhile	No			
5. babysits your children to give you a break	No	No			
6. gives you praise and encouragement for your parenting	No	No			
7. provides you with a model of a good parent	No	No			
8. lends or gives you food, money, clothes, or transportation	Yes	Yes			

e. Which helpers know each other? (initials under appropriate column)	Both each	Know other			
f. Which helpers do you see at least once a week? (place "x" under appropriate column)	X				
g. Which of the above helpers do you help? (place "x" under appropriate column)	X				
h. Which of the above helpers do you count on the most? (list 1-5)	1	2			
I. How long have you known each helper?	forever	forever			
J. Degree of satisfaction. How satisfied are you with the help you have received? 1) Very Satisfied V.S. 2) Satisfied S 3) Dissatisfied D	S	S			

Naomi

In Naomi's social network map (Figure 9), all members listed were reported as positive influences and they included her immediate family, aunt, uncle, three friends, and two neighbors who modeled parenting skills. Like Michele, Naomi reported a loss of friends following her pregnancy, however, she stated it was a positive transition, describing her lost friends as superficial. Naomi described a long school history of difficulties and negative experiences with peer relationships, and stated the Adolescent Parent Centre was the first environment to which she felt connected. In fact, two of the three friendships listed on her network map were initiated at the Adolescent Parent Centre. Naomi described her family as fairly supportive. During group, Naomi described her mother as nurturing, instrumentally and emotionally supportive and overprotective. She also seemed controlling from Naomi's accounts during group discussions. Similar to Michele, Naomi only identified two people, her mother and sister, as supportive during the past few months (Figure 10), the former providing instrumental and emotional support and the latter providing primarily instrumental support (childcare).

Naomi's perception of family and friend support were reported as moderate on all pre/post test measurements. Her scores seemed consistent with her social network map, however, inconsistent with her personal network assessment.

On reviewing of her personal network, Naomi wished to strengthen her existing relationships and increase her circle of friends She seemed apprehensive and anxious about starting new friendships due to negative past experiences and fears of rejection.

Group discussion served to increase her understanding of social interactions and the skills necessary to meet new people.

FIGURE 9: NAOMI

SOCIAL NETWORK MAP

(adapted from Fuchs & Lugtig, 1992)

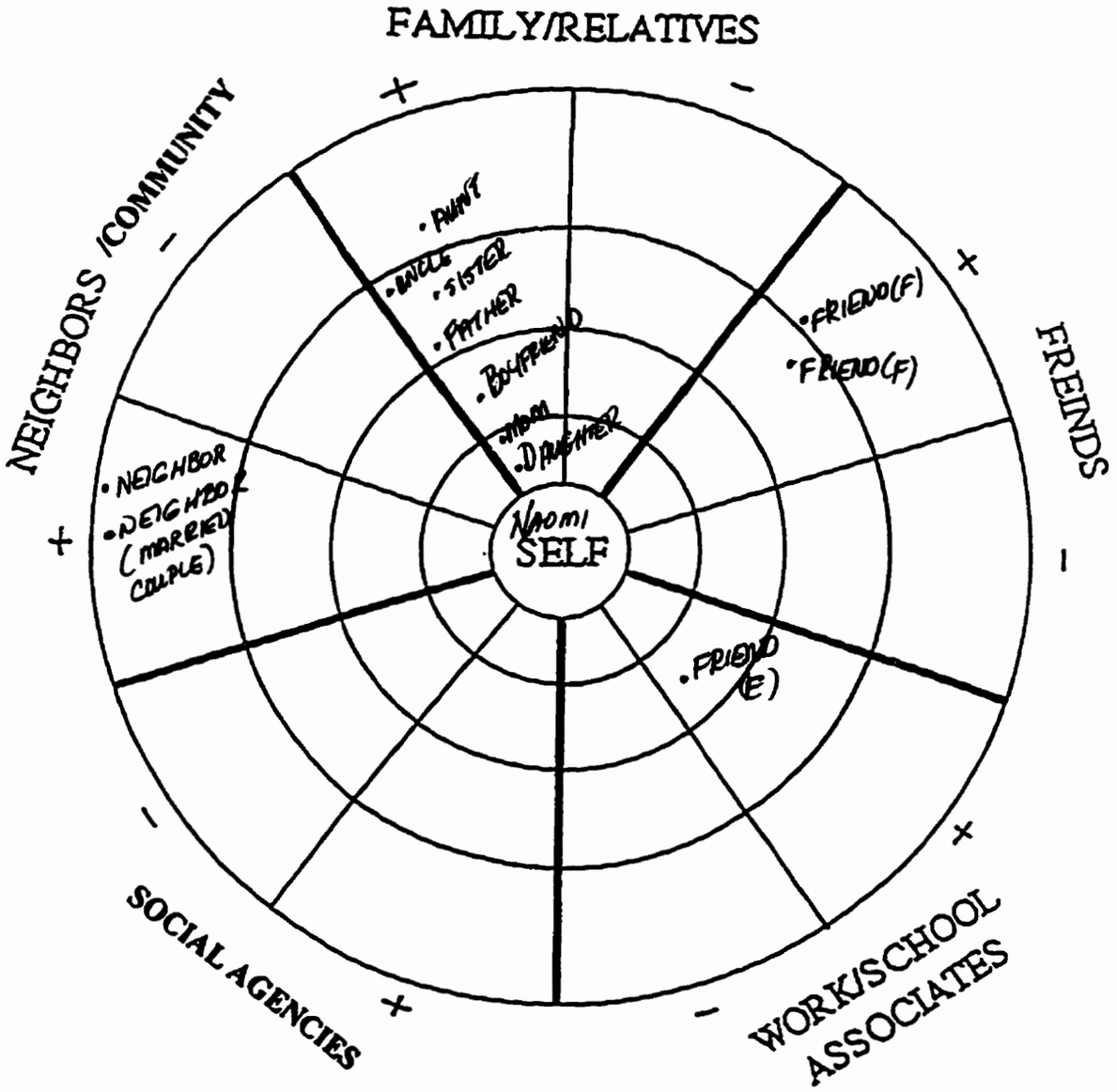


FIGURE 10

PERSONAL NETWORK ASSESSMENT INSTRUMENT

(Adapted from Fuchs & Lugtig, 1992)

Parents need help and support from others. Please list 5 people who have assisted you in being a parent in the past six months.

a. initials of helpers					
b. relationships of helpers to you	Mom	Sister			
c. where does the helper live? (ie. your household, your street, same neighborhood, outside city)	My home	My home			
d. kinds of support/help you get from each helper 1. listens to your concerns about parenting	Yes	No			
2. gives you information and advice about raising and caring for your children	Yes	No			
3. tells you how you are doing as a parent- both positive and negative	Yes	No			
4. babysits your children when you have an appointment or emergency	Yes	Yes			
5. babysits your children to give you a break	Yes	Yes			
6. gives you praise and encouragement for your parenting	Yes	No			
7. provides you with a model of a good parent	Yes	No			
8. lends or gives you food, money, clothes, or transportation	Yes	No			

e. Which helpers know each other? (initials under appropriate column)	Know other	each			
f. Which helpers do you see at least once a week? (place "x" under appropriate column)	X	X			
g. Which of the above helpers do you help? (place "x" under appropriate column)	X	X			
h. Which of the above helpers do you count on the most? (list 1-5)	1	2			
I. How long have you known each helper?	18 yrs.	15 yrs.			
J. Degree of satisfaction. How satisfied are you with the help you have received? 1) Very Satisfied V.S. 2) Satisfied S 3) Dissatisfied D	VS	S			

4.7 Journal Writing

At each group's closure, members used journals to privately monitor their personal feelings and behaviors and share thoughts about peers or the group's functioning with the facilitator without the verbal risks of sharing during group (Appendix K). The journal writing also assisted the facilitator to plan for group sessions, and alter them to reflect members' issues. The facilitator kept the journals from group to group to allow her to respond to any entries; at group termination, all members were given their journals. The majority of journal entries were extremely positive. Commentaries included enjoyment of themes or discussions, comments about commonalties, and connection to fellow members. The journal writing appeared to be a beneficial tool in allowing the SAM's to express themselves.

The benefits of the social support group as perceived by the SAM's was evident from the feedback received through the journal writing. The SAM's confided about the importance of sharing their feelings and experiences in a relaxed, trusting, and accepting environment. The SAM's also wrote about the importance of meeting with women in similar situations; this seemed to reduce feelings of isolation and loneliness when parenting, promote new friendships, as well as allow different ideas and viewpoints to be shared. In their journals, many of the SAM's pleasantly noted that their expectations of group were exceeded during group, not only for the reasons stated above, but also because hidden feelings were forced to the surface and genuine support received from group was appreciated. Some of the SAM's comments were as follows:

* "Everyone shared; we all seem to have alot in common."

* "It's nice not to feel so alone."

* "I really enjoyed the warm-ups; I feel I can trust everyone here."

* "I am really glad I decided to join group."

4.8 Group Evaluation Form

SAM's reported enjoying the group; the majority found the sessions beneficial and some believed their networks improved over the course of the group. Most SAM's reported the number and length of group sessions as appropriate or too short. Most SAM's commented on enjoying the mutual sharing of thoughts and feelings in a very supportive environment.

4.9 Summary

As can be observed by the various ways in which data was collected to explore the results of the practicum intervention, the effect on each of the participants was unique. The vignettes provided examples of how the practicum intervention affected three of the participants.

In terms of data analysis, none of the findings reached a level of statistical significance. In reviewing the raw data, no individual trends were observed. The data indicated some changes on individual scores, however, this data was inconsistent. This may be due to poor sensitivity of the scales to discern changes as a result of the intervention. Another

factor that may have limited change may have been the short time span (8 weeks) between the pre and post test. As indicated by Lovell (1991), relationships develop over time; a one year follow-up of post test administration, although impractical due to the questionable availability of SAM's, may have yielded changes that reached statistical significance.

In assessing the level of clinical significance, participants responded favorably to the intervention. Through both verbal and written expressions, members believed the group was a positive experience and strongly felt they would utilize the skills learned and information acquired, as time progressed. Furthermore, through group the SAM's were able to add new members and types of social support to their networks for new friendships were formed within the group, as well as SAM's were taught the skills necessary to strengthen or increase their current social support networks.

CHAPTER 5

COMMON THEMES IN GROUP INTERVENTIONS

Several themes were common in both groups. First, the majority of group members shared histories of physically, sexually or verbally abusive relationships, and discussion repeatedly focused on the essential issue of trust in interpersonal relationships (McCann, Pearlman, Sakheim & Abrahamson, 1988) and the difficulty of trusting when one has been victimized. This betrayal of trust may manifest itself in a number of different ways, including fear of betrayal or abandonment, rage toward past or potential betrayers, self doubt, withdrawal, and isolation (McCann et al., 1988). The SAM's who disclosed abuse expressed difficulties with trust and boundaries in relationships to a greater extent than did other participants. During group sessions, the SAM's began to trust and establish boundaries with their peers and this vicariously became the first step in strengthening their network ties as they were able to 'practice' skills in the safe environment of group. Fear of abandonment was commonly expressed by group members, and many reported continuing relationships with their baby's father despite ongoing abuse so that they would not be alone. Low self-esteem was also an issue that was 'universal' among the SAM's; many allowed abusive relationships to continue after years of repeated verbal abuse, with comments such as 'no other man would want used goods' because of their poor self perception. Group members appreciated the facilitator's and peers' support during these discussions and felt less isolated by the commonality of their negative experiences.

As documented by Bass and Davis (1988), communication, or the sharing of thoughts and feelings, provides the foundation for developing an environment of trust, safety, and intimacy. Since the sequelae of the traumatized individual includes being unable to cope with strong feelings (Gil, 1992), survivors of abuse, for example the SAM's, were taught through group to identify their feelings and begin to cope with them in a healthier manner, so that they could begin to communicate and form trusting relationships with others.

The concept of control over one's life was another important theme. Group members acknowledged a limited understanding and knowledge pertaining to the issue of control. Many of the participants reported feeling a sense of no control in their lives, which related directly to their abusive situations, where they typically did not have the opportunity to learn about personal power or be allowed the experience of a healthy balance of power in relationships (Gil, 1992). Alot of discussion centered around the fact that one has the power to control all of one's relationships in life. For many of the members, control was synonymous with exertion and power. The group allowed the SAM's to experiment with control in the positive sense. A common statement reiterated by this writer throughout both groups was: "You are in control of your relationships. It is your decision who you let into or out of your life".

Another theme involved changes in lifestyle and friendships during pregnancy. The majority of participants found their social networks dramatically changed once they became pregnant, with their lifestyles transforming from extremely active to very quiet. Alot of sadness and anger was shared, with members questioning the true concept of 'friendship'.

Fear of rejection was a strong theme throughout all groups. Many of the participants believed that their motherhood status would prevent future potential relationships. This psychologically pushed several SAM's to reengage with their child's fathers in an effort to reduce feelings of loneliness and fears of being alone. Fear of rejection closely tied into the fear of loneliness. The majority of participants were frightened by the idea of being alone. Adolescence is observed as a time when one connects strongly with relationships, both same and opposite gender.

Another common theme was social isolation. As cited in the literature and apparent from the mapping exercises, many SAM's have minimal opportunity for socialization due to financial insecurity or lack of childcare supports, and consequently, spend the majority of their time with their children (Thompson, 1986). The groups, the recognition that others shared a common life event, and common feelings seemed to decrease some of the social isolation. Several group member exchanged personal data to ensure group friendships would continue, and group members commented frequently on the desire to connect with new relationships or reconnect with past friendships.

A final theme was the lack of connection to external resources. When sharing personal networks during the mapping exercises, it became evident that the majority of SAM's were not connected to any external supports. According to participants, this was due to lack of awareness and knowledge of existing community resources, as well as a fear of connecting with others in the new role of parent. Research has indicated that although many programs and services have been developed to meet the identified needs of pregnant and parenting adolescents, many teenagers continue to be reluctant to use them (Bergman,

1989). Failure to utilize available services may reflect lack of information, lack of access, different perception of need, and /or the fact that adolescents may be receiving assistance from other sources (Bergman, 1989) or it may mean services are structured in an inappropriate manner to effectively meet their needs. The facilitator provided each member with a resource guide at the end of group titled, 'Parenting on Your Own' (Manitoba Women's Advisory Council in partnership with Taking Charge, 1996); hopefully, this will assist members in expanding their external networks.

5.1 Issues And Implications For Groupwork With SAM's

The application of the practicum intervention and the analysis of the findings suggested three major issues. First, the experience of the practicum indicated that the inclusion of network building interventions in programming related to adolescent parenting would be both beneficial and meaningful. Second, some of the tools utilized in the intervention such as the Relationship Roadmap (Lovell, 1991) and the feltboard mapping may be helpful in social work practice. Finally, the social milieu which contributed to the need for social support interventions with SAM's is an issue which cannot be addressed solely on an individual level but has wider implications for practice; the intervention described in this report could be most effective as part of a larger strategy to further strengthen and/ or increase social support with the SAM population.

As a group, practicum participants typically had small networks that were generally not perceived as very helpful. The SAM's were eager to participate in the practicum and were able to identify goals to improve or strengthen their personal networks. Participants

reported finding the group intervention helpful in understanding the importance of social support and the skills necessary to improve their own support networks. The findings of the practicum supported the general research which indicated that a lack of social support is a common problem of SAM's (Bergman, 1989; Whitman et al., 1991). This consequently suggests that inclusion of network building interventions in the adolescent parent programming curriculum at the Adolescent Parent Centre and other school settings or agencies would be beneficial.

Some of the tools utilized in the intervention may be helpful for general assessment by social work clinicians. The Relationship Roadmap (Lovell, 1991) was a helpful tool to better understand general and personal relationships. Network mapping provided visual feedback for the facilitator and participants to better understand their networks and target areas for change. The mapping also provided information about satisfaction with networks, amounts of ties, and levels of reciprocity. The Perceived Social Support- Fr/ Fa Scales and the SSA Scale facilitated structured clinical discussion about network ties and were also used in the evaluation process. Finally, utilizing journal writing as a group closure activity allowed anonymous expression of feelings and thoughts and strengthened the facilitator-member connection.

Although none of the observed changes reached a level of statistical significance, there were changes of clinical significance. This indicated the efficacy of network building interventions for SAM's.

In summary, the social support group intervention described in this report would seem to be effective in empowering, educating, connecting, networking, and providing support to SAM's in a variety of settings. This may hopefully reduce some potentially negative factors associated with adolescent parenting, such as social isolation, continuation of abusive relationships, and high risk lifestyles faced by these young women.

CHAPTER 6

EVALUATION OF STUDENT LEARNING

RECOMMENDATIONS, AND CONCLUSIONS

This practicum experience has provided this writer with the opportunity to broaden her theoretical and clinical understanding of social support group intervention with SAM's.

To begin with, the literature on social support furthered this writer's knowledge and understanding of the attributes and components of social support systems which was essential in assessing coping resources and predicting adaptation to life transitions (Gottlieb, 1983). In addition, a review of the literature on group intervention allowed this writer to gain a further understanding of the different types of group interventions utilized in the social service field, and aided in defining and the intervention utilized for this practicum. Finally, the literature on adolescent parents heightened the sensitivity of the writer to the many difficulties this population experiences, and facilitated growth of the writer as a group facilitator. This writer learned about hope and positive action in spite of daily challenges and hopelessness. This writer felt herself experiencing the SAM's confusion and mixed feelings that were associated with them being young single mothers with limited support in all areas of life. No matter how difficult and hopeless their situations appeared, there seemed to always be a tinge of hope that the SAM's viewed ahead. Overall, the exploration of the literature combined with the implementation of the group provided an opportunity to expand knowledge, strengthen clinical skills, and reevaluate the priorities /goals for social work practice at the Adolescent Parent Centre.

The goals initially described in the proposal were achieved through the practicum. The writer was able to develop skills when preparing and facilitating the group intervention. These skills included learning the importance of the prescreening phase, the major stages of group development, how to choose an appropriate measurement instrument, as well as how to evaluate the findings. Independent and supervised review of the audio-tapes, following each group session, enhanced direct service skills. Finally, utilizing pre and post clinical measures provided the writer with an introduction to the use of measures in clinical practice and allowed for skill development in the evaluation of an intervention.

Based on this practicum experience, the following recommendations are suggested:

1. To offer the social support group to SAM's at the Adolescent Parent Centre on an ongoing basis, and for the group to be included in the Centre's curriculum. To offer social support group interventions in other schools within the Winnipeg School Division #1 that have adolescent populations. To present the social support group intervention strategy to other school divisions or social service agencies in Winnipeg as an adjunct to their existing programs.
2. To increase the number of sessions offered in the social support group (from 8-12) to enable more time to practice new skills and techniques focused at increasing or strengthening social support networks. The twelve session group would be assessed at group's closure to determine if the increase of sessions proved its purpose.
3. To continue to utilize the feltboard to learn about personal networking, for it proved to be an excellent visual and hands-on tool.
4. For participants to map their personal networks in the pre-group phase and intervention phase to allow further comparison of actual personal networks.

5. To limit social support group membership to six participants to enable all participants to receive the full benefit of the group experience.
6. To arrange a follow-up meeting with each participant after a 6 month time period to assess if her actual social support networks have increased or become stronger.
7. To continue videotaping each group session for it served as an excellent tool for self-appraisal.
8. To further review the pre and post test measurements utilized during group. It would be interesting to focus on one scale at a time during group to determine if similar results are obtained.

In conclusion, research suggests that strong social supports lead to better outcomes for SAM's (Barth & Schinke, 1984). Social support has been found to have a direct and positive impact on the well-being of the individual. It plays an adaptive role, as well as acts a buffer to the stress of single adolescent motherhood (Dormire et al., 1988). Social support enables the SAM "to function adequately as a parent, to mature, and to become self-supporting and self-sufficient" (Zittner & Miller, 1980, p. 4).

The collected data suggested some success in increasing participants' awareness about the function and importance of social support networks and the social network skills required to continue and expand current healthy relationships. The participants were also able to meet others in similar situations, with similar problems, and learn new ways to cope with difficult issues through healthy role modeling, didactic teaching, and resource sharing. The two social support groups enhanced the writer's group facilitation skills and the evaluation component of the practicum expanded the writer's evaluative skills. By

heightening the SAM's awareness about the role of social support and teaching them the skills required for social network development, the difficult transition to adolescent motherhood was hopefully eased.

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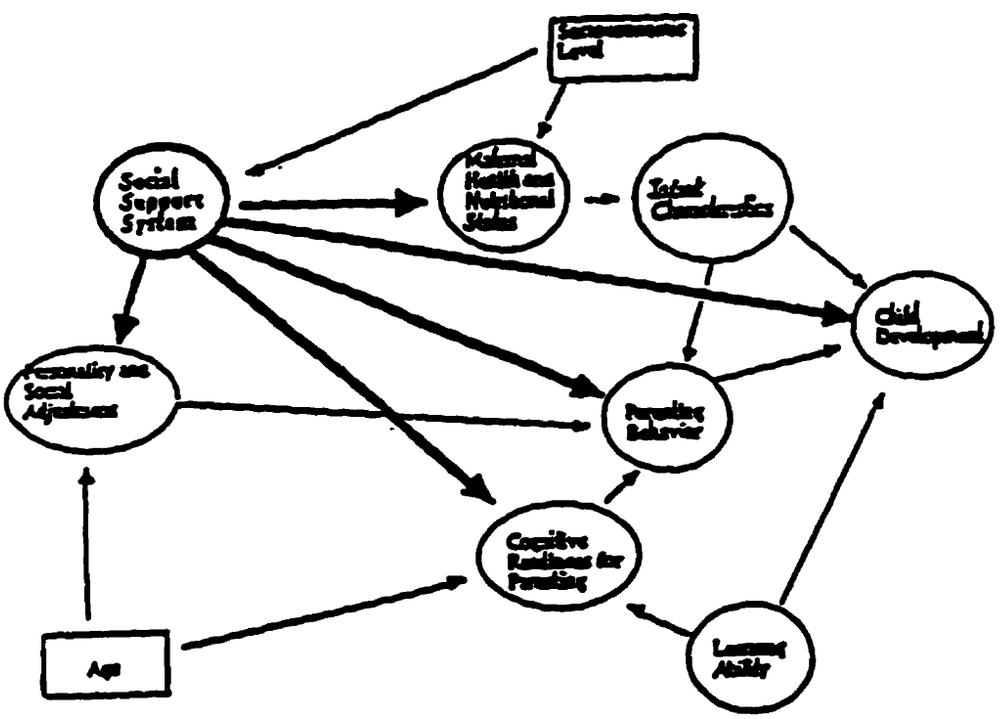
APPENDIX A

WHITMAN, NATH, BORKOWSKI & SCHELLENBACH (1987) MODEL

A model of teenage parenting and child development



- predicts that the adolescent mother's personality and cognitive readiness for parenting are age-related variables which are influenced by the social support system.
- learning ability also affects cognitive readiness and has an indirect effect on parenting.
- the social support system influences maternal health and nutritional status; both are associated with socioeconomic status and are the major sources of influence on the infant's physical status at birth.
- the model hypothesizes that the behavior of mothers and their infants in parenting situations are influenced directly by the social support system, the adolescent mother's personality and social adjustment skills, her readiness for parenting, as well by biologically based characteristics of the infant.
- the model maintains that the development of the infant is a product of the genetic and social transmission of learning ability, the adolescent mother's parenting skills, the infant's characteristics and the mother's social support system.

APPENDIX B

SOCIAL SUPPORT GROUP

DO YOU SOMETIMES WISH YOU HAD SOMEONE TO TALK TO WHEN YOU ARE FEELING ALONE, UPSET OR HAVE A PROBLEM?

DO YOU SOMETIMES WISH YOU HAD SOMEONE TO HELP YOU WITH CHILDCARE SO THAT YOU COULD HAVE SOME FREE TIME TO YOURSELF?

DO YOU SOMETIMES WISH YOU COULD RECONNECT WITH AN OLD FRIEND OR FAMILY MEMBER?

DO YOU SOMETIMES WISH MEETING NEW PEOPLE WASN'T SO DIFFICULT AND FRIGHTENING?

THEN... THIS GROUP MAY BE FOR YOU!!!

IF YOU ARE 16-19 YEARS OLD AND HAVE A CHILD LIVING WITH YOU UNDER THE AGE OF ONE, COME AND SEE CINDY YUSIM FOR MORE INFORMATION. ALL INQUIRIES WILL BE KEPT CONFIDENTIAL.

GROUP WILL RUN THE MONTHS OF MARCH AND APRIL (8 WEEKS). FULL PARTICIPATION WILL EARN A 10% CREDIT IN FAMILY STUDIES OR ANOTHER AGREED UPON COURSE.

APPENDIX C

ADOLESCENT PARENT CENTRE
PARTICIPANT CONSENT FORM

I agree to participate in the practicum, ***The Art of Social Support Group Intervention With Single Adolescent Mothers***, which has been reviewed and passed by the Faculty of Social Work at the University of Manitoba and the Research Committee at the Winnipeg School Division #1.

I understand that I may be asked to complete questionnaires about my social support system. I understand that I may be asked to be a participant in an 8 week group, whereby I may learn skills needed to improve my social support system.

I understand that all information obtained will be kept anonymous and confidential. I know that participation in this practicum is voluntary and that further treatment or intervention at the Adolescent Parent Centre will not be affected by refusal to participate. Further, I know that I may withdraw from the study at any time without penalty.

I understand that sessions may be videotaped for group learning and for researcher's skill development.

Date_____

Signature_____

ADOLESCENT PARENT CENTRE
PARENTAL CONSENT FORM

I agree as parent/guardian to allow my child to participate in the practicum, ***The Art of Social Support Group Intervention With Single Adolescent Mothers***, which has been reviewed and passed by the Faculty of Social Work at the University of Manitoba and the Research Committee at the Winnipeg School Division #1.

I understand the she may be asked to complete questionnaires about her social support system. I understand that she may be asked to participate in an 8 week group, whereby she may learn skills to improve her social support system.

I understand that all information obtained will be kept anonymous and confidential. I know that participation in this study is voluntary and that further treatment or intervention at the Adolescent Parent Centre will not be affected by refusal to participate. Further, I know that she may withdraw from the study at any time without penalty.

I understand that sessions may be videotaped for group learning and for researcher's skill development.

Date_____ Signature_____

ADOLESCENT PARENT CENTRE

THE ART OF SOCIAL SUPPORT GROUP INTERVENTION WITH SINGLE ADOLESCENT MOTHERS

Thank you for volunteering to participate in this practicum on social support group intervention with single adolescent mothers. Your involvement is greatly appreciated. While completing the questionnaires, please keep in mind that this is not a test and there are no right or wrong answers. Also, the information that you provide is completely anonymous and confidential. Please answer the questions as well as you can. It is important that you answer all the questions. Please remember, that your participation is completely voluntary and if you feel that you would like to withdraw from this practicum at any time, you may do so.

Thank you

APPENDIX D

SOCIAL SUPPORT GROUP
PRESCREENING INTERVIEW

Please complete the following form as best you can. All of your answers will be kept confidential and will not affect group therapy or any service that you receive in the future.

DATE: _____

NAME: _____

ADDRESS: _____

TELEPHONE #: _____

D.O.B.: _____

AGE: _____ GRADE: _____

CHILD'S NAME: _____AGE: ___

LIVING ARRANGEMENT: Own___ Family___ Other___

1. Do you know what the purpose of this group is?

_____
_____
_____

2. Why are you interested in attending this group?

_____
_____
_____

3. Can you briefly describe any groups you have previously been involved in.

_____
_____
_____

4. Are you comfortable participating in a group?

_____
_____

5. This group is about social support. I am going to try to show you ways that may help you increase the supports in your life which may lead to an easier time parenting.

   In this group, we will be doing exercises which may be new to you such as role playing, journals, homework tasks, and group sharing. Would you be comfortable in doing these kind of exercises?

6. What/ who are your current supports?

7. What do you hope to learn in this group?

8. What are your concerns about the group?

9. What things do you think might get in the way of your participation in this group?

10. What are your strengths?

    What are your weaknesses?

COMMENTS/ QUESTIONS:

APPENDIX E

PROCIDANO & HELLER (1983)

PERCEIVED SOCIAL SUPPORT- FRIEND SCALE (PSS- Fr)
PERCEIVED SOCIAL SUPPORT SCALE- FAMILY SCALE (PSS- Fa)

PSS- Fr

The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with *friends*. For each statement there are three possible answers: Yes, No, Don't Know. Please circle the answer you choose for each item.

Yes No Don't Know 1. My friends give me the moral support I need.

Yes No Don't Know 2. Most other people are closer to their friends than I am.

Yes No Don't Know 3. My friends enjoy hearing about what I think.

Yes No Don't Know 4. Certain friends come to me when they have problems or need advice.

Yes No Don't Know 5. I rely on my friends for emotional support.

Yes No Don't Know 6. If I felt that one or more of my friends were upset with me, I'd just keep it to myself.

Yes No Don't Know 7. I feel that I'm on the fringe in my circle of friends.

Yes No Don't Know 8. There is a friend I could go to if I were just feeling down, without feeling funny about it later.

Yes No Don't Know 9. My friends and I are very open about what we think about things.

Yes No Don't Know 10. My friends are sensitive to my personal needs.

Yes No Don't Know 11. My friends come to me for emotional support.

Yes No Don't Know 12. My friends are good at helping me solve problems.

Yes No Don't Know 13. I have a deep sharing relationship with a number of friends.

Yes No Don't Know 14. My friends get good ideas about how to do things or make things from me.

Yes No Don't Know 15. When I confide in friends, it makes me feel uncomfortable.

Yes No Don't Know 16. My friends seek me out for companionship.

Yes No Don't Know 17. I think that my friends feel that I'm good at helping them solve problems.

Yes No Don't Know 18. I don't have a relationship with a friend that is as intimate as other people's relationships with friends.

Yes No Don't Know 19. I've recently gotten a good idea about how to do something from a friend.

Yes No Don't Know 20. I wish my friends were much different.

PSS- Fa

The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with their *families*. For each statement there are three possible answers: Yes, No, Don't Know. Please circle the answer you choose for each item.

Yes No Don't Know 1. My family gives me the moral support I need.

Yes No Don't Know 2. I get good ideas about how to do things or make things from my family.

Yes No Don't Know 3. Most other people are closer to their family than I am.

Yes No Don't Know 4. When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable.

Yes No Don't Know 5. My family enjoys hearing about what I think.

Yes No Don't Know 6. Members of my family share many of my interests.

Yes No Don't Know 7. Certain members of my family come to me when they have problems or need advice.

Yes No Don't Know 8. I rely on my family for emotional support.

Yes No Don't Know 9. There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.

Yes No Don't Know 10. My family and I are very open about what we think about things.

Yes No Don't Know 11. My family is sensitive to my personal needs.

Yes No Don't Know 12. Members of my family come to me for emotional support.

Yes No Don't Know 13. Members of my family are good at helping me solve problems.

Yes No Don't Know 14. I have a deep sharing relationship with a number of members of my family.

Yes No Don't Know 15. Members of my family get good ideas about how to do things or make things from me.

Yes No Don't Know 16. When I confide in members of my family, it makes me uncomfortable.

Yes No Don't Know 17. Members of my family seek me out for companionship.

Yes No Don't Know 18. I think that my family feels that I'm good at helping them solve problems.

Yes No Don't Know 19. I don't have a relationship with a member of my family that is as close as other people's relationship with family members.

Yes No Don't Know 20. I wish my family were much different.

APPENDIX F

VAUX, PHILLIPS, HOLLEY, THOMPSON, WILLIAMS & STEWART (1986)

SOCIAL SUPPORT APPRAISALS SCALE (SSA)

SSA

Below is a list of statements about your relationships with family and friends. Please indicate how much you agree or disagree with each statement as being true.

	(Circle one number in each row)			
	Strongly agree	Agree	Dis-agree	Strongly disagree
1. My friends respect me.	1	2	3	4
2. My family cares for me very much.	1	2	3	4
3. I am not important to others.	1	2	3	4
4. My family holds me in high esteem.	1	2	3	4
5. I am well liked.	1	2	3	4
6. I can rely on my friends.	1	2	3	4
7. I am really admired by my family.	1	2	3	4
8. I am respected by other people.	1	2	3	4
9. I am loved dearly by my family.	1	2	3	4
10. My friends don't care about my welfare.	1	2	3	4
11. Members of my family rely on me.	1	2	3	4
12. I am held in high esteem.	1	2	3	4
13. I can't rely on my family for support.	1	2	3	4
14. People admire me.	1	2	3	4
15. I feel a strong bond with my friends.	1	2	3	4

16. My friends look out for me.	1	2	3	4
17. I feel valued by other people.	1	2	3	4
18. My family really respects me.	1	2	3	4
19. My friends and I are really important to each other.	1	2	3	4
20. I feel like I belong.	1	2	3	4
21. If I died tomorrow, very few people would miss me.	1	2	3	4
22. I don't feel close to members of my family.	1	2	3	4
23. My friends and I have done a lot for one another.	1	2	3	4

PSS-Fa/ PSS- Fr Method of Scoring

The PSS- Fr and PSS- Fa are scored "yes", "no", and "don't know" ("don't know is scored 0 on both scales). On the PSS- Fr, an answer of "no" is scored +1 for items 2, 6, 7, 15, 18, and 20. For the remaining items, "yes" is scored +1. For the PSS- Fa, answers of "no" to items 3, 4, 16, 19, and 20 are scored +1, and for all other items a "yes" is scored +1. Scale scores are the total of item scores and range from 0 to 20 for the PSS- Fr and the PSS- Fa. Higher scores reflect more perceived social support.

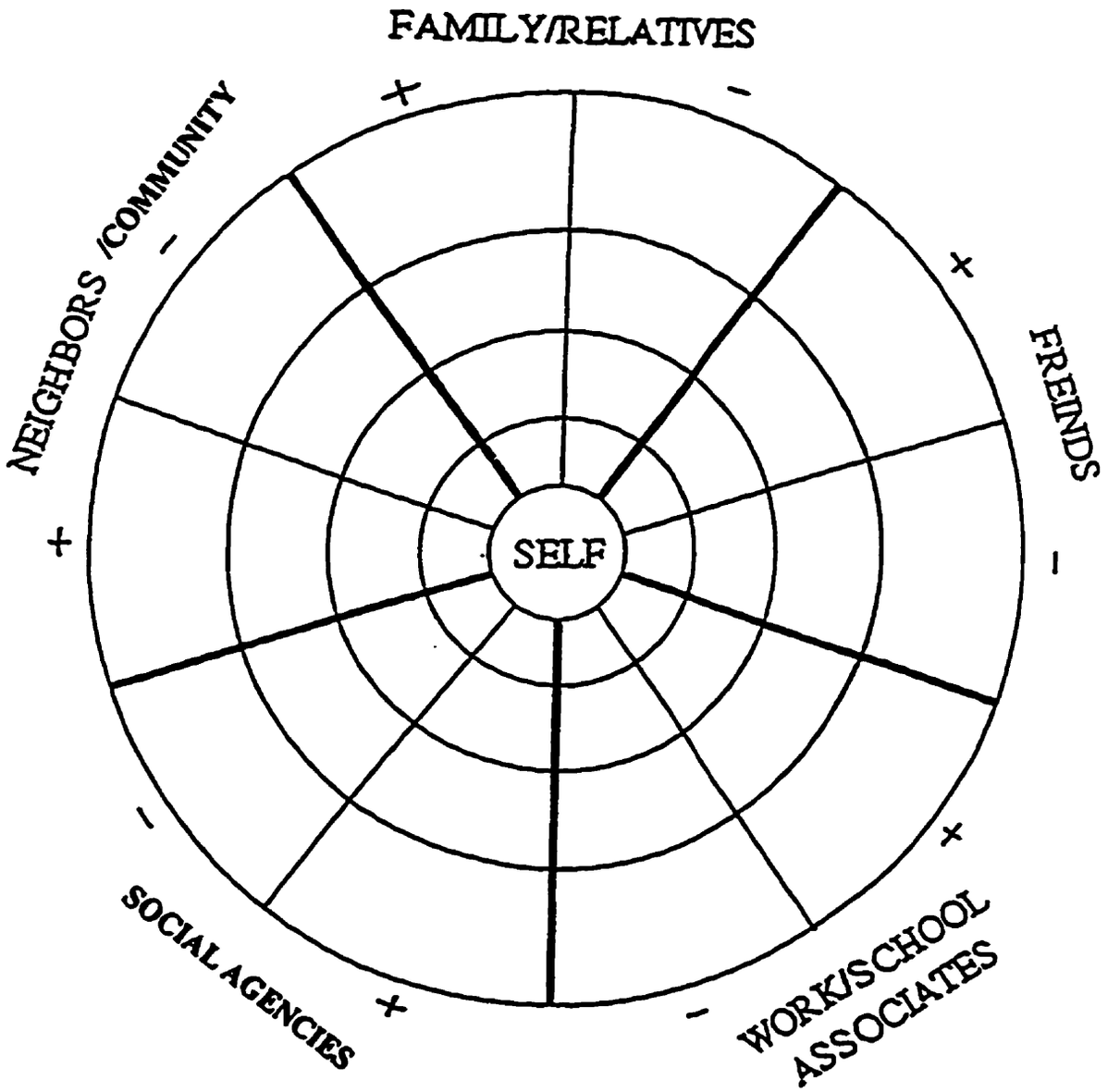
SSA Method of Scoring

The SSA is scored by reverse-scoring items 3, 10, 13, 21, and 22. The individual items are added up for a total score, with lower scores indicating a stronger subjective appraisal of social support. In addition to the total score, the 8 "family" items make up an SSA- Family subscale and the 7 "friend" items make up an SSA- Friend subscale. The remaining items refer to people or others in general.

APPENDIX G

SOCIAL NETWORK MAP

(adapted from Fuchs & Lugtig, 1992)



PERSONAL NETWORK ASSESSMENT INSTRUMENT

(Adapted from Fuchs & Lugtig, 1992)

Parents need help and support from others. Please list 5 people who have assisted you in being a parent in the past six months.

a. initials of helpers					
b. relationships of helpers to you					
c. where does the helper live? (ie. your household, your street, same neighborhood, outside city)					
d. kinds of support/help you get from each helper 1. listens to your concerns about parenting					
2. gives you information and advice about raising and caring for your children					
3. tells you how you are doing as a parent- both positive and negative					
4. babysits your children when you have an appointment or emergency					
5. babysits your children to give you a break					
6. gives you praise and encouragement for your parenting					
7. provides you with a model of a good parent					
8. lends or gives you food, money, clothes, or transportation					

e. Which helpers know each other? (initials under appropriate column)					
f. Which helpers do you see at least once a week? (place "x" under appropriate column)					
g. Which of the above helpers do you help? (place "x" under appropriate column)					
h. Which of the above helpers do you count on the most? (list 1-5)					
I. How long have you known each helper?					
J. Degree of satisfaction. How satisfied are you with the help you have received? 1) Very Satisfied V.S. 2) Satisfied S 3) Dissatisfied D					

APPENDIX H

SOCIAL SUPPORT GROUP EVALUATION FORM

Your opinions are important to me! In order to plan for future social support groups, I have prepared this short confidential questionnaire to survey your thoughts regarding your involvement in the social support group.

I appreciate your honesty. Information that you share will in no way affect present or future treatment at the Adolescent Parent Centre.

Please circle the appropriate response.

1. Did you enjoy coming to the Social Support Group?

no, definitely not	no, I don't think so	Yes, I think so	Yes, definitely

2. Did you feel the group was helpful?

yes, definitely	yes, I think so	no, I don't think so	no, definitely not

Please provide examples.

_____

_____

_____

3. Did you notice any improvements in your support networks over the course of the group?

no, definitely not	no, I don't think so	yes, I think so	yes, definitely

If yes, please provide examples.

_____

_____

_____

4. Did you feel the length of the sessions was appropriate? (2 hours)

yes, definitely	yes, I think so	no, I don't think so	no, definitely not

5. **Did you feel the number of sessions (8) was appropriate?**

no, definitely not	no, I don't think so	yes, I think so	yes, definitely

6. **Please suggest additional topics you would have liked covered during the group sessions.**

_____
_____
_____

7. **Did you try to do any of the techniques discussed in the room? How did they work?**

_____
_____
_____

8. **General Comments and/ or concerns:**

_____
_____
_____

RELATIONSHIP ROADMAP

(Adapted from Lovell, 1991)

APPENDIX I

A FEW MEETINGS

ACQUAINTANCE
1) Smile
2) Say hi
3) Nod
4) Have general conversation

3 MONTHS

BUDDY
1) Occasionally do things of a non-personal nature together
2) May have some interests or hobbies.

6 MONTHS

FRIEND
1) Phone calls
2) Might call each other in an emergency
3) Confide in each other
4) Support each other

MORE THAN 6 MONTHS

PERSONAL FRIEND
1) Introduce to others in your network
2) Can count on them to support you
3) They can count on you for support
4) Can be honest in your feelings with each other

BEST FRIEND/ PARTNER
1) discuss dreams and fears
2) Plan future together
3) Consult each other in decision-making
4) Can live together
5) Can raise children together
6) Can be sexual

APPENDIX J

COLLECTING INFORMATION ON COMMUNITY RESOURCES

Resource Name: _____

Address: _____

Telephone Number: _____ **Contact Name:** _____

Description of Activity(ies) Offered: _____
_____
_____
_____
_____
_____
_____

Who Attends: _____
_____
_____

Times of Program(s): _____
_____

Cost: _____

Availability of Daycare: _____

How to Join: _____
_____

APPENDIX K

CLIENT LOG/ JOURNAL

Date of Session: _____

Group Member: _____

Please circle the number that comes closest to describing your feelings about today's session. Your response in no way will affect further treatment.

1	2	3	4	5	6	7	8	9
not productive at all				moderately productive				extremely productive

Please try to describe at least one positive and one negative incident or a part of the discussion that occurred during the session that might help explain your rating.

Positive Incident: _____

_____

Negative Incident: _____

_____

Describe any problems or feelings that you were concerned about during the session:

_____

_____

_____

How did you feel about coming to today's session: _____

_____

_____

Additional Comments/ Concerns: _____

_____

_____

- If you choose to hand in your journal, I will respond to your comments.

APPENDIX L

PROCEDURE FOR NETWORK MAPPING

The network map is a way of organizing network members according to the type of relationship, for example family or friend, and the intensity or closeness of that relationship. The participant's name is placed in the centre of the map. Network members are then mapped on the diagram in the appropriate sector, and the sectors are categorized according to family, friend, work/ school associate, social agency, and neighbors/ community. Network members are placed on the map, as well according to the intensity of the participant's relationship with them; the more intense the tie, the closer to the centre of the map it is positioned.

APPENDIX M

PARTICIPANT BIOGRAPHIES

Group #1

Participant #1

The participant was an 18 year old mother, completing her grade 12, and residing at home with her mother and 2 month old son. At the time of group, she remained connected to her boyfriend, the baby's father, who was serving time at Headingley Jail for break and enter related crimes.

Participant #2

The participant was a 16 year old mother, completing her grade 10, and residing in a foster home. Just prior to group commencement, she regained guardianship of her 3 month old son, who was apprehended at approximately 6 weeks of age due to concerns of neglect. Participant #2 described a strong connection with her baby's father.

Participant #3

The participant was a 19 year old mother, completing her grade 10, and living at home with her mother, younger brother, and 2 month old son. She was not connected to the baby's father at the time of group.

Participant #4

The participant was a 17 year old mother, completing her grade 10, and residing with her parents, 3 younger siblings, and 2 month old daughter. She described her relationship with her boyfriend/ baby's father as very connected.

Participant #5

The participant was a 19 year old mother, completing her grade 11/12, and living independently with her 1 year old daughter. She described her relationship with her daughter's father as on and off.

Participant #6

The participant was a 19 year old mother, completing her grade 11, and residing at home with her mother, step-father, older brother, and 5 1/2 month old son. She only recently reconnected to her son's father; she described really wanting her son to know his father and stated this as the sole reason for the reunion.

Group #2

Participant #1

The participant was a 16 year old mother, completing her grade 9, and residing with her mother and 9 month old son. She described having no contact with her son's father, and at the time of group was pursuing a new relationship.

Participant #2

The participant is a 17 year old mother, completing her grade 11, and residing with her mother and 11 month old daughter. During group, her relationship with her baby's became threatening and abusive; at group's closure she was pursuing a new relationship.

Participant #3

The participant was a 17 year old mother, completing grade 10, and residing with her mother and 2 month old daughter. During group, she reconnected with the baby's father and described the relationship as "going well so far".

Participant #4

The participant was an 18 year old mother, completing her grade 12, and residing at home with her parents, younger sister, and 6 week old daughter. Her relationship with the baby's father terminated during her pregnancy due to threatening behavior; during pregnancy participant #4 became involved in a new relationship which she described as "fairly positive", in spite of her questionable satisfaction with it.

Participant #5

The participant was an 18 year old mother, completing her grade 10, and residing independently with her 1 year old son. Her relationship with her boyfriend/ baby's father remained disjointed, whereby one week he would be a part of her life and the next week uninvolved.

Participant #6

The participant was an 18 year old mother, completing her grade 10, and residing independently with her 81/2 month old son. Her relationship with her boyfriend/ baby's father was positive and he took a very active role in parenting his son.

Participant #7

The participant was a 16 year old mother, completing her grade 9/10, and residing in the upper level of her parent's duplex with her 7 month old son. Her relationship with her baby's father was described as abusive at the time of group.