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Do Peer-Led Parent Groups Make Young Mothers Better Parents?

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Abstract

The purpose of this paper is to describe the participant behaviors and to evaluate the effectiveness of a parent support program for young mothers in two diverse counties in the mid-South. The goals of the program were to encourage maternal self-sufficiency, improve participants' parenting skills, and provide safe and nurturing environments for their children. A non-randomized, one-group, post-test only design was used to evaluate the effectiveness of this program with 40 pregnant and parenting culturally diverse females ages 14 to 21 years. The goal of providing safe and nurturing environments for the children of participants was met, and all of the children had all recommended immunizations with an established care provider (a medical home). Nurturing behaviors, including appropriate discipline and communication techniques, celebrating special events, and reading books to their children, were reported by the majority of parents. Forty-five percent of the children had developmental and social delays. In this population, focused parent groups are effective in producing positive parenting behaviors.

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Introduction

Under the direction of a master's prepared community health nurse, the staff of a small non-profit organization serving pregnant and parenting young mothers in the mid-South identified areas for improvement in the agency's programming. Although the primary goals of the program were to help participants stay in

school, avoid more pregnancies, and prevent child abuse and neglect, it was difficult to get the participants to comply with home and school visits and to delay subsequent childbearing. Based on identified areas for improvement, the agency transitioned from a low-impact home visitation program to a primarily peer-led, parent group program that produced consistent, long-lasting results and renewed the staff's passion to serve this population. This is an account of the organization's paradigm shift and how the effectiveness of the programming change was evaluated.

Background

Experientially and in the literature, low income, young mothers have higher rates of child maltreatment than the general population. A chaotic life, multigenerational and matriarchal households, frequent changes of residence, trouble meeting basic needs, limited future orientation, and constant exposure to violence characterize this population.[7,12,15,25,47,49,50] Children raised in these households often go on to perpetuate the cycle of early childbearing and child maltreatment.[10,36,48]

To be successful, programs serving these young women must find a balance between individualized support for the mother at her stage of development and encouraging her independence.[25,34,35] When a young woman becomes a parent prematurely, she may lose ties to her peer group and the social support she needs as she navigates adolescence and early adulthood. This lack of social support often leads to maternal depression and behavior problems in her child.[8,30,49] Creating social networks for these young women through regularly scheduled peer group meetings may provide the emotional support needed to become independent and learn the skills to become a nurturing parent.

The agency in this evaluation shifted its focus from only case management, an approach it had used for two decades, to peer-led parent groups in order to create a more effective way to provide relevant solutions to the daily issues these young women face. Under the case management model, clients rarely kept home visit appointments with case managers and often disappeared until their next pregnancy. Adding parent groups to the home visitation and case management program was expected to create stronger connections with the participants, thereby showing them a different way to parent, and giving them a vision of a future beyond their life experience. Several staff that had been former clients became site coordinators so they could lead and organize the peer-led group model of care. Unexpectedly, these staff served as cultural guides for the other staff as this new way of relating to clients through peer group meetings was developed.

The agency became adept at quickly establishing peer groups of pregnant and parenting teens through consistent monthly meetings at convenient locations. These connections were established rapidly due to the fluidity of the teens'

commitments. As groups developed, supplying a meal was found to increase attendance. Childcare provided by volunteers from service organizations during group enticed parents to return to subsequent meetings. Transportation was offered to those who needed it. “Baby Bucks”, a reward system allowing mothers to purchase infant care products from the agency incentive store, added to family resources for childcare. For example, mothers could earn Baby Bucks by finishing high school, getting to group and helping others get to group, making doctor visits, completing immunizations, and remaining on birth control. The Baby Bucks currency was treated like real money and lost or forgotten bills were not replaced nor was credit given. Participants became very responsible with this system and carefully saved and planned for their purchases each month.

An intergenerational model was incorporated in the peer support program by bringing childcare with focused reading and play activities into the monthly parent groups. As the children of the participants experienced a warm and nurturing environment at group, the mothers learned effective parenting techniques and child development that helped them become more nurturing at home. Parenting behaviors covered in group included daily reading and conversations with children, appropriate time outs and distraction in place of spanking, child growth and development, nutrition and exercise, and the importance of celebrations and play.

Five years after the program change took place, a program evaluation was implemented to determine the extent to which the program was effective helping participants achieve the program goals of greater maternal self-sufficiency, improved parenting skills, and the creation of safe and nurturing environments for children. The evaluation was a cross-sectional, point-in-time design, and used a convenience sample of all participants in the parenting groups. Baseline data for the group prior to program implementation was not available due to the transience of program participants.

Significance of the problem

Resilience, the characteristic of positive adaptation despite personal adversity, is a common theme among researchers working with young, high-risk mothers. As researchers watched some young women thrive in adversity and others flounder, they attempted to identify what elements in the individual and the environment created the ability to “bounce back’ or persevere under difficult circumstances.[10,24,29,38] When common characteristics of “survivors and thrivers” were identified,[1,4,14,22,45] one of the most common elements was the connection to a caring adult or series of adults who guided the young person through childhood and adolescence.[2,3,9,32,33,37,39,40,44,45]

When a pregnant adolescent or young adult lacks connections to a caring adult, the social support provided by a parent group may provide enough care and nurturing to help the young woman find her way through a difficult adolescence

and gain needed resilience. Logsdon and others[30] calls this “piecing together a quilt” as the young mother finds the support she needs from adults, peers, and partners. These investigators claim that these young women do better in their health and life circumstance outcomes if there is a match, or congruence, between the amount of social support desired and the social support received.[31] This support may be on several levels: the macrosystem (the parental home and community in which the young woman lives), the mesosystem (interpersonal dynamics in the her life), and the microsystem (the young woman’s temperament and other personal characteristics). Key elements missing in any of these systems may affect a young mother’s life outcomes; social support through a caring adult or peer group within a mesosystem framework may make up to some extent for what is missing.

Daily life in the culture of poverty

Young mothers living in poverty often face challenges beyond the experience of those delivering care in agency settings. In their thoughtful analysis of the daily challenges facing the low-income, young mother, Beeber and Canuso[5] explain that life in the culture of poverty is based the following tacit principles:

1. It is organized around basic survival needs that take precedence over anything else, including doctor appointments, being on time, and job interviews.
2. It has unpredictable resources. The ability to keep appointments may be dependent upon the availability of transportation, access to a telephone, and spur-of-the–moment childcare, all which must be available at the same time to be useful.
3. It is based in present time. Resources are in present time and there is little regard for or understanding of future orientation, which may explain their low regard for education and literacy.
4. It is energy consuming. What someone outside the world of poverty interprets as lazy or a poor choice may actually be energy conservation.
5. It brings out qualities of resilience. What is seen as abusing the system may be the mother’s determination to provide for her family because the resources are present today. She is actually demonstrating the resilience needed to live in the culture of poverty.
6. It is the only life they know. Low-income young mothers have watched their sisters, mothers, and grandmothers model a similar life trajectory of early parenthood, dependence upon public assistance, and limited education. The ability to envision and plan for the future is not in their life experience.

Methods

A non-randomized, one-group, post-test only design was used to evaluate the effectiveness of this program with a convenience sample of 40 pregnant and

parenting culturally diverse females ages 14 to 21 years, and their children. A simple, non-experimental evaluation of the program's implementation was conducted in order to examine the efficacy of peer-led parent education groups in improving parenting behaviors, providing safe and nurturing environments for participants' children, and increasing behaviors leading to self-sufficiency, i.e., school completion, employment, less social isolation.[21,29,35] Institutional review board exempt status was granted for the evaluation.

The parent groups met on a monthly basis for two years and used a peer-led, self-help model by training volunteer teams of women to lead the groups who had been young parents themselves. Group facilitators used the Meld parenting curriculum in monthly meetings (www.parentsasteachers.org) that covered child development, child guidance, health, family management, and parent development on a rotating basis over two years. Program participants completed an informed consent and demographic form, including basic demographics, involvement with the child's father (including child support and paternity), level of education, hours and place of employment, with whom the participant lived, to whom she turned to for support, 5-year goals, and hours of exposure to the curriculum. Participants, with the help of their case managers who were trained by the executive director, completed forms and questionnaires before the evaluation began. Due to the unpredictability of group membership, pre-evaluation data for specific individuals was difficult. Therefore, only one set of data was collected for each participant.

Instrumentation

Two tools were used in the evaluation. A parent outcome survey created by the agency looked at nurturing parenting behaviors, health and safety and preventive health care, family strengths, and social support. The second evaluation tool, The *Ages and Stages Questionnaires (ASQ): A Parent-Completed, Child-Monitoring System,*[13] was used to measure cognitive and social development of children in the program. The ASQ was chosen because it is an observational questionnaire easily administered by parents or caregivers, it has proven reliability (90%) and validity (83%), and it has proven efficacy in monitoring the development of at-risk children.

In addition to the data derived from the evaluation tools, questions were developed by the staff to determine program implementation strategy and efficacy as suggested by Grembrowski:[23]

1. *What are the participant demographics?*
2. *How many participants have a stable relationship with the father of their youngest child?*
3. *What kinds of positive parenting behaviors are present?*
4. *Are participants able to name at least one 5-year goal?*
5. *Who derives the most benefit from parent group meetings?*

6. *How many families are linked with a pediatric care provider (medical home) and other social services?*
7. *How many children are on track socially and developmentally?*
8. *Are participants satisfied with the program?*

Methods

Typical case protocols were as follows: upon enrollment in the program, the participant signed the program evaluation informed consent after the program was explained. A general demographic information sheet and the parent outcome survey were administered by one of six case managers who had received training by the executive director. Once the initial data collection was completed, the evaluator created a coding sheet and entered data into spreadsheets. Each participant was assigned a number to assure confidentiality. All children ages 4 to 60 months were administered the Ages and Stages Questionnaire. Results of these questionnaires were assembled into the spreadsheets along with the number of meetings attended during the evaluation period. In data analysis, the response to each question was divided by the sample size of 40 to calculate the percentage of responses in each category. No other data analysis was used.

Results

Participant Demographics

Forty young women and 59 children participated in the program evaluation. The ages of the young women ranged from 14 to 21 years. Twenty-seven (67.5%) were between 16 and 19 years of age. The ages of participant's children ranged from 6 weeks to 6 years. Additional demographic details are provided in Table 1.

Results of the Ages and Stages Questionnaire

This questionnaire helped staff determine if children were on track developmentally and socially. Of the 27 eligible children for the Ages and Stages questionnaire, 22 were available for testing and 5 could not be located for various reasons. Of the 22, 45% (10) were lagging in one to four areas of development and 45% (10) were lagging in all five areas. Most of the lags were in fine motor skills and problem solving. Therefore, 55% had no developmental lags.

Results of the Parent Outcome Survey

Positive Parenting Behaviors. The top discipline strategies were to praise good behavior (68%), use time outs, and redirect behavior. A high awareness of literacy and its importance among participants may have been due to the agency's partnership with the local library in literacy programs. Other parenting behaviors are recounted in Table 2.

5-year Goals. Participants were asked for 5-year goals to determine their ability to "envision the future. Individuals with little or no social support had difficulty stating goals, which may mean they could not envision the future, a quality found in resilient young mothers (Table 3). Social support came from mothers (56%), fathers (15%), grandparents (10%), siblings (97%), friends (7%), partners (24%), and in-laws (24%).

Participant Satisfaction. Five questions asked participants to rate the program on a five point Likert Scale as follows: How well do you feel you are supported in the group? How well do you feel you understand new information? How well prepared do you feel to make decisions based on what you learn in the group? How well prepared do you feel to try what you have learned with your child? Do you feel your voice is welcome? Is there anything that would make the group more beneficial to you?

The mean score for each question was 4.5, leading to the conclusion that participants were very pleased with the group. Suggestions for making the group more beneficial included pairing participants with a buddy for support outside group, allowing participants to give more input about the curriculum, providing childbirth preparation classes, making people be more punctual, and making the sessions longer. Others suggested the following topics: more newborn care and development, information about twins, and nutrition. Several asked to have a dentist and a pediatrician speak to the group.

Additional questions

Who Derived the Most Benefit from Parent Meetings? All of the participants were enrolled in the parent group program and attended at least one meeting prior to the evaluation period. The groups had consistent numbers of attendees but fewer consistent individual members, though the most dependable attendees in these groups were either 14 years old or greater than 18. Most inconsistent in their attendance were the 15 to 17 year olds, which may reflect their phase of development.

Characteristics of this subgroup are in Table 4.

Linkage with medical home and social services. Due to excellent case management, all participants and their children were with an established health care provider (medical home). All participants were enrolled in every social service program for which they qualified. The majority of participants received three to four types of assistance. The top four sources were WIC, the state children's Medicaid program, food stamps, and pregnancy Medicaid. Other sources of help were Temporary Assistance for Needy Families (TANF), child support, and Section 8 Housing.

Relationship with Father of Youngest Child. The most recent relationship was evaluated because some participants had different fathers for each child. Fathers of the children ranged in age from 15 to 38 years. Most were 17 to 22 years of age, and ten were 1 to 5 years younger than their partners. Five of the fathers were also enrolled in the agency programs. Fifteen percent (6)of the young women had no contact with the father of their babies, and two did not know the age of the father or his last name. Paternity was sought by 62.5% (25), 45% (18) received some help from their child's father (diapers, cash) and 57.5% (23) said they would not pursue child support payments.

Conclusions

The goal of providing a safe and nurturing environment was quantifiable, with 100% of the children having all recommended immunizations within a medical home. Positive reinforcement discipline techniques were used by 68% of parents, 49% read to their children, 66% used questions and 44% used imitation in communicating, and 17% reported never speaking with their children. Fifty-five percent of the children had no social or developmental lags and 51% of their mothers had future oriented goals. Focused parent groups appear to be effective in producing positive parenting behaviors in this population.

Discussion

The findings of this evaluation support the concept that programs for vulnerable families do the most good "when they focus on providing parents with new skills, insights, and approaches to the complex task of parenthood and are least effective when they attempt to change longstanding family problems and difficulties."[19p785] In an evaluation of a similar program of case management and parenting support, Fergusson and others[18,19] followed New Zealand families enrolled in the Early Start program. Participants were followed for 36 months at specified intervals throughout their child's life and more frequently if they were high-risk. These researchers concluded that the program did not produce parent and family related benefits. However, there were child related benefits in terms of health (medical home, immunizations), preschool education, child abuse and neglect, parenting practices, and child behavior.[19] The findings of Fergusson's studies supports the conclusions of this evaluation, in that the parent and family related benefits of peer-led parent groups, such as improvement in 5-year goals, moving toward self-sufficiency, less dependence upon public assistance, and enrolling in a trade school, were difficult to quantify. However, the child related benefits (medical home, immunizations, social and cognitive development) were more recognizable. In other words, the program was most effective in creating "new learning" related to child health, development, and behavior.

The difficulty of life in a violent, impoverished neighborhood can diminish the effects of positive interventions in the form of home visitation and parent groups.[2,17,21] A review of 13 parent program evaluations found the long-term

benefits of these programs to be minimal[6] because they were too comprehensive and adult-oriented. These results also corroborate findings previously published[2,6,17,21] describing the chaotic lives these young women experience and the multiple social drains on their resources. Child outcomes were more easily quantified than maternal outcomes in these studies, reinforcing how quickly an intervention should be implemented with the evanescence of participant commitment in this population.

The small size of this evaluation was a limitation in its application to larger populations. Use of an agency-devised parent outcome survey tool without established validity and reliability restricted its comparison to other evaluations. More complex statistical analysis of the data beyond percentages was difficult due to the transience of the participants. As a strength, this evaluation represents the cumulative efforts of an agency to apply a thoughtful approach to a unique population. The evaluator had the opportunity as executive director to observe participants and staff over six years in order to get a sense of the program's success. This opportunity was also a limitation as some objectivity was most certainly lost. Other strengths include a diverse and committed staff that were passionate about the program and wanted to see participants succeed. In spite of implementation difficulties with an unpredictable population, the fact that several of the staff had been agency clients in the past may have contributed to the program's success because the staff could relate so well to the participants.

Although other disciplines, most notably psychology, education, and sociology, have explored the world of the vulnerable young parent for several decades, nursing has just begun to share its unique contribution.[1,2,5,10,15,16,24,26] [27,29-31,41-43] The bio-ecological model described by Logsdon and others,[19] provides a strong conceptual basis for future nursing research by incorporating the complex, multidimensional world of the adolescent and young adult. Future nursing research could examine variations in the level and hours of exposure to a program, the effect and preparation of the case manager (college educated or peer with special training; nurse, health educator, or social worker), the resources of the participants (personal, interpersonal, community and family), the amount of personal chaos in each mother's life, the role of the father of the baby, and interventions that incorporate all members of a multi-generational household, including grandmothers.

Programs designed for young mothers must take into account her developmental stage, age, cognitive abilities, and need for physical and emotional support at the point in time she is a part of the program. Individualized support, rather than a one size fits all approach, will bring more success. Last, understanding the context of poverty in the life of many of these mothers will help those providing care and services to be more effective.

As Fergusson and others observed,[19] the high-risk populations that enter home visitation and parent education programs do not possess a common set of

problems, standard treatment protocols are difficult to implement, and outcomes are difficult to measure. Questions continue to be asked about the value of home visitation for high-risk parents, particularly whether implementation of these programs on a large, society-wide scale is cost-effective.[17-19,21] However, the design and implementation of programs for vulnerable young families incorporating outcomes-proven, evidence-based features are a worthy investment.

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Table 1

Demographic Characteristics of Participants

Characteristic	N	Percent
Ethnicity		
African American	10	25
White	23	57.5
Hispanic	4	10
Native American	3	7.5
Marital Status		
Single	24	60
Unmarried with partner	3	7
Separated, divorced	4	10
Married, with partner	9	23
Pregnant/Parenting Status		

Pregnant	25	64
Parenting	15	36
Pregnant and parenting	15	36

Table 2

Positive Parenting Behaviors by Participants (N=40)

Parenting Behavior	N	Percent
Discipline Strategies		
Time outs	17	41
Praise good behavior	28	68
Redirect behavior	17	41
Remove privileges	8	20
Social Interactions		
Play with others	23	56
Go to the park	28	44
Go to the library	7	17
Go to Head Start	6	15
Go to church	9	22
Communication with Child		
Baby talk	11	27
Imitation	18	44
Ask child questions	27	66
Don't talk to child	7	17
Rituals and Celebrations		
Bedtime/mealtime rituals	17	41
Celebrate holidays	35	85
Attend community events	15	37
Tell stories about past		61
Literacy		
Read books	20	49
Sing songs	26	63
Draw pictures	16	39
Visits with Healthcare Professionals		
Brings list of questions	7	17
Asks questions if doesn't understand	14	34
Asks for written information	31	76
Attends follow-up visits	14	34
Attends well child visits	26	63
Goes to doctor when sick	27	66
Gets immunizations	28	68
	33	80
Child Safety		
Child gate at stairs	9	22

Covered electrical sockets	16	39
Medicines locked away	28	68
Small objects put away	30	73
Bathroom door closed	27	66
Daily Nutrition		
Formula/breast milk	18	44
Fruits and vegetables	22	54
Dairy	18	44
Water or juice	27	66
Whole grains	14	34
Exercise Daily		
Dance, crawl, jump	20	49
Play outside	20	49
Go to the gym or YMCA	3	7
Walks with mom	20	49

Table 3

Relationship of Social Support to 5-Year Goals (N=40)

	No Goal	One Goal	Two Goals	Three Goals
Two Sources of Support	2%	41%	7%	2%
One Source of Support	7%	22%	5%	2%
No Support	2%	7%	0	2%

Table 4

Characteristics of Individuals Deriving the Most Benefit from Parent Meetings (N=14)

Characteristic	N	Percent
Age		
14-17	4	28
18 and older	10	72
Marital Status		
Single	9	65
Married	3	21
Cohabiting	2	14
Ethnicity		
White	11	79
Native-American	3	21
Sources of Public Assistance		
WIC	13	93
Food stamps	8	60

ARKids	9	67
SSI	1	6
Pregnancy Medicaid	2	12
HUD	2	12
Free lunch	3	27
TANF	1	6
Parenting Status		
Pregnant	6	43
Parenting	3	21
Both	5	36
Ages of Children		
Unborn	12	8
0-24 months	7	47
25-48 months	2	12
49-72 months	3	20
Education		
Drop Out	2	14
Graduate	6	43
In School	6	43
Employment		
Unemployed	13	93
Employed	1	7
Amount of Social Support		
None	2	12
One Source	4	28
Two Sources	4	28
Three or More Sources	4	28
5 Year Goals		
One goal	10	71
Two Goals	2	12
Three Goals	1	6
No Goal	1	6