TEENAGE PARENTS

OVERVIEW

Teenage pregnancy is considered to be one of the most important adolescent health problems in Western society. It is associated with a high economic cost involving both direct monetary expenditure for public assistance for welfare and child health care as well as negative societal outcomes in terms of child abuse, neglect and poverty (Quinlivan, 1994). Australia now has one of the highest adolescent fertility rates in the world.

Some teenage mothers may experience a number of adverse outcomes associated with teenage pregnancy including failure to complete secondary schooling, inability to find a job, and increased risk of poor health (Quinlivan, 2004; Social Exclusion Unit, 1999). There is considerable evidence that many teenage mothers who remain with their baby at least until birth, have an increased risk of poor health and are more likely to experience high levels of stress, depression and anxiety compared with young women who have not become pregnant (Einfeld, 2003; Kilpatrick et al, 2003).

The father’s role is not often considered however teenage fathers may also experience a number of disadvantages as a result of their teenage mother’s pregnancy, such as unemployment, poor educational attainment and a lack of natural paternal involvement (Stevens and Simon, 2007). Many teenage parents may also be unable to receive an education at the same time as having to manage the additional demands of parenthood (Barclay et al, 2005). 

In many rural areas, teenagers do not attend antenatal care as they cannot afford transport payments, and this has important implications for both local hospital and health service planners to plan for antenatal care services. Furthermore, funding support for such antenatal services has been secured as local and state government have grown much more aware of these issues. The failure to involve the teenage couple in antenatal planning means that issues that could have been adequately addressed in pregnancy may now be left as emergencies at delivery. This increases the chance of a need to seek emergency medical notification to child protection authorities.

Some teenage parents may be able to receive intensive educational interventions to encourage return to school may be useful. Evaluation of these programs needs to occur soon to determine whether they can be put into effective services. There is also some evidence that effective interventions that engage both parents and fathers in particular. Many services continue to experience difficulties in engaging teenage fathers.

Practical help

Practical help is effective and appreciated by teenage parents. Practical help includes assistance to find stable accommodation, furniture, advice on food, and access to free or cheap clothing and baby equipment, as well as planning important days of crises.

OTHER ISSUES

Domestic violence

A major concern in the setting of a teenage pregnancy is domestic violence (Quinlivan, 2004; Social Exclusion Unit, 1999; Quinlivan et al, 2004). In dealing with teenage parents it is important to screen for violence in the current relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

Housing uncertainty

This is a common issue among teenage parents. In many cases, the single teenage mother can expect a higher proportion of her unemployed housing than the family who is not a lone parent or with children. This places couples who remain together in a difficult situation. Pradee housing is usually too expensive or located far from centres such as public transport or medical care.

Community Paediatric Review

COMMUNITY PAEDIATRIC REVIEW

POSTNATAL DEPRESSION AND MOTHER-INFANT INTERACTION

BECOMING A PARENT – A TIME OF VULNERABILITY

Parenthood is a major life transition. Although becoming a parent is a time of great joy and celebration, the experience of motherhood is often not what new mothers anticipated and imagined. Current experiences of new mothers struggle with the countless changes and challenges associated with adjusting their lives to accommodate and nurture a new baby. The following are some quotes from mothers who have attended our Infant Clinic at the Perinatal Research Institute (PRI), Austin Health.

‘...Sometimes it’s as though a myth isn’t there about motherhood, and how easy it is ... It is not as natural to everybody isn’t it? I mean as a woman’s, it’s natural to be a mother...’

‘We just pressure on ourselves. We assume we are perfect, we are women and we can do it all.’

The unexpected difficulties new parents face with the arrival of a baby have a significant impact on maternal and paternal wellbeing and the development of young children (Kazemi-Kia and Sartorius, 1983). Inadequate parental involvement and intervention may result in negative feelings of guilt regarding the possible impact on their infant.

I feel like such a failure at a parent.”

‘My baby doesn’t fit the answers’

Up to 30% of women experience mild depressive symptoms, adjustment problems and postnatal period difficulties (Johnson, 2001). The following are some of the known factors that contribute to the development of poor mother-infant interaction.

Commonly lead to feelings of not coping and inadequate parenting.

POSTNATAL DEPRESSION – THE EXTENSIVE PROBLEMS

Postnatal depression is a devastating experience for new mothers. While a substantial proportion of women experience difficulties adjusting, clinical depression affects around 10% of women both pre- and post-natally (Reid, 2004). Postnatal depression during the childbirth years presents with the same symptom profile as depression at other life stages and occurs across cultures.

MAJOR DEPRESSIVE DISORDER (MDD) DIAGNOSIS

In order to make the diagnosis of MDD (according to Diagnostic and Statistical Manual of Mental Disorders, 4th – DSM-IV), women need to experience the following symptoms in the two weeks prior:

• Depressed mood/motor retardation
• Diminished interest in activities
• Fails more of the following:
  • Significant weight loss
  • Changes in appetite
  • Changes in sleep
  • Fatigue
  • Feelings of worthlessness
  • Inability to think clearly or concentrate
  • Recurrent thoughts of death or suicide
  • Psychomotor agitation or retardation.

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Women rarely recognize the symptoms of depression in themselves and yet consider it as normal for new mothers due to lack of depression in the men in the family of their life cycle. They continue to try to cope, to look after their baby partner, family and themselves.

…it when you’ve got a baby girl, you’ve got a beautiful home and partner: why would you be depressed?”

Given the high prevalence, lack of recognition of symptoms in the women themselves, and the serious far-reaching consequences of postnatal depression, efforts have been put into identifying risk factors so health professionals can identify those mothers most vulnerable.

Findings from the beyondblue National Postnatal Depression Program support midwives and Child and Family Health Nurses to universally and routinely screen mothers for depression and anxiety. Using a simple tool, the Edinburgh Postnatal Depression Scale (EPDS), screening has been found to be highly acceptable to women and health professionals. Women identified as potentially depressed on the EPDS can then be assessed more thoroughly and other risk factors taken into account. Appropriate next-steps can then be taken.

There is a strong belief among new mothers that Child and Family Health Nurses play a vital role in identifying and managing postnatal depression. In a recent focus group study by Child and Family Health Nurses (2008) mothers felt that Child and Family Health Nurses were the most helpful health professionals and that they would say “it’s coming”, recognize it and take control… “Offer the right option (for treatment) at the right time”.

Risk factors for postnatal depression include:

• Antenatal depression and anxiety
• Fear of history of depression
• Fear of history of depression
• Fear of history of depression
• Low social support from partner, mother

There is evidence that postnatal depression can have adverse inter-relationship and lay down the foundation for the infant’s social development. From observation, we can identify some characteristics as good enough or poor/rigidity, which are rhythmic, oscillating cycles of engagement and disengagement. Mothers build positive interactions with their infants through:

• Eye contact
• Physical responsiveness
• Empathy
• Understanding what the infant might be feeling
• Sensitivity through immediate and appropriate responses to infant cues
• Mother’s response being paced to her infant’s cues
• Emotional engagement
• Emotional and social engagement
• An environment that creates the expectancy for interaction
• Balancing stimulation with soothing and quieting interaction

There is now substantial evidence that many postnatally depressed mothers have difficulty interacting with their infants.

DEPRESSED MOTHERS MAY:
• Go on and rock their infants less
• Are less active and decisive
• Have less well-formed responses to their infants’ demands
• Demonstrate less warm acceptance of their infant
• Lack energy and motivation
• Be irritable and/or be intrusive with their infants
• Feel overwhelmed by the ‘infants’ cues
• Be emotionally ‘flat’
• Be disengaged.

The symptoms of depression such as ‘flat affect’ make it difficult for depressed women to engage in a warm, nurturing mother-infant interaction, despite their genuine efforts to be the best mother they can be. Depressed mothers report feeling less attached to their infants, finding their infants more demanding, and having diminished feelings of parenting competence. Up to 70% of depressed women have these difficulties. It is needed to be noted that mother-infant interactions following depression differ; some mothers may be withdrawn, others may be intrusive, while others may continue to find ways to interact optimally with their infants despite their depression. The way the mother’s partner or other close people interact with the infant will also influence attachment and child development. A father’s attachment to the infant can buffer the effects of maternal depression and is key to improving infant well-being. However, to avoid further undermining the mother’s feelings of competence, it is important that the support be given in a sensitive way.

EFFECTS ON INFANTS’ BEHAVIOUR
Infants are very sensitive to the quality of their interpersonal environment when it is disrupted experientially even in brief and mild ways. It is not surprising that infants of depressed mothers have been described as more drowsy, distressed and/or fussy, look at their mothers less and tend to engage in less self-directed activity. Some infants show avoidance and withdrawal behaviours whereas others show more protest behaviour. Increased emotional and behavioral disturbances such as problems with sleeping, eating, crying and separation have also been reported.

IMPACT ON ATTACHMENT AND LATER CHILD DEVELOPMENT
Appropriate maternal responsiveness leads to a secure attachment between the infant and her mother. This primary attachment relationship helps to form a child’s sense of ‘self’ and forms the base from which children explore themselves, others and the world. Securely attached infants are more curious, flexible, and confident, can cope with stress, are more likely to have high self-esteem, and can manage success, failure, hurt, jealousy and conflict, of a sensitive response from their mother. The insecurely attached child communicates anxiety and may be highly anxious, demanding, crying and clinging (ambivalent). Insecurely attached children lack confidence that someone will ‘be there’ for them. Mothers may be dismissive or overreassuring when their child is needy as a result of being unable to handle her own negative feelings.

There is growing literature on the association of maternal depression and compromised attachment, emotional and social development in children, possibly resulting from a response mismatch infant-interaction and poor quality of attachment.

DOES MATERNAL DEPRESSION IMPROVE THE MOTHER-INFANT INTERACTION?
Recent studies on treatment targeting maternal depression, have not only failed to find substantial improvements in the quality of the mother-infant interaction, irrespective of the treatment modality, counselling, psychodynamic therapy or cognitive behavioral therapy.

A Peto study showed that maternal mood improved following 12 week psychodynamic behavioral therapy program. However, the relationship difficulties between mother and infant were still present. It appears that when interactions deteriorate, it is an risk of ongoing vicious cycle. Maternal ‘flat affect’ and infant ‘demanding’ results in a less intense ongoing infant who he/she maternal feelings of failure and this pattern may continue. However, Peto’s findings have led to the conclusion that the relationship can be helped with appropriate support.

DIFFERENT WAYS TO SUPPORT MOTHER-INFANT ATTACHMENT
By targeting a parent’s internal world we can gain insight into the parent’s representations of the child this links discussion of early family relationships, current close relationships and the connections between the parents. In the past, parents have been asked to identify that communication strategies learned in the past can either facilitate or undermine current relationships.

2. Parenting behavior can be addressed directly. Attachment theory highlights the need to integrate the child into the dyadic mother-infant relationship. Parents need to be supported in learning about their infant’s behavior and how to provide responsive and consistent care.

3. The therapeutic relationship formed between the mother and the therapist can be regarded as a corrective attachment experience for the mother. The therapist becomes a secure base for the parent and teaches attachment and support and encouragement for the parent. The therapist is then a secure base for the child.

MANAGEMENT PLAN FOR POSTNATAL DEPRESSION
A management plan for postnatal families should include the following:

• Always consider depression may be present and ask about it or use the EPDS. Early recognition and diagnosis minimise long-term consequences for mother, infant and partner

• Think about the mother, the infant, the partner and other children. Maternal depression is correlated to other children. Ask how he feel)

• Connect the mother with her baby and ask how she respond to her interactions. Does she understand her baby? can she be able to soothe to the baby when needed? Do they have good eye contact?

• Discuss the woman, her partner and family what support is available and what she would feel helpful. Enlist family support.

• Develop a treatment plan which may focus on maternal symptoms (see www.beyondblue.org.au), mother-infant interaction, partner relationship, partner’s mental health, specific baby needs (ongoing monitoring, support, referral or management).

• Refer for specialist intervention where required, general practitioners, psychiatrist, psychologist, Mother-baby unit, Crisis Assessment and Treatment Team (CAT), or other State/Territory funded programs.

Most importantly, if depression is suspected, device a plan and give emergency contact numbers, follow up and support them to take up the help offered.

Professor Jeanette Milgrom Ms Jennifer Erickson and Dr Bronwyn Leigh Parent-Infant Research Institute (PRI) Infant Clinic, Austin Health, Melbourne www.pni.org.au

PRI has developed the Parent and Baby Wellbeing program (sponsored by IBA) that provides free support services for parents with young babies. These services are fully covered for IBA members with hospital cover (Victoria only).

For more information, including a case study and a complete list of references for this article, please visit www.ncbi.nlm.nih.gov (click on Publications and Resources and then click Child Health newsletters).

REFERENCES
1) As part of your routine practice with new mothers, do you apply the Edinburgh Postnatal Depression Scale? Do you feel confident in its application?
2) A new mother is at her baby’s 3 month check, that she is experiencing feelings of self-harm. What action do you take?
3) How well do you know your local mental health service network? Have you browsed a list of key contacts?
The EFFECT OF POSTNATAL DEPRESSION ON THE INFANT

There is evidence that postnatal depression can have immediate and long-term effects on the infant as well as the mother. The difficulties that arise in these relationships are triggered by postnatal depression, which may persist even after the mother’s symptoms have improved.

IMPACT ON MOTHER-INFANT INTERACTION

From birth, mothers and infants engage in face-to-face interactions. As a way to lay down the foundation for the infant’s social development, from observation, we can identify characteristics of good enough mother-infant interactions, which are rhythmic, oscillating cycles of engagement and disengagement. Mothers build positive interactions with their infants through:

- Eye contact
- Physical responsiveness
- Empathy
- Awareness of what the infant might be feeling
- Sensitivity through immediate and appropriate responses to infant cues
- Mother’s response being paced to her infant’s cues
- Emotional engagement
- Emotional alertness
- An environment that creates the expectancy for interaction
- Balancing stimulation with soothing and quieting interactions

There is now substantial evidence that many postnatally depressed mothers have difficulty interacting with their infants.

- Infant depression and anxiety
- Fact history of depression
- Family history of depression
- Lack of social support from partner, mother

Risk factors for postnatal depression include:

- Antenatal depression and anxiety
- Poor health experiences
- Young maternal age
- Early exposure to life stressors
- History of child abuse
- Premature birth
- History of smoking
- Low income
- Interpersonal conflict
- History of childhood abuse

Depressed mothers may:

- Gauge and rock their infants less
- Are less active and decisive
- Have less well-formed responses to their infants’ demands
- Demonstrate less warm acceptance of their infant’s needs
- Lack energy and motivation
- Be irritable and/or be irritable with their infants
- Be emotionally “flat”
- Be disengaged.

The symptoms of depression such as ‘fatigue’ make it difficult for depressed mothers to engage in a warm, nurturing mother-infant interaction, despite their genuine efforts to be the best mother they can.

Depressed mothers report less attachment to their infants, finding their infants more demanding, and having diminished feelings of parenting competence. Up to 70% of depressed women have these difficulties.

It is noted that mother-infant interactions following depression differ; some mothers may be withdrawn, others may be intrusive, while others may continue to find ways to interact optimally with their infants despite their depression.

The way the mother’s partner or other close people interact with the infant will also influence attachment and child development. A father’s attachment to his infant can buffer the effects of maternal depression and is key to improving infant well-being. However, to avoid further undermining the mother’s feelings of competence, it is important that this support be given in a sensitive way.

EFFECTS ON INFANTS’ BEHAVIOUR

Infants are very sensitive to the quality of their interpersonal environment when it is disrupted experientially even in brief and mild ways. It is not surprising that infants of depressed mothers have been described as more drowsy, distressed and/or fussy, at times ignore their mothers less and tend to engage in self-directed activity. Some infants show avoidance and withdrawn behaviour, whereas others show more protest behaviour. Increased emotional and behavioural disturbances such as problems with sleeping, eating, crying and separation have also been reported.

DIFFERENT WAYS TO SUPPORT MOTHER-INFANT ATTACHMENT

1. Interventions targeting a parent’s internal world: may also appeal to the parent’s representations of the child’s development, by encouraging close relationships, current close relationships and the connections between these. Parents are helped to understand that communication strategies learned in the past can either facilitate or undermine current relationships.

2. Parenting behavior can be addressed directly. Attachment theory highlights the need to integrate the child’s experiences and development with parenting, support and encouragement. Parents need to be supported in learning about their infant’s behavior and how to provide responsive and consistent care.

3. The therapeutic relationship formed between the mother and the therapist can be regarded as a corrective attachment experience for the mother. The therapist becomes a secure base for the parent and encourages the parent’s confidence in their own ability to handle their own negative feelings.

There is growing literature on the association of maternal depression and compromised physiological, emotional and social development in children, possibly resulting from a response mismatch-infant interaction and poor quality of attachment.

DOES TREATING MATERNAL DEPRESSION IMPROVE THE MOTHER-INFANT INTERACTION?

Recent studies on treatment targeting maternal depression have only failed to find substantial improvements in the quality of the mother-infant interaction, irrespective of the treatment modality: counselling, psychological therapy or cognitive behavioral therapy.

A PPT study showed that mothers became more involved following 12 weeks of cognitive behavioral therapy program. However, the relationship difficulties between mother and infant often persist. It appears that when interactions deteriorate, it is a risk of an ongoing cyclic process. Maternal “fatigue” and “irritability” may result in a less intimate and engaged infant who initiates maternal feelings of failure and who may become withdrawn. However, PPT’s results do not ensure that long-term interventions can have the relationship that can be sustained with appropriate support.

The aim of this study was to contribute to the current literature about the effects of maternal depression on the mother-infant relationship. The study was conducted in our psychology center.

The main finding of this study was that there was a significant improvement in the quality of the mother-infant interaction following maternal depression treatment. This improvement was maintained at the 6-month follow-up.

It is important that, if depression is suspected, advice is given, and an expert to contact is identified, both for the mother and the infant.

In order to improve the mother-infant relationship, it is important to address maternal depression. This can be achieved through a combination of medication, psychotherapy, and support groups.

Several factors have been identified as important in the treatment of postnatal depression, including:

- The mother’s sense of self-confidence
- The mother’s social support network
- The mother’s ability to handle stress

Integrated maternal and infant care is essential in the treatment of postnatal depression. This model is characterized by a multidisciplinary approach that involves close collaboration between the mother, the infant, and the healthcare providers.

In conclusion, the treatment of postnatal depression is a complex and multifaceted process that requires a holistic approach. It is important to address both maternal and infant factors to improve the quality of the mother-infant relationship.
Women rarely recognize the symptoms of depression in themselves and justify them as normal. For new mothers due to lack of sleep, the demands of caring for a baby, and the transition to parenthood, they continue to try to cope, to look after their baby partner, family and themselves. ‘when you’ve got a baby girl, you’ve got a beautiful home and partner; why would you be sad?’

Given the high prevalence, lack of recognition of symptoms in the women themselves, and the serious far-reaching consequences of maternal depression, efforts have been put into identifying risk factors so health professionals can identify those mothers most vulnerable.

Identifying risk factors: • Antenatal depression and anxiety • Past history of depression • Family history of depression • Lack of social support from partner, mother

Depressed mothers may: • Go back and run their infants less • Are less active and decisive • Have less well-formed responses to their infants’ demands • Demonstrate less warmth acceptance of their infant • Lack energy and motivation • Be irritable and/or be intrusive with their infants’ cues • Be emotionally flat • Be disengaged.

The symptoms of depression such as ‘flat affect’ make it difficult for depressed women to engage in a warm, nurturing mother-infant interaction, despite their genuine efforts to be the best mother they can be. Depressed mothers report less attachment to their infants, finding their infants more demanding, and having diminished feelings of parenting competence. Up to 70% of depressed women have these difficulties.

It is noted that a mother-infant interaction following depression differ; some mothers may be withdrawn, others may be intrusive, while others may continue to find ways to interact optimally with their infants despite their depression.

The way the mother’s partner or other close people interact with the infant will also influence attachment and child development. A father’s attachment to the infant can buffer the effects of maternal depression and is key to improving infant well-being. However, it is crucial to further understand the mother’s feelings of competence, as it is important that the support be given in a sensitive way.

Effects on infants’ behaviour

Infants are very sensitive to the quality of their interpersonal environment when it is disrupted experimentally even in brief and mild ways. It is not surprising that infants of depressed mothers have been described as more drowsy, distressed and/or fussy, lack at attention to their mothers less and tend to engage in self-directed activity. Some infants show avoidance and withdrawal behaviors, whereas others show more protest behavior. Increased emotional and behavioral disturbances such as problems with sleeping, eating, crying and separation have also been reported.

Managing depression and following a treatment plan for postnatal families should include the following: • Always consider depression may be present and ask about it or use the EPDS. Early recognition and diagnosis minimize longer term consequences for mother, infant and partner. • Think about the mother, the infant, the partner and other children. Maternal depression is typically correlated to maternal infant interaction, ask how she is coping. • Observe the mother interacting with her baby and how she responds to and interprets her behaviour. Does she understand her baby’s needs? Is she able to soothe her infant when needed? Do they have good eye contact? • Discuss with the woman, her partner and family what support is available and what would be helpful. Enlist family support.

DIFFERENT WAYS TO SUPPORT MOTHER-INFANT ATTACHMENT

1. Interventions targeting a parent’s internal world to provide insight into the parent’s representations of the child the child’s impact on the attachment process, current close relationships and the connections between these relationships may help to understand that communication strategies learned in the past can either facilitate or undermine current relationships.

2. Parenting behaviour can be addressed directly. Attachment theory highlights the need to integrate the child’s emotional and developmental needs appropriately. Parents need to be supported in learning about their infant’s behavior and how to provide responsive and consistent care.

3. The therapeutic relationship formed between the mother and the therapist can be regarded as a corrective attachment experience for the mother. The therapist becomes a secure base for the parent, providing support and encouragement for the parent. The parent is then more able to form a secure attachment relationship.

MANAGEMENT PLAN FOR POSTNATAL DEPRESSION

A management plan for postnatal families should include the following:

• Always consider depression may be present and ask about it or use the EPDS. Early recognition and diagnosis minimize longer term consequences for mother, infant and partner.
• Think about the mother, the infant, the partner and other children. Maternal depression is typically correlated to maternal infant interaction, ask how she is coping.
• Observe the mother interacting with her baby and how she responds to and interprets her behaviour. Does she understand her baby’s needs? Is she able to soothe her infant when needed? Do they have good eye contact?
• Discuss with the woman, her partner and family what support is available and what would be helpful. Enlist family support.

1) As part of your workplace practice with new mothers, do you apply the Edinburgh Postnatal Depression Scale? Do you feel confident in its application?
2) Are your staff aware at her baby’s 3 month check, that she is experiencing feelings of self-harm. What action do you take?
3) How well do you know your local mental health service network? Have you described a joint key list?
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Teenage pregnancy is considered to be one of the most important adolescent health problems in Western society. It is associated with a high economic cost involving both direct monetary expenditure for public welfare and child health care as well as negative societal outcomes in terms of child abuse, neglect and poverty (Quinlan, 2004). Australia now has one of the highest adolescent fertility rates in the world.

Teenage mothers may experience a number of adverse outcomes associated with teenage pregnancy including failure to complete schooling, inability to find a job, and increased risk of poor health (Quinlan, 2004; Social Exclusion Unit, 1999).

There is now considerable evidence that many teenagers ideologically perceive pregnancy and parenthood and regard it with high expectations. A significant proportion of adolescent pregnancies result as a consequence of predisposed, idealised attitudes to pregnancy, parenthood and personal change rather than by accident or negative attitudes to contraception (Condon et al., 2001).

The father's role is not often considered; however, research has shown that up to 60% of teenage baby fathers remain at least partially engaged at 6 months post partum (Quinlan, 2004; Social Exclusion Unit, 1999).

SUPPORT FOR TEENAGE PARENTS

• Antenatal services

Specialised teenage antenatal clinics can introduce the couple to parenting skills. Antenatal education can focus on preparing the couple for a safe home environment and parenting strategies for both mother and father. There is evidence that these services result in favourable pregnancy outcomes and reduce the rate of preterm delivery (Neaust et al., 2003; Stevens, Simon et al., 2003). Evidence demonstrates that nurses are more effective in service delivery than paraprofessionals in achieving results (Haralambous et al., 2002; Stevens-Simon et al., 2003). Nurses are better able to provide the necessary information to prevent teenage pregnancy and paraprofessionals do not have the experience to do so. The teenage parents in a probationary baby face the additional demands of a preterm infant or a setting in which a term infant is hard enough. Difficult transportation to medical appointments become practical barriers to care when both parents lack a driver’s licence, or they cannot afford a car and petrol.

In many rural areas, teenagers do not attend antenatal care as they cannot afford petrol payments, however, some rural hospitals and local health services offer free antenatal clinic services. Furthermore, funding cuts have seen antenatal antenatal services reduced and they are now rare. The failure to involve the teenage couple in antenatal planning means that issues that could have been addressed in a timely manner may be left as emergencies at delivery. This increases the chances to receive needed antenatal notification to child protection authorities.

Teenage parents may be able to receive antenatal care during a school holiday period through volunteers and not for profit programs. However, continuity of care remains a challenge as many non-government organisations are dependent upon the sometimes unpredictable policy directions and funding cycles of all levels of government.

Sustained home visitation by nurses

Research suggests that home visitation is a cost-effective way to support and enhance parenting skills, reduce child abuse and neglect, and improve maternal mental health. Successful home visitation programs are capable of engaging all care-givers, and can focus on the couple.

An Australian randomised trial evaluated the effectiveness of nurse-referedte who met the teenage mother in the antenatal period and performed home visits. The visits were associated with a reduction in the pooled adverse effects of death, non-accidental injury, and care and protection notifications from 13% to 3%, and improvements in knowledge and use of contraceptives (Stevens-Simon et al., 2003; 2004).

Domestic violence

A major concern in the setting of a teenage pregnancy is domestic violence (Quinlan, 2004; Social Exclusion Unit, 1999; Quinlan et al., 2004). In dealing with teenage parents it is important to screen for violence in the couple’s relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

Housing uncertainty

This is a common issue for pregnant teenage parents. In many cases, the single teenage mother can earn a higher hourly wage than employed housing the family. This places couples who remain together in a difficult situation. Private housing is usually too expensive or located far from services such as public transport or medical care.

Childbearing years presents with the same diagnostic process that occurs in men and women during the childbearing years. This is an important outcome for teenage parents, as the childbearing period is associated with a high risk of mental health disorders for women, pregnancy being a period of significant stress.

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Specialised teenage antenatal clinics can introduce the couple to parenting skills. Antenatal education can focus on preparing the couple for a safe home environment and parenting strategies for both mother and father. There is evidence that these services result in favourable pregnancy outcomes and reduce the rate of preterm delivery (Neaust et al., 2003; Stevens, Simon et al., 2003). Evidence demonstrates that nurses are more effective in service delivery than paraprofessionals in achieving results (Haralambous et al., 2002; Stevens-Simon et al., 2003). Nurses are better able to provide the necessary information to prevent teenage pregnancy and paraprofessionals do not have the experience to do so. The teenage parents in a probationary baby face the additional demands of a preterm infant or a setting in which a term infant is hard enough. Difficult transportation to medical appointments become practical barriers to care when both parents lack a driver’s licence, or they cannot afford a car and petrol.

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• Antenatal services

Specialised teenage antenatal clinics can introduce the couple to parenting skills. Antenatal education can focus on preparing the couple for a safe home environment and parenting strategies for both mother and father. There is evidence that these services result in favourable pregnancy outcomes and reduce the rate of preterm delivery (Neaust et al., 2003; Stevens, Simon et al., 2003). Evidence demonstrates that nurses are more effective in service delivery than paraprofessionals in achieving results (Haralambous et al., 2002; Stevens-Simon et al., 2003). Nurses are better able to provide the necessary information to prevent teenage pregnancy and paraprofessionals do not have the experience to do so. The teenage parents in a probationary baby face the additional demands of a preterm infant or a setting in which a term infant is hard enough. Difficult transportation to medical appointments become practical barriers to care when both parents lack a driver’s licence, or they cannot afford a car and petrol.

In many rural areas, teenagers do not attend antenatal care as they cannot afford petrol payments, however, some rural hospitals and local health services offer free antenatal clinic services. Furthermore, funding cuts have seen antenatal antenatal services reduced and they are now rare. The failure to involve the teenage couple in antenatal planning means that issues that could have been addressed in a timely manner may be left as emergencies at delivery. This increases the chances to receive needed antenatal notification to child protection authorities. Teenage parents may be able to receive antenatal care during a school holiday period through volunteers and not for profit programs. However, continuity of care remains a challenge as many non-government organisations are dependent upon the sometimes unpredictable policy directions and funding cycles of all levels of government.

Sustained home visitation by nurses

Research suggests that home visitation is a cost-effective way to support and enhance parenting skills, reduce child abuse and neglect, and improve maternal mental health. Successful home visitation programs are capable of engaging all care-givers, and can focus on the couple.

An Australian randomised trial evaluated the effectiveness of nurse-referedte who met the teenage mother in the antenatal period and performed home visits. The visits were associated with a reduction in the pooled adverse effects of death, non-accidental injury, and care and protection notifications from 13% to 3%, and improvements in knowledge and use of contraceptives (Stevens-Simon et al., 2003; 2004).

Domestic violence

A major concern in the setting of a teenage pregnancy is domestic violence (Quinlan, 2004; Social Exclusion Unit, 1999; Quinlan et al., 2004). In dealing with teenage parents it is important to screen for violence in the couple’s relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

Housing uncertainty

This is a common issue for pregnant teenage parents. In many cases, the single teenage mother can earn a higher hourly wage than employed housing the family. This places couples who remain together in a difficult situation. Private housing is usually too expensive or located far from services such as public transport or medical care.

Childbearing years presents with the same diagnostic process that occurs in men and women during the childbearing years. This is an important outcome for teenage parents, as the childbearing period is associated with a high risk of mental health disorders for women, pregnancy being a period of significant stress.
Overview

Teenage pregnancy is considered to be one of the most important adolescent health problems in Western society. It is associated with a high economic cost involving both direct monetary expenditure for public welfare and child health care as well as negative societal outcomes in terms of child abuse, neglect and poverty (Quinlivan, 2004). Australia now has one of the highest adolescent fertility rates in the world.

Teenage mothers may experience a number of adverse outcomes associated with teenage pregnancy including failure to complete schooling, inability to find a job, and increased risk of poor health (Quinlivan, 2004; Social Exclusion Unit, 1999).

There is considerable evidence that many teenagers ideologically believe pregnancy and parenthood as regret with high expectations. A significant proportion of adolescent pregnancies result as a consequence of positivism, idealised attitudes to pregnancy, parenthood and personal change rather than by accident or negative attitudes to contraception (Condon et al., 2001).

The father’s role is not considered often however research has shown that up to 60% of fathers of preterm infants still remain at least partially engaged at 6 months post partum (Quinlivan, 2004; Social Exclusion Unit, 1999).

Support for teenage parents

- Antenatal services
  Specialised ante-natal clinics can introduce the couple to parenting skills. Antenatal education can focus on the importance of eating a healthy diet, weight management, selecting a home environment and preparing strategies for both mother and father. There is evidence that these services result in better pregnancy outcomes and reduce the rate of preterm delivery (Neaust et al., 2005; Hooper et al., 2003; Euro PCI, 2005; O’Callaghan et al., 2003; O’Brien et al., 2000).

- Home intervention
  Evidence demonstrates that nurses are more effective in service delivery than paraprofessionals in achieving results for new families (Oliva et al., 2002; Stevens-Simon et al., 2001). Nurses are better able to anticipate the needs of a family and provide tailored care. Paraprofessionals, on the other hand, are likely observed less or no efficacy of employed paraprofessional home visitation.

The Australian Government has recently committed to provide sustained home intervention visitation services using nurses to all Aboriginal and Torres Strait Islander families. As a disproportion amount of these families fall into the teenage cohort, this will play an important role in service delivery.

- Mothers, fathers and couples groups
  New parents’ and fathers’ groups, other community based group activities, peer support initiatives and educational interventions to encourage return to schooling may be useful. Evaluation of these programs is necessary to see how many mothers put into effective services. There is also evidence of supportive services that engage both parents and fathers in particular. Many services continue to experience difficulties in engaging teenage fathers.

- Practical help
  Practical help is effective and affordable by teenage parents. Practical help includes assisting to find stable accommodation, furniture, advice on food, and access to free or cheap clothing and baby equipment, as well as planning the lives of crises.

Other issues

- Domestic violence
  A major concern in the setting of a teenage pregnancy is domestic violence (Quinlivan, 2004; Social Exclusion Unit, 1999; Quinlivan et al., 2004). In dealing with teenage parents it is important to screen for violence in the current relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

- Housing
  Unemployment may be important in screening for violence in the current relationship and any past relationships. The father of the baby may also report a violent family background and this may impact on his behaviour and actions as a father.

Reflexion questions

1. Do you attempt to engage teenage mothers into your child and family safety protocol?
2. Have you ever seen an old baby for a regular baby? You raise issues of partner violence at home. (What implications does this have for your practice in relation to: a) The safety of the child? b) The safety of the partner? c) The safety of the baby?)

Conclusion

- Prevention of second teenage pregnancy is an important outcome for teenage parents, and the subsequent pregnancy that commits the family to a life dependency on welfare (Stop Smoking, 2002; Forsenberg et al., 1990).

- Return to education
  Flexible strategies to assist a return to education are usually as vital that the break of the inter-generational poverty cycle. teenage parents require support to make the transition to adult living, however current strategies are yet to be evaluated to help guide those parents in the move.

- Conclusion
  This paper focuses on the challenges and opportunities for new mothers and their families as they begin a new phase in their lives. The findings indicate that many teenage parents face multiple challenges that can delay or hinder their transition to parenthood. The challenges include financial strain, lack of social support, and difficulty in accessing professional help. The study highlights the importance of providing comprehensive support services that address the unique needs of teenage parents. It emphasizes the need for multidisciplinary approaches to care and the importance of involving fathers in the process. The findings also underscore the need for early intervention to prevent negative outcomes for both parents and children. The study contributes to the growing body of research on teenage pregnancy and highlights the importance of tailoring interventions to meet the specific needs of this population. The findings have implications for policy and practice, calling for targeted support services and evidence-based approaches to address the challenges faced by teenage parents.