Promotion of adjustment to the exercise of parental role in adolescence

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Summary

Introduction. Parental exercise itself constitutes a very demanding challenge – however, when pregnancy occurs in adolescence, often unplanned, it converges tasks of different stages of development, irreversibly modifying an identity, roles and functions, not only of the young woman, but also of her family.

Objectives. Applying the Dynamic Model of Family Assessment and Intervention (MDAIF), by Figueiredo (2012), and assessing the impact of nursing care in the promotion of skills for a transition to the parental role's exercise in the teenager and her family.

Methods. Qualitative study, conducted based on MDAIF, as a theoretical and operational reference, in clinical and community context in Primary Health Care, based on the process of family intervention who experienced an adolescent pregnancy. Seven nursing consultations to family were carried out, as a unit, from April to May 2016.

Results and discussion. Extended family, with several subsystems and strict limits. Middle-class family. Although unplanned, and the antagonistic relationship with her parents, the instrumental and emotional support provided by them became critical in adapting to motherhood and the newborn's development.

Conclusions. With MDAIF's use, nurses have developed their skills for a personalized approach to the family, centered on the adaptation and holistic transition to the parental process. It also made it possible to respond to the identified family needs, not only through the restructuring of a parental and personal identity, based on values, personal and professional goals and priorities (the teenager pursued her academic training), but also promoting a family environment based on trust and harmony.

KEYWORDS: ADOLESCENT; PARENTING; EMOTIONAL ADJUSTMENT; PRIMARY CARE NURSING.

Introduction

According to the World Health Organization, about 16 million girls aged 15 to 19 and some one million under 15 give birth every year[1]. Complications during pregnancy and childbirth are considered the second cause of death among girls with the same age group, globally.

Currently, teenage pregnancy assumes itself as a problematic situation of great interest around the world. In Portugal, despite the recent decriminalization of abortion (2007) and the evident efforts that have been made, either through awareness campaigns for the use of contraceptive methods, through the implementation of Sexual Education in schools or the disclosure of free access to planning consultations family and reproductive health; and the delivery, also at no cost, of contraceptive methods in Primary Health Care; it is verified that these strategies, already adopted, are still not enough. To the apparent disinterest, disinformation or inefficient training of the target group, the teenagers, the approach to this subject is particularly important.

Parental exercise itself constitutes a very demanding challenge, as it emerges from the construction of basic skills and knowledge in caring for, protecting, developing and bonding (parents-child), with the birth of the first child. However, when pregnancy occurs in adolescence, often unplanned, it converges tasks of different stages of development, irreversibly modifying an identity, roles and functions, not only of the young woman, but also of her family.

Factors that may influence the reproductive decision

The factors that can influence a reproductive decision can be divided into individuals (age of the adolescent, adolescent cognitive skills,

RISK FACTORS AND PROTECTIVE FACTORS FOR ADEQUATE ADJUSTMENT TO EARLY PREGNANCY **1**

Risk factors	Protective factors
(1) Family restructuring and dysfunctionality	Resilience
(2) Minor supervision and parental support	Family support and affective relationships
(3) Low educational level	Positive relationship with the baby's father
(4) Disadvantaged socioeconomic context	Social support
(5) Experience of adverse events	
(6) Risk behaviours	
Risk or protective factors	
Parenting Styles and Practices	
Characteristics of the peer group	
Prior personality of the pregnant woman	

☒ Adjustment to early pregnancy

☒Adjustment to early pregnancy

Sources: Martins[16]; Carmona[8]; Canavarro & Pedrosa[3]; Pires[21]; Pires et al.[2]

autonomy in the decision-making process and prior birth control), social (social context, family features, school involvement) and environmental (place of residence)[2].

Canavarro and Araújo Pedrosa argue that the occurrence of a pregnancy in adolescence does not mean, inevitably, that it is an insurmountable challenge that leads to damage situations[3]. The results of greater or lesser success in adaptation depend to a large extent on the contexts in which gestation and birth occur and the degree of support available to the girl and her child.

Currently, particular importance has been given not only to risk factors and their interaction, but also to the protective factors, often determinant for an adequate adjustment to early pregnancy (table 1).

The main risk factors for the occurrence of a teenage pregnancy are (table 1): (1) the fact that the adolescent lives in a dysfunctional and rigid family environment (characterized by stress, pressure and conflicts); (2) less supervision and parental support, based on a unstructured family environment; (3) (4) experiencing poverty and exclusion from the education or employment system; (5) experiencing sexual abuse situations; (6) early sexual activity, ineffective use of contraceptive methods and/or alcohol and drug use. As protective factors for early pregnancy can be highlighted resilience[3], socio-family contexts, the perception of social and family support, a positive relationship with the baby's father and the characteristics of the peer group.

Teenage pregnancy: implications

Adolescent pregnancy is considered an emerging health problem not only because of its physical implications, but also because of its emotional, social, cultural, economic and family implications.

At the physical level, a teenager has not yet fully reached its development and maturity. Situations like trauma, infections and the sperm's pH itself can attack the immature uterine epithelium, increasing the likelihood of cervical dysplasia and carcinoma *in situ* in young adults[4]. Also the peak of bone mass can be impaired, since part of the calcium needed to its construction will be sent to the fetus[4]. In addition, there is a higher incidence of medical obstetric complications (anemia, nutritional deficits, high blood pressure during pregnancy, preterm delivery, higher incidence of elective cesarean sections and increased maternal mortality, as well as a higher incidence of neonatal complications: newborn low birth weight, small for gestational age babies, higher incidence of neonatal mortality, higher risk of subsequent pregnancies, and higher incidence of postpartum depression).

Teenagers who become mothers face multiple changes in their social and relational roles. Often, they are confronted with the need to accept new parental responsibilities and to resolve their developmental tasks divergently.

The way how the adolescent, the family and the significant figures in her social network can negotiate these challenges will be critical to the adaptation and development of her and her baby. Although it is an initially distressing situation, it ends up mobilizing the whole family, triggering not only a financial support network but also emotional[5,6].

Some authors state that the most frequent situation is the cohabitation of the adolescent and her child with their nuclear or extended family or with newborn's father[7]. However, during this period, "grandparents as parents" may emerge, which due to the urgent need to care for the newborn, end up hindering the process of autonomy and growth of the adolescent as a mother.

At the social level, Carmona states

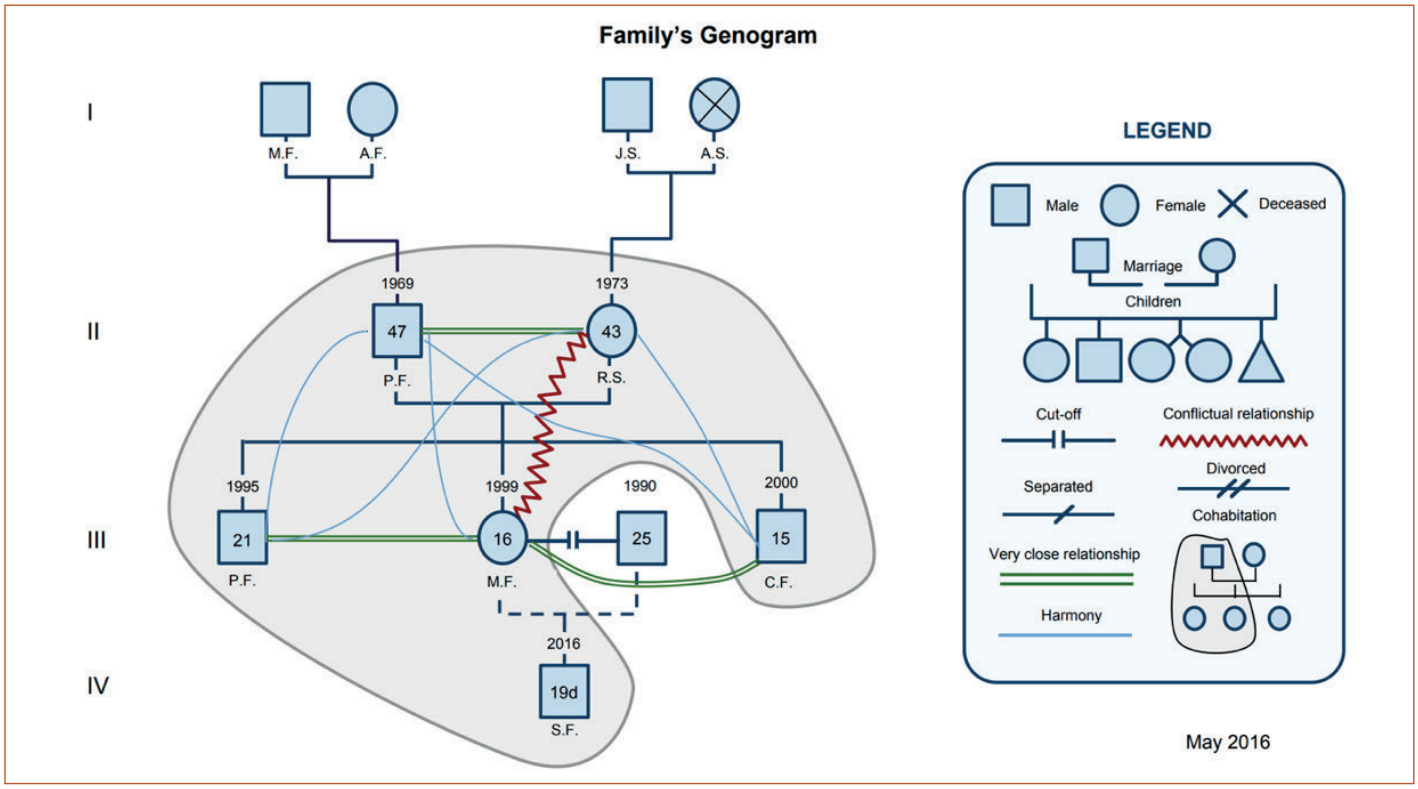

Figure 1. Family's Genogram (May 2016)

that the teenager may suffer losses such as: dropping out or interrupting school or even a precarious and poorly paid early career, with the aggravation of, in some situations, disclaim and disinterest in all aspects related to your child[8].

Becoming a mother will also imply changes in relationships with peers and the group of friends: less availability for leisure or professional activities, which often culminates in a dissatisfaction with life in general by these adolescent mothers.

Despite all the implications in the different spheres/domains of adolescent life and those closest to her, Fonseca concludes that the high prevalence of adolescent pregnancy is not justified by the lack of knowledge about contraceptive methods, but by the absence of a life project in adolescents[4].

Methods

The study was based on the intervention process of a family who experienced an unplanned and unplanned adolescent pregnancy and motherhood up to 24 weeks of gestation, the result of an occasional relationship through virtual correspondence.

It was defined as a general research question "What are the contributions of the Dynamic Model of Family Assessment and Intervention[9] for evaluation and intervention in a family that has experienced an early pregnancy and motherhood?".

The main objectives of this study are applying the Dynamic Model of Family Assessment and Intervention (MDAIF)[9] and assessing the impact of nursing care in the promotion of skills for a transition to the parental role's exercise in the teenager and her family.

This is a non-experimental, qualitative, descriptive and follow-up case study. It took place over a time horizon from May 2016 to July 2017.

It was used the following data collection instruments: interview, questionnaires and scales –based on the Dynamic Family Assessment and Intervention Model[9], as a theoretical and operational framework– and also the observation. This model mentions three main categories: structural, functional and developmental.

For the assessment of the structural dimension, it was used the Genogram, the Ecomap and the Graffar Scale[10]. In Family Development dimension, the Stages and Developmental Tasks in the Family Life Cycle[11] and the Mother-infant Bonding Scale[12]. In the functional dimension, the Family Adaptability and Cohesion Evaluation Scale (FACES III)[13], Family Apgar[14], the Social Support Satisfaction Scale[15] and the Healthy Kids Resilience Assessment Module (version 6.0)[16].

Participants

Non-random sample, for convenience. The inclusion of study participants obeyed the following criteria: family with adolescent children; being greater than 14 years old; one of the family members be female between the ages of 14 and 18 (exclusively) who has experienced pregnancy and/or maternity in adolescence.

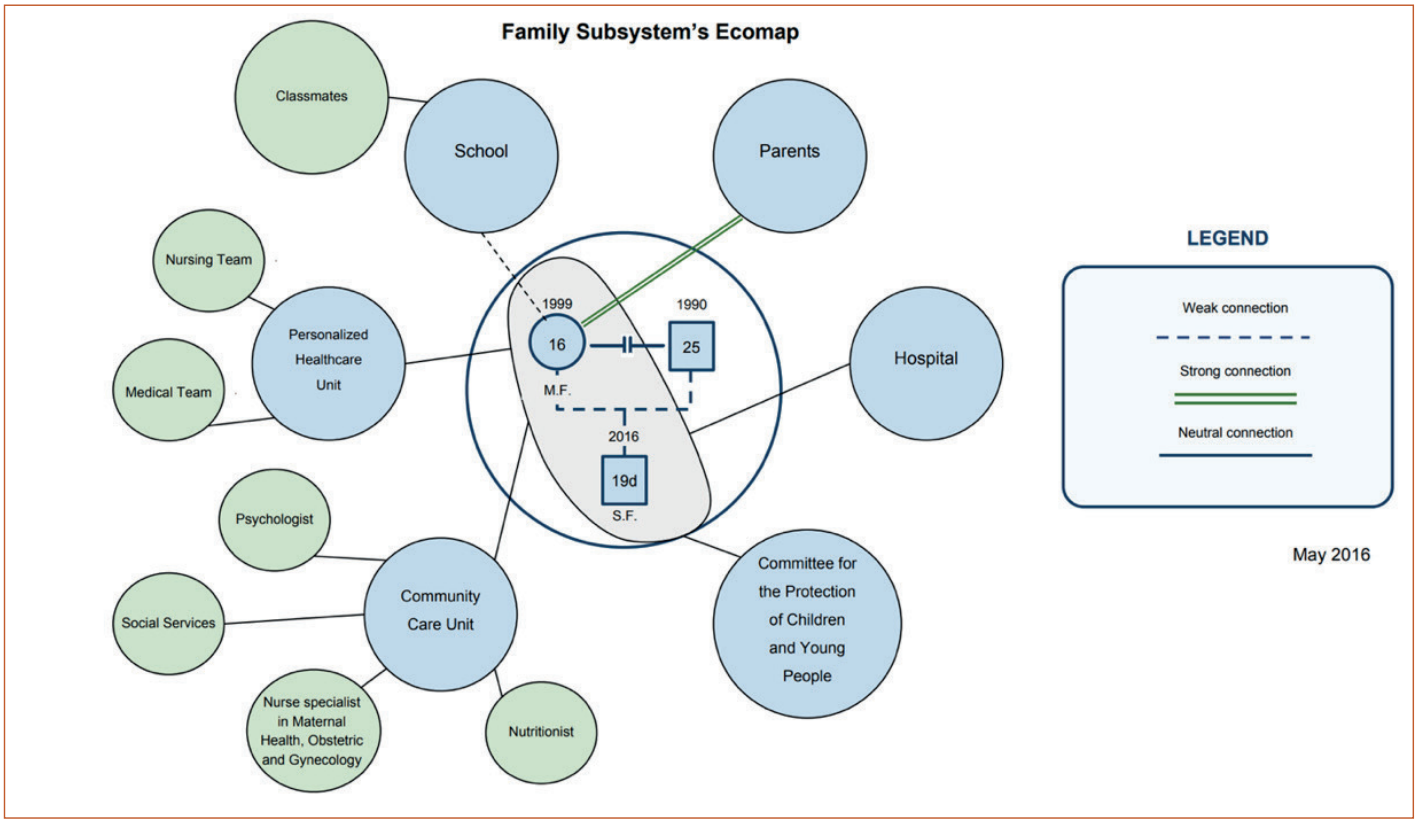

Figure 2. Family subsystem's ecomap (May 2016)

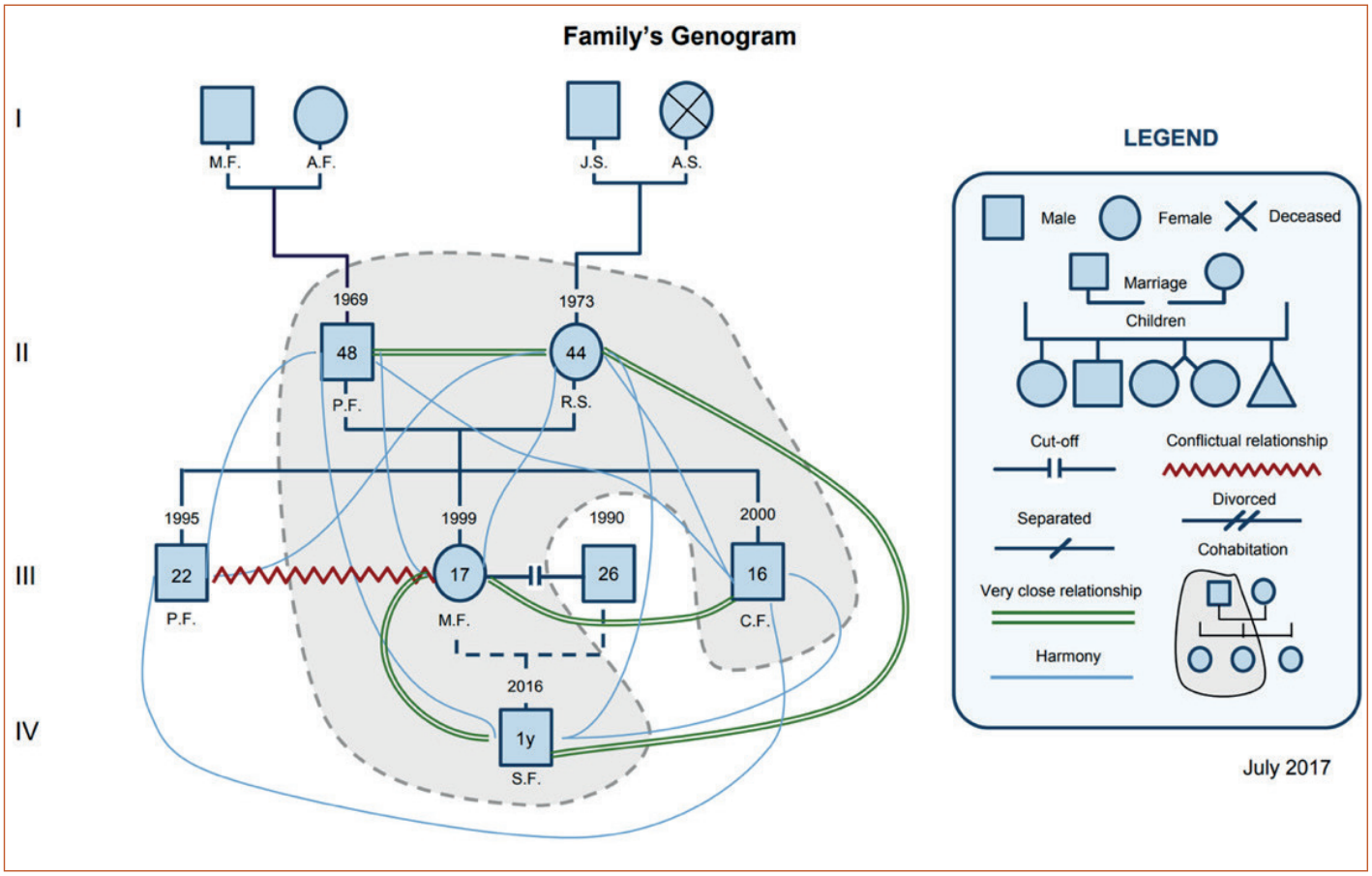

Figure 3. Family's Genogram (July 2017)

Procedures

Concerning the collection of information, authorizations were requested from Portuguese Data Protection Authority (Comissão Nacional de Proteção de Dados), Ethics Committee of Central Regional Health Administration (Portugal), Health Centers Group of Dão Lafões (Agrupamento de Centros de Saúde Dão-Lafões) and from the Healthcare Unit where the study was conducted.

The data were collected in the months of May to July of 2017, directly and indirectly, through interviews, questionnaires and application of scales. The interview was applied by the researchers and the other data collection instruments delivered in closed envelope, to each participant.

Previously, it was requested the collaboration of the Healthcare Unit (in which it was intended to carry out the study), in order to intermediate a first contact with the family. The researchers only met the family after their prior consent in that contact with the Health Unit.

All data obtained are confidential and the anonymity was guaranteed using fictitious names. Participants were informed, at the first contact, about the optional nature of their participation and the guarantee of confidentiality and anonymity. Family members who agreed to participate in the study signed a free and informed consent. No audio or image recording has been made.

Data were retained up to one month after the end of the study and were destroyed after that date.

Findings

The evaluation of the interventions effectiveness, sustained in MDAIF, was performed one month after the childbirth and one year after the beginning of the study (follow-up).

Contextualization: This is a study of a 15-year-old teenager's family, who met a boy nine years older on social networks (Facebook). From an encounter resulted an unplanned and unsupervised pregnancy until 24 weeks of gestation. In a final phase of gestation, the adolescent interrupted her academic formation to dedicate herself exclusively to the maternity.

Findings: one month after the study's start

Structural dimension

It is a tri-generational and extended family, in cohabitation, with strict limits. The Fernandes family is composed by the teenager in the study, Mary (M.F., female, 16 years), by her son Simon (S.F., male, 19 days), by her brothers Peter (P.F., male, 21 years) and Charles (C.F., male, 15 years) and their parents Paul (P.F., male, 47 years) and Rita (R.F., female, 43 years). Currently, Mary does not have any kind of relationship with the newborn's father (not identified with initials), since he did not accept or provide any kind of support after the discovery of pregnancy (figure 1).

By using the Graffar Scale[10], the Fernandes family is located socially at grade 3 (middle class). The family is dependent only from the male parent income (Paul). All family individuals have a low educational level (9th grade).

Through genogram analysis it is possible to glimpse the family members and realize the links existing between them. The couple Paul and Rita, like the relationship between their children, have a relationship of proximity. The relationship between the couple and their children is harmonious; however, there is a conflictual relationship between Rita and Mary, mother and daughter.

In an early stage after the baby's birth, the grandmother played an overprotective role, preventing the young mother from caring for her newborn. In this way, Rita impaired the exercise of the parental role of Mary and, consequently, her relationship and bonding with Simon (newborn).

Mary finds some support structure in her community, namely at the School (at Adolescent Support Office (Gabinete de Apoio ao Adolescente) and in the Psychologist), and some classmates and a friend. Every week, the teenager is visited by a nurse of the Community Care Unit (CCU) to support her in the experience of motherhood (figure 2).

The newborn is referenced, since birth, to Committee for the Protection of Children and Young People due to the absence of effective family support. Moreover, an unsupervised pregnancy contributes to an indicator of social risk, so the family is also referred to Social Services (figure 2).

The teenager finds on her parents an important support to meet her needs as well as the needs of her baby. Despite the conflicting relationship she has with her mother, it is in the family that the Mary sees herself comforted and supported.

Dimension of family development

The Fernandes family, as system, is in the Stage V – Family with teenage children, proposed by Duvall[11]. The family subsystem, constituted by mother and child and integrated in the system, is in Stage II – Family with newborn.

Parental role of the conjugal subsystem

Parents-children communication was ineffective, since communication was often followed by a conflict. In addition, parents tended to oversee their children, as well as their relationships they had been established with their peer group, often leaving no room for socialization and autonomy.

The desires for autonomy and the search for identity of the adolescent were great factors of parental stress and seemed to be the genesis of the parents' difficulty in dealing with their children. This difficulty worse-

INTERVENTIONS PROPOSED TO THE FAMILY IN THE DIMENSION OF FAMILY DEVELOPMENT – PARENTAL ROLE PLAYED BY THE YOUNG WOMAN (NEWBORN) **2**

Diagnosis		Interventions proposed (based on MDAIF)
Focus	**Judgment**	
Parental role	Not shown	**Newborn** • To teach/instruct/train the adolescent about care to the umbilical stump. • Teaching adolescents about breastfeeding. • To instruct/train the adolescent about breastfeeding technique. • Teaching the teenager about artificial breastfeeding. • To instruct/train the adolescent about artificial breastfeeding technique. • Teaching adolescents about physiological weight loss. • To teach/instruct/train the adolescent about newborn positioning. • Teaching the adolescent about the transport of the newborn and prevention of Sudden Death Syndrome.
Parental role not shown: • Knowledge about the role (newborn) not shown. • Adherence behaviour not shown. • Conflict yes.		• To teach/instruct/train the adolescent about newborn's hygiene. • Teaching the adolescent about warning signs of the newborn. • Teaching adolescents about health surveillance. • Teaching the adolescent about the characteristics of the newborn. • Teaching the adolescent about newborn skills. • Teaching the teenager about bonding process. • Motivating adolescent to adhere the vaccination of the newborn. • Guiding to social services. • Guiding to community services. • Promoting expressive communication of emotions. • Evaluating the non-consensual dimensions of paper. • Encouraging the redefinition of parental tasks by family members. • Negotiating the redefinition of parental tasks by family members. • Promoting coping strategies for the exercise of the role.

ned with the experimentation of risky behaviors by their daughter, which resulted in an unwanted early pregnancy.

Adolescent's parental role

Initially, Mary did not assume the parental role of Simon, since it was played by Rita. She felt an excessive preoccupation and exercised an overprotection of the newborn, not allowing Mary to play her role as a mother.

Thus, the role of caring for the newborn relied on Rita, instead of Mary, either because of lack of experience or knowledge, or because of the grandmother's overlap. The mother-child affective bond had not been established – first because it had been an unwanted pregnancy and secondly because there was an overlap of roles, with parental role substitution.

Between 4 and 6 weeks of age, in order to evaluate Simon's development with was used Mary Sheridan Test[17]. After filling it, it was verified that the RN presented a development considered normal for the age.

Around this time, Mary returned to school. Rita, unemployed, was taking care of Simon while his mother was at School. At first, Mary had very difficulties because of the need to fulfil her role as a mother and her role as a student. "I just wanted to do it all by myself and sometimes I couldn't do it. For example, having school homework to do and having Simon calling for me. It was difficult to reconcile it all" (Mary).

In the following table are some of the interventions proposed to enable Mary in the exercise of her parental role (table 2).

Functional dimension

In order to evaluate the family's functionality, it was used Smilkstein Family Apgar Scale[14]. Mary considered her family as highly functional (score 8), indicating that she is almost always satisfied in all the dimensions to which this Scale refers.

Follow-up (one year after the start of the study)

Structural dimension

Compared to 2016, the Fernandes family became structural, organizational and dynamically more competent. Although specific nursing interventions were not implemented at the level of the structural dimension, those performed in the remaining dimensions had an inevitable impact on the family structure, easily understood through genogram and ecomap analysis (figures 3 and 4).

The main points of change on family structure, development and functionality are reflected in greater family flexibility, with redefinition of roles and limits (having undergone a change from strict to clear limits),

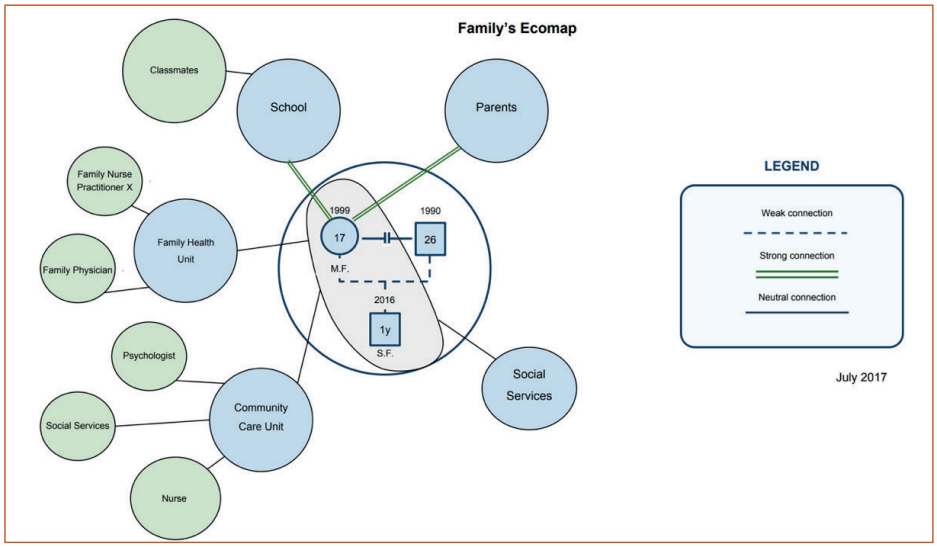

Figure 4. Family subsystem's ecomap (July 2017).

the transition to the exercise of an adequate parental role (either between the parents and their adolescent children, or between the young mother and her child) and the establishment of a strong and healthy bond between Mary and Simon.

At the structural level, the couple Paul and Rita, similarly to the relationship between Mary and Charles, and Rita and Mary with Simon present a relationship of proximity. The relationship between the couple and their children is harmonious (figure 3).

The psycho-emotional development of the young woman and consequent assumption of responsibilities as a mother, as well as the direct intervention of the multi-professional team that accompanied the case, appeased the conflict between mother and adolescent.

Currently, the young woman finds in the School, in her classmates and friends, and also in the Psychologist and CCU's Nurse, a fundamental support (figure 4).

In order to monitor the growth and development of Simon, Mary and Rita go to the Healthcare Unit at the time of consultations on child health surveillance. In addition, Mary is followed up in Consultations on Reproductive Health and Family Planning.

Finally, it is in her parents that Mary finds a fundamental support in all aspects of her life, as well as those of her baby. Improving the relationship between parents and Mary had an unavoidable impact on how the young woman perceived her satisfaction with family support.

Dimension of familiar development

At the level of the family development dimension, in particular the exercise of parental role that was not adequate, interventions were developed that had as objectives and purposes: to teach the parents (the conjugal/parental subsystem) about the changes levels in adolescence, motivate them to the importance of the frequency of adolescent surveillance consultations and the importance of adolescents' socialization and autonomy; besides these, allowed to promote the familiar communication and the expressive communication of emotions, to evaluate the conflicting dimensions of their roles and to motivate for the redefinition of the roles by the members of the family. This empowerment of parents with knowledge and strategies to improve their parental role has translated into an adequate performance of the same.

As for the ability to allow the privacy of their children, parents are now able to respect the privacy of their children; so does socialization: parents are more flexible about their child's friends chosen by them. However, in the case of the young woman, maternity does not allow her to spend the time she would like with friends.

Currently, Mary does not feel any difficulties in relating to her baby or in understanding his needs. However, tiredness and fear of hurting the baby are emotions and feelings that arise to her more often.

In addition, Mary thinks that she has all the knowledge related to the baby (infant food standard, sleep and rest pattern, hygiene and comfort care, child development, prevention of domestic and non-domestic accidents, oral hygiene…), information validated by the Family Nurse and easily proven by the parameters of growth and development of Simon. The child, like the rest of the family, presents the duly updated vaccination record.

In relation to maternal postnatal bonding, in its entirety and in two dimensions (quality of bonding and intensity of concern), the link between the young woman and her child can be classified as strong and healthy. This interpretation came from the results of the application of the Mother-infant Bonding Scale[12]: at a rate of 19 to 95 points, Mary obtained 87.

As previously stated, Mary, at the end of her pregnancy, had to interrupt her studies. About a month after giving birth, she resumed her school career. Nowadays, she is carrying out her life project, in the different spheres: personal, family and social.

Functional dimension

The Fernandes family is balanced (showing a better family functioning, in terms of adaptability and cohesion). Mary continues to realize the functionality of her family as

highly functional (score 8)[14]. Mary is more resilient (score 51) compared to how the family (score 41) and the nursing team consider her resilience (score 40)[16].

She is currently satisfied with the support she receives from the surrounding community, especially with the family (score 14/15), friends (score 23/25) and level of intimacy (score 15/20). However, she is not satisfied with the social activities she performs (score 4/15)[15].

Discussion

Regarding the results of the study, although there was no adaptation to pregnancy from the outset (due to the fact that the adolescent concealed it), as soon as it was followed in the context of pregnancy surveillance, health professionals tried to promote the best adaptation to pregnancy.

Some authors[18] argue that the figure of the grandmother is seen as a pillar of support and maintenance of the family structure, being recognized its importance in the emotional aspect, affective and as main source of information during the entire gestational process of the adolescent and, especially, after its termination. Other authors[19] add that the relationship of the pregnant woman to her mother is significantly important in adapting to pregnancy and motherhood.

When grandmothers become the primary caregivers of the children of adolescent mothers, they are more distant and less competent in performing their maternal role[20]. Moreover, they end up hindering the process of autonomy and growth of the adolescent as a mother[7]. In fact, initially there was an overlap of roles; however, the young woman has overcome her difficulties gaining autonomy in providing care for the newborn, always with the help of grandmother.

Currently, the relationship between the mother and the adolescent is close, harmonious and mutually supportive, with the initial conflict being resolved. A well-developed process of interaction between parents and children leads to the constitution of a healthy relationship that, through communication, will define the functioning and roles within the family[7]. Communication between the different elements of the Fernandes family as a whole became effective, not only because they already established a dialogue among all, but also because it fostered family trust and harmony.

The newborn presents being well cared for, not showing neediness or any kind of carelessness, refuting ideas of some authors[22], when they report that the children of adolescent mothers present greater risks of impairment in the child's development in the short and long term.

In addition, at the social and school levels, the adolescent also suffers losses, such as dropout or school interruption or even a precarious and poorly paid early career[8]. However, Maria only interrupted her school career in the final stages of pregnancy to prepare for motherhood, having returned to school about a month after giving birth and having successfully completed the 9th grade. Currently, the adolescent is aware of the importance of a lifelong project in her life and is motivated to start a professional career. The success of this case is in contrast with the results of some authors[23], who report that young adolescent mothers from unstructured families have a lower rate of return to school and academic success than those from a stable and less disadvantaged family environment.

Methodologically, despite the possible limitations, the authors consider that the results obtained are a true picture of the reality and a contribution to qualitative research on the subject. Moreover, additional data about the relationship between Maria and the newborn with the father and the baby. The issues raised by this study indicate the need for further studies, both qualitative and quantitative, to assess and understand the implications of pregnancy and motherhood in adolescence and how this can impact the development of the child and the lives of these families. In future investigations, the use of the Dynamic Model of Family Assessment and Intervention[9] for further development of the knowledge and skills of health professionals is suggested. It is also suggested to follow the first years of the baby, allowing to study the variables associated with the development of children and, later, adolescents children of adolescent mothers.

Conclusions

Adolescent pregnancy is a problematic situation as it converges tasks at different stages of development. The experience of an early motherhood has clear implications on family structure and dynamics.

Thus, it can be concluded that the family evaluation and intervention were effective, allowing not only to respond to the family's needs, but also to help the adolescent to continue with the realization of her life project. As there is a link between the different support networks, namely between the Personalized Healthcare Unit, the Community Care Unit (for intervention in the school and home context) and the Commission for the Protection of Children and Young People, the researchers have obtained a broader picture of the situation, its complexity, and the importance of a strong support network working in partnership for the success of the interventions.

At the level of structure, development and family functioning, there is a greater flexibility, with redefinition of roles and limits: Paul and Rita play their parental role adequately, allowing their children to have the right to their privacy and to choose their friends; there is effective communication between them; they are concerned about the balanced and varied diet of the family, encouraging the ingestion of at least five meals a

day; encourage the brushing of teeth at least twice a day, with the use of dental floss and the promotion of family activities.

The support provided by the group of friends it was also an important source of emotional support. The young woman reinforced an increase in the concern for her own well-being by her friends and that this was also decisive for her adaptation. Although she does not spend as much time as she likes with her friends, due to the exercise of her role as mother, she is satisfied with the support received both by the family and by the surrounding community (School and Healthcare Unit).

Another change that occurred with the interventions was the sexual and reproductive health surveillance of Mary, which became a regular surveillance, allowing her to start a contraceptive method suitable for her. Furthermore, currently she knows that the only way to prevent the transmission of sexually transmitted infections is to associate her method with a contraceptive barrier method.

Regarding the performance of her parental role, Mary was able to establish a strong and healthy bond with Simon. Although she says that she has all the knowledge about how to care for and relate to her baby, constant learning and training should be considered.

The newborn is well cared for and there is no food, hygiene, emotional or general neglect of his health. According to the literature, the quality of the care provided to a child in the first years of life, as well as the relationship that it establishes with its mother, are fundamental for a correct development and mental well-being.

Implications of the study

Adolescent mothers who benefit from adequate social support are able to achieve a favorable level of adjustment, since it reduces the anxiety associated with the tasks of motherhood. In addition, protective factors of individual, relational and social order are also aspects to be considered in the socioemotional adjustment of the adolescent to the process of maternity.

The use of the Dynamic Model of Family Assessment and Intervention[9] allows to give a prominent place to the whole family as a unit and to guide the practices of nurses to promote family health, considering their real needs and reso

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