

Résumé

Une exploration de la relation entre les pratiques de promotion de la santé, le travail lié aux soins de santé et le stigmatisme ressenti chez les familles dirigées par une mère adolescente

Adrienne Fulford et Marilyn Ford-Gilboe

Cette étude a pour objectif d'examiner les liens entre le stigmatisme et la promotion de la santé chez les familles composées d'enfants d'âge préscolaire et dirigées par une mère adolescente, en testant les hypothèses issues du *Developmental Model of Health and Nursing* [modèle développemental de la santé et des soins infirmiers] et en explorant, de façon descriptive, l'expérience du stigmatisme auprès d'un échantillon de 63 mères adolescentes vivant dans des communautés du Sud-Ouest de l'Ontario, au Canada. Les mères ont répondu verbalement à des questions portant sur le stigmatisme ressenti selon une gradation établie, le travail liés aux soins de santé familiale, les pratiques de vie saines et à un questionnaire démographique au cours d'une entrevue structurée. Leurs expériences de stigmatisme ont ensuite été explorées lors d'une brève entrevue dialogique. Conformément à la théorie, la recherche a révélé une relation modérément positive entre le travail lié à la santé familiale et le mode de vie sain des mères ($r=0,52, p < 0,001$). Le stigmatisme ressenti ne portait pas sur le travail liés aux soins de santé ni sur la présence d'un mode de vie sain dans l'ensemble. Le stigmatisme ne semblait pas non plus avoir d'effets directs sur les efforts de promotion de la santé familiale mais influait sur d'autres aspects de la vie des participantes, de façons positives et négatives. Des implications relativement à la pratique et aux futures recherches ont été identifiées.

Mots clés : mères adolescentes, *Developmental Model of Health and Nursing*, promotion de la santé familiale, stigmatisme

An Exploration of the Relationships Between Health Promotion Practices, Health Work, and Felt Stigma in Families Headed by Adolescent Mothers

Adrienne Fulford and Marilyn Ford-Gilboe

The purpose of this study was to examine the relationship between stigma and health promotion in families with preschool children headed by adolescent mothers, by: (a) testing hypotheses derived from the Developmental Model of Health and Nursing, and (b) descriptively exploring the experience of stigma in a community sample of 63 adolescent mothers in southwestern Ontario, Canada. The mothers verbally responded to established measures of felt stigma, family health work, healthy lifestyle practices, and a demographic questionnaire during a structured interview. Then their experiences of stigma were explored during a brief dialogic interview. Consistent with the theory, a moderate positive relationship was observed between family health work and mothers' healthy lifestyle ($r = .52, p < .001$). Felt stigma was not related to either health work or global healthy lifestyle. Stigma did not appear to affect family health promotion efforts directly but influenced other aspects of the participants' lives in both positive and negative ways. Implications for practice and future research are identified.

Keywords: adolescent mothers, Developmental Model of Health and Nursing, family health promotion, stigma

Historically, childbearing during adolescence was socially and culturally acceptable (Kitzinger, 1978). However, over the last 3 decades in Western society, adolescent motherhood has come to represent personal irresponsibility and social pathology (Smith Battle, 2000). In Canadian society, the stigma associated with adolescent motherhood remains pervasive (Kelly, 1996) and is linked to a range of perceived disadvantages for mother and child. Adolescent mothers are often presumed to be ineffective parents, uneducated, unemployed, and financially dependent on the social system (Hechtman, 1989; Kelly, 1996). The stigma of adolescent motherhood may marginalize the mother and undermine her confidence and motivation, negatively affecting her development, parenting, and health promotion practices (Sword, 1997; Whall & Loveland-Cherry, 1993).

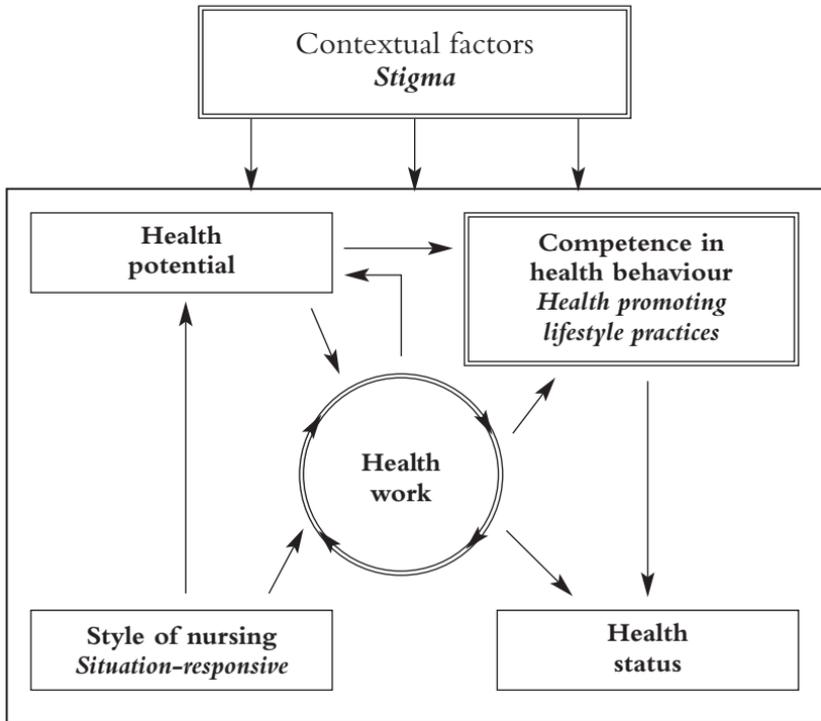
Health promotion is defined as the process of enabling people to increase control over and improve their health, with an emphasis on the building of resources and capacities needed to support these goals (World Health Organization, Canadian Public Health Association, and Health and Welfare Canada, 1986). Families have been found to play a key role in the development of health promotion behaviour (Duffy, 1988; Pender, 1996) and there is growing evidence that the period between birth and age 5 is a critical one for promoting optimal child health and development (McCain & Mustard, 1999). Few studies have examined factors affecting family health promotion processes, particularly in families headed by adolescent mothers. Yet health promotion strategies may be crucial in offsetting the negative effects of disadvantage on health while supporting the establishment of health practices that persist into adulthood. This study examined the relationship between one type of disadvantage, stigma, and the health promotion efforts of families with preschool children headed by adolescent mothers.

Literature Review

The Developmental Model of Health and Nursing (DMHN) (Allen & Warner, 2002; DeMarco, Ford-Gilboe, Friedman, McCubbin, & McCubbin, 2000; Ford-Gilboe, 2002a), with its distinctive focus on family health promotion, served as the theoretical framework for this study. A theoretical extension of the McGill Model of Nursing (Allen, 1983; Gottlieb & Rowat, 1987), the DMHN has as its purpose the generation of knowledge on the nature of healthy development in individuals and families and the role of the nurse in supporting this process. In the DMHN the focus is on process and the family is viewed from a strengths perspective. The theoretical propositions of the DMHN have been supported in studies with families featuring various structures and socio-economic backgrounds (Ford-Gilboe, 2002a), including two recent studies (Black & Ford-Gilboe, in press; Sgarbossa & Ford-Gilboe, 2004) with families with preschool children headed by adolescent mothers.

In the DMHN, health is viewed as a family characteristic — a way of living that is learned in the social context of family life (Allen & Warner, 2002). The pattern of health within families is complex and best represented by a number of dimensions: health potential, health work, competence in health behaviour, and health status (Ford-Gilboe, 2002a) (Figure 1). The central concept in the DMHN, health work, is an active process through which a family achieves healthful living by learning to cope with health situations and by setting and striving towards goals for healthy individual and family development (Allen & Warner; Ford-Gilboe, 2002a). For example, in the case of adolescent mothers, health

Figure 1 *Key Concepts and Proposed Relationships in the Developmental Model of Health and Nursing*



Source: Modified from Ford-Gilboe (2002a). Variables addressed in current study.

work may be seen as how the mothers respond to the challenges of understanding and responding to their child's cues, developing satisfaction in their parenting role, or instituting new family routines. The extent to which a family participates in health work is influenced by its health potential (i.e., internal and external capacities) and, when present, the assistance of the nurse in supporting its ability to respond to everyday health situations in a way that builds its capacity for healthy growth and development (Ford-Gilboe, 2002a). As participation in health work increases over time, families adopt new problem-solving and development strategies and incorporate them into their repertoire of skills and behaviours (DeMarco et al., 2000; Ford-Gilboe, 2002a), ultimately affecting health status. Thus, competence in health behaviour, an outcome of health work, reflects the family's effectiveness in managing health situations and achieving health goals and in adopting healthy ways of living

that are consistent with its health needs and priorities (Ford-Gilboe, 2002a). Therefore, family health promotion can be understood as both a process (i.e., health work) and an outcome (i.e., competence in health behaviour), including lifestyle behaviours.

Previous studies with single-parent families, including families headed by adolescent mothers, have provided some description of their health promotion processes. In a grounded theory study with 56 single-parent families headed by women, Duffy (1984) found that the families engaged in health promotion processes on a continuum that ranged from choosing existing options in order to promote stability, to transcending existing options in order to embrace personal growth and change. Duffy (1986) further identified lack of social support and role overload as barriers to primary prevention behaviours and health maintenance. Similarly, mothers' internal resources, including resilience, optimism, and general self-efficacy, have been found to be positively associated with both family health work and health outcomes, including health promoting lifestyle practices and general family functioning (Black & Ford-Gilboe, in press; Ford-Gilboe, Berman, Laschinger, & Laforêt-Fliesser, 2000). However, most studies of health promotion in families headed by adolescent mothers have focused on parenting practices. For example, adolescent mothers have been found to seek preventive health care for their children (Hermann, Van Cleve, & Levisen, 1998), to use various anticipatory coping strategies to problem-solve and secure support that facilitates their transition to parenting (Panzarine, 1986), and to engage in more effective interactions with their children when they have access to adequate support (Dormire, Strauss, & Clarke, 1988).

Lifestyle practices of adolescent mothers and their children may also be key in promoting healthy growth and development. According to Pender (1996), a health promoting lifestyle is a multidimensional pattern of self-initiated actions and perceptions that are directed towards maintenance or enhancement of one's well-being, personal fulfilment, and productive living. Mothers' healthy lifestyle practices and attitudes have been found to influence not only the health promotion behaviours of their families, but also the health practices of their children (Duffy, 1986, 1988; Loveland-Cherry, 1986). Children's health behaviours are shaped and acquired in the context of the family, including the manner in which it responds to health or illness situations (Allen & Warner, 2002; Mullen, 1983). In studies with single-parent and two-parent families with young children, health work has been found to be positively associated with mothers' health promoting lifestyle practices (Ford-Gilboe, 1997; Ford-Gilboe et al., 2000; Monteith & Ford-Gilboe, 2002). A limited body of research has identified additional factors that influence healthy lifestyle practices in adolescents, including perceived self-efficacy (Gillis, 1997)

and parental role modelling of positive health practices (Donovan, Jessor, & Costa, 1991; Gillis). Similarly, adolescent mothers who maintain a relationship with the child's father are more likely to participate in preventive health care (Kelly, 1995). However, few studies have focused specifically on the development of healthy lifestyles in adolescent mothers.

In the DMHN, the broader context of family life is purported to influence family health, although the nature of this influence is thought to be situation-dependent (DeMarco et al., 2000; Ford-Gilboe, 2002a). Consistent with an ecological perspective, context includes: (a) characteristics of the family; (b) characteristics of the immediate environment; and (c) socio-political forces affecting family life, including cultural biases, stereotyping, and social policies (DeMarco et al.). Stigma is a common feature in the lives of adolescent mothers and, thus, an important context for health promotion in families headed by these mothers.

Stigma refers to those attributes of an individual or group that engender negative evaluation of one's social identity (Crocker, Major, & Steele, 1998). Felt stigma, the feelings of shame associated with being different, is more distressing than enacted stigma, which features actual instances of discrimination or labelling (Scambler & Hopkins, 1986). In contemporary society, stigma is typically associated with conditions for which people are considered culpable (Scambler, 1998). With the advent of reproductive options, such as contraception and abortion, adolescents who choose to give birth and raise their child may be blamed for their circumstances. Findings from qualitative studies suggest that such young women experience stigma in the form of social exclusion (Whitehead, 2001) and negative labelling by their families (Kaplan, 1996), the public (Hyde, 1998), and health professionals (Farber, 1991). Stigma may disrupt relationships within support networks, which have been found to facilitate adolescents' adjustment to motherhood (Dormire et al., 1988; Mercer, 1986) and the development of effective parenting (Turner & Avison, 1985). However, there is a dearth of research on stigma experienced by adolescent mothers. Further study is needed in order for us to better understand its impact on family health and development, including efforts to promote health.

Although the direct health impact of stigma on adolescent mothers has not been studied, research conducted with adults experiencing various physical and mental illnesses suggests that stigma is associated with low self-esteem (Fife & Wright, 2000), poor physical and emotional health (MacDonald & Anderson, 1984), limited social interaction (Jacoby, 1994), and lower quality of life (Rosenfield, 1997). Further, stigma has been found to be associated with lower self-esteem in adolescents (Gershon, Tschann, & Jemerin, 1999; Westbrook, Bauman, & Shinnar,

1992) and with tense social interactions and poorer mental health among young single women who are pregnant (Hyde, 1998).

Stigma has also been found to negatively affect health promotion behaviours, such as seeking preventive health care or screening, due to fear of harm or labelling by health professionals (Barth, Cook, Downs, Switzer, & Fischhoff, 2002; Stevens & Hall, 1988; Van Hook, 1999). Responses to stigma vary from secrecy and selected social avoidance to disclosure in an attempt to educate others, alleviate the stress of secrecy, or cope with the experience (Goffman, 1963; Joachim & Acorn, 2000). Thus, the energy and resources expended in managing stigma may divert or impede health promotion activities. For families that differ from the "nuclear ideal," stereotyping and social expectations are powerful factors that can hamper healthy family development (Kissman & Allen, 1993). A broader understanding of how stigma influences health promotion in families headed by adolescent mothers is crucial in developing programs and services that support the development of healthy family living.

Based on a review of the literature and the DMHN, this study addressed the following hypotheses and research questions. The theoretical variables under consideration include health work, competence in health behaviour (operationalized as health promoting lifestyle practices), and felt stigma (an aspect of the broader social context).

Hypothesis 1: *Family participation in health work is positively related to adolescent mothers' use of health promoting lifestyle practices.*

Hypothesis 2: *Adolescent mothers' felt stigma is negatively related to family participation in health work.*

Hypothesis 3: *Adolescent mothers' felt stigma and health promoting lifestyle practices are negatively related.*

Research question 1: *What is the experience of stigma and how does it affect the lives of adolescent mothers and their children?*

Research question 2: *What are the relationships between selected demographic variables (age, living arrangement, mother's level of education, employment status, social support, marital status, partner involvement with children) and adolescent mothers' felt stigma, family health work, and health promoting lifestyle practices?*

Method

Design and Sample

A mixed method design was used to examine the meaning and context of felt stigma, including its relationship with health promotion efforts, experienced by adolescent mothers. Data were collected using structured self-report measures of the study variables followed by open-ended questions about their stigma experiences during a brief dialogic interview. Quantitative data obtained from the self-report measures enabled hypo-

thesis testing, while qualitative data obtained in a more exploratory way was used to more fully describe variation in the participants' experiences of stigma, providing a context in which the quantitative findings could be more readily interpreted.

A convenience sample of 63 adolescent single mothers was recruited from urban and rural communities in southwestern Ontario, Canada. Sample size was based on a power analysis using a moderate effect size of .30, alpha of .05, and power of .80 (Cohen, 1988). Mothers were eligible to participate if they were English-speaking, were no more than 21 years of age, and had custody of at least one child between the ages of 6 months and 5 years. Women were recruited using: (a) contacts in health and social agencies that provide services to adolescent mothers and their children, (b) advertisements placed in public settings, and (c) referral of other adolescent mothers by the study participants. In all cases, potential participants were given information about the study and directed to the research team. Of the 65 mothers who expressed an interest in participating, 63 (97%) completed an interview, one failed to attend a scheduled interview, and one relocated and could not be found.

The mean age of mothers was 19 years ($SD = 1.57$, range 15–21) at the time of the interview, and 17 years ($SD = 1.67$, range 14–21) when they had given birth to their first child. The number of children per family ranged from one to four, with the majority of families ($n = 51$, 81%) having one child. Most mothers reported being “single and never married” ($n = 53$, 84%). However, almost two thirds ($n = 40$, 63.5%) were currently in a relationship, approximately half ($n = 22$, 55%) with fathers of their children. Slightly more than half of the participants ($n = 36$, 57%) reported regular contact between fathers and children, through either frequent visiting ($n = 14$, 22%) or co-parenting ($n = 18$, 29%).

Mothers had completed an average of 11 years of formal education ($SD = 1.66$), with 60% ($n = 38$) enrolled in school at the time of the interview. Of the 25 mothers who were not enrolled in school, 17 (68%) had already completed secondary school. Three quarters ($n = 47$, 75%) of the participants were unemployed, with the majority ($n = 42$, 67%) reporting social assistance as their main source of income. Only 35% of mothers ($n = 22$) received financial assistance from fathers of their children, although half of the participants ($n = 33$, 52%) received financial assistance from extended family members. Sources of support most frequently identified by participants were their own mothers ($n = 44$, 70%), followed by friends ($n = 33$, 52%), partners and extended family members ($n = 25$, 40%), health professionals, their own fathers ($n = 21$, 33%), and their siblings ($n = 16$, 25%).

Instruments

Data were collected using established summated rating scales to measure felt stigma, health work, and health promoting lifestyle practices. A brief dialogic interview was used to explore mothers' experiences of stigma. Information on selected personal and family characteristics — including family composition; sources of income and support; and mother's age, education, employment status, marital status, relationship status, and living situation — was collected using a demographic profile.

The Health Options Scale (HOS) (Ford-Gilboe, 1997, 2002b; Laudenbach & Ford-Gilboe, 2004) is a 21-item scale designed to measure family participation in health work. Responses are scored on a four-point Likert scale ranging from "strongly disagree" to "strongly agree" and indicate the extent to which families engage in health promoting lifestyle practices consistent with health work. Items are arranged in three subscales: Attending, which reflects the family's active involvement in health matters (8 items); Goal Attainment, which reflects identification and pursuit of health goals (6 items); and Experimenting, which reflects the use of problem-solving in the management of health situations (7 items). Concurrent validity has been established through moderate correlations with several established measures of theoretically related concepts, including the Health Promoting Lifestyle Profile (HPLP) (Walker, Sechrist, & Pender, 1987), a measure of individual health promoting lifestyle practices ($r = .66$); the Problem Solving Inventory, a measure of individual problem-solving style ($r = -.35$) (Heppner, 1988); and the Family APGAR ($r = .29$), a measure of global family functioning (Smilkstein, 1978; Ford-Gilboe, 1997, 2002b). Internal consistency has been acceptable for total scores ($\alpha > .70$) but more variable for subscales across families of various life stages and contexts. The HOS has been used in studies with both single- and two-parent families (Ford-Gilboe, 1997; Ford-Gilboe et al., 2000; Monteith & Ford-Gilboe, 2002), including two studies with families headed by adolescent mothers (Black & Ford-Gilboe, in press; Sgarbossa & Ford-Gilboe, 2004). In the present study, Cronbach's alpha was .85 for the total HOS, while subscales ranged from a low of .59 for Experimenting to .68 for Goal Attainment and .80 for Attending.

The 52-item HPLP II, a revised version of the 48-item HPLP (Walker et al., 1987), was used to measure mothers' participation in health promoting lifestyle activities in six areas: Health Responsibility (9 items), Nutrition (9 items), Spiritual Growth, (9 items), Interpersonal Relations (9 items), Physical Activity (8 items), and Stress Management (8 items). Participants rate the frequency with which they engage in

health behaviours on a four-point Likert scale ranging from “never” to “routinely.” Using data from 712 adults aged 18 to 92, the six-dimensional structure of the HPLP II was confirmed through factor analysis. Construct validity was also supported through the positive correlations between the HPLP II and the Personal Lifestyle Questionnaire ($r = .68$) and measures of perceived health status and quality of life. Internal consistency was .94 for the total scale and .79 to .87 for the subscales. Test-retest reliability over a 3-week interval was .89 (Walker & Hill-Polerecky, 2001). For the present study, internal consistency using Cronbach’s alpha coefficients was .89 for the total scale, with four subscales greater than .70; two subscales, stress management and nutrition, approached acceptable levels of .67 and .68, respectively.

The Stigma Scale (Jacoby, 1994) is a three-item measure of individual perceptions of felt stigma that has been used in several studies with adults who have epilepsy. In the present study, the Stigma Scale was modified from its original yes/no response format to a five-point Likert scale ranging from “never” to “always,” in order to enhance sensitivity of measurement with respect to feelings of stigma based on status as a “young mother.” Concurrent validity of the Stigma Scale has been supported through significant negative correlations between scores on the Stigma Scale and scores on the SF-36, a measure of general health status (Ware & Sherbourne, 1992), as well as positive associations between stigma and negative feelings about life and worry in a study with adults who have epilepsy (Baker, Brooks, Buck, & Jacoby, 1999). In the present study, the Cronbach’s alpha coefficient for the Stigma Scale was higher (.86) than that reported by Jacoby (.72) in a sample of adults.

A brief dialogic interview using two open-ended questions and a series of prompts was conducted with all participants in order to more fully explore the nature and extent of stigma in their lives. The women were asked if they had been judged or treated differently because they were “young mothers” and, if so, to describe their experiences. Prompts were used selectively to identify those who had this experience and the circumstances surrounding it. The participants were then asked what effect, if any, such experiences had on their own and their family’s physical or mental health, routines or practices, relationships, and feelings about themselves.

Procedures

Ethics approval was obtained from the Research Ethics Board at the study site. After informed consent had been obtained, standardized measures of the study variables were administered to each participant and her responses recorded by the interviewer on a copy of each tool. The par-

participant was then asked to describe her experiences of stigma. This part of the interview was audiotaped and transcribed verbatim. Interviews were conducted in a quiet location selected by the participant, most often the home, and lasted from 30 to 60 minutes. To acknowledge the value of participants sharing their personal experiences, a \$15 cash honorarium was provided at the end of the interview.

Data Analysis

Descriptive statistics appropriate to the level of data were calculated for all study variables. Pearson's *r* correlations were used to test the study hypotheses. The relationships between study variables and selected demographic characteristics were examined using appropriate measures of association. The level of significance for all statistical analyses was $p < .05$.

Content analysis was used to summarize participants' descriptions of their stigma experiences (Sandelowski, 2000). Two interviews were inaudible and could not be transcribed, while nine mothers did not identify stigma experiences, leaving 52 interviews (83%) for inclusion in the qualitative analysis. The participants' responses were reviewed using data management and analysis approaches described by Miles and Huberman (1994), and initial themes were inductively generated from the data that described the salient aspects of the stigma experience. Transcripts were then coded using initial themes and commonalities and differences noted. Finally, matrices were created to help identify patterns in the data across participants in an attempt to better understand the relationships between the quantitative data and the emerging qualitative themes. Qualitative findings were shared with a subgroup of participants ($n = 8$) during two focus-group sessions and modified slightly based on their feedback.

Results

Descriptive statistics for the study variables are presented in Table 1. The mean score for health work was moderate (2.9/4) and comparable to that reported in previous studies with single adolescent mothers of preschool children (Black & Ford-Gilboe, in press) and single- and two-parent families (Ford-Gilboe, 1997). The mean score for health promoting lifestyle practices was also moderate (2.7/4) and comparable to the results obtained in studies with families with preschool children (Monteith & Ford-Gilboe, 2002) and families headed by adolescent mothers (Black & Ford-Gilboe). The mean score for felt stigma was moderate (2.6/5). Comparative data for felt stigma were not available.

Table 1 *Descriptive Statistics for Study Variables (N=63)*

Variable	Mean		SD	Range	
	Overall	Scale ^a		Possible	Actual
Felt stigma	7.9	2.6/5	2.63	3–15	3–15
Health work	61.2	2.9/4	6.48	21–84	48–77
Attending	23.9	3.0/4	3.03	8–32	17–30
Goal attainment	17.0	2.8/4	2.47	6–24	11–23
Experimenting	20.3	2.9/4	2.21	7–28	15–26
Health promoting lifestyle practices	138.2	2.7/4	18.81	52–208	104–178
Health responsibility	23.1	2.6/4	5.03	9–36	13–36
Physical activity	18.6	2.3/4	4.69	8–32	10–32
Nutrition	22.8	2.5/4	4.79	9–36	12–31
Spiritual growth	27.3	3.0/4	4.17	9–36	18–36
Interpersonal relations	28.1	3.1/4	4.05	9–36	16–36
Stress management	18.4	2.3/4	4.18	8–32	8–29

^a Mean score converted into the scale of measurement for ease of interpretation.

Few demographic variables were related to study variables. Moderate negative relationships were observed between felt stigma and mothers' age both at the time of interview ($r = -.38, p = .002$) and at the time of the birth of her first child ($r = -.35, p = .005$). Mothers who reported receiving partner support had lower levels of felt stigma than those who did not $t(2, 61) = 2.63, p = .011$. Women with lower felt stigma also reported frequent involvement by the children's fathers, while those with high felt stigma reported little or no involvement by fathers $\Pi^2(1, 63) = 6.02, p = .014$, Kendall's tau- $b = -.31, p = .008$. Health work was also higher in families in which fathers were involved compared to those in which there was no such involvement $t(2, 61) = -2.50, p = .015$.

Tests of the Hypotheses

Correlations among the study variables are presented in Table 2. Consistent with theoretical expectations, a moderate positive relationship was found between family health work and mothers' health promoting lifestyle practices ($r = .52, p < .001$), providing support for hypothesis 1. Each dimension of health promoting lifestyle practices was positively

Table 2 Correlation Matrix of Study Variables (N=63)

	HWORK	attend	goal	exper	HPLP	healthresp	activity	nutrition	spiritual	interpersonal	stress	STIGMA
HWORK	1.0	.91*	.84*	.75*	.52*	.31*	.30*	.46*	.47*	.35*	.30*	.03
attend		1.0	.68*	.54*	.45*	.22*	.27*	.43*	.41*	.27*	.31*	-.01
goal			1.0	.41*	.48*	.22*	.33*	.49*	.44*	.39*	.16	-.05
exper				1.0	.39*	.35*	.14	.20	.32*	.24*	.27*	.16
HPLP					1.0	.65*	.72*	.72*	.83*	.75*	.53*	.12
healthresp						1.0	.26*	.38*	.46*	.44*	.13	.29*
activity							1.0	.53*	.65*	.42*	.12	.02
nutrition								1.0	.47*	.29*	.27*	.12
spiritual									1.0	.62*	.34*	.01
interpersonal										1.0	.46*	-.02
stress											1.0	.04
STIGMA												1.0

**p* < .05

HWORK = health work; attend = attending; goal = goal attainment; exper = experimenting; HPLP = health promoting lifestyle practices; healthresp = health responsibility; activity = physical activity; nutrit = nutrition; spiritual = spiritual growth; interpersonal = interpersonal relations; stress = stress management; STIGMA = felt stigma.

related to health work ($r = .30-.47$). Likewise, moderate positive relationships were observed between overall health promoting lifestyle practices and each of the dimensions of health work ($r = .39-.48$). Felt stigma was not related to health work or any dimension of health work. Thus, hypothesis 2 was not supported. Similarly, no relationship was observed between felt stigma and health promoting lifestyle practices, resulting in a lack of support for hypothesis 3. The health responsibility dimension of health promoting lifestyle practices was positively associated with felt stigma ($r = .29, p = .01$), but in the opposite direction to that predicted in the hypothesis.

Mothers' Experiences of Felt Stigma

Full presentation of qualitative findings is beyond the scope of this paper. Instead, a brief description of findings related to the mothers' stigma experiences is presented in order to illuminate key aspects of these experiences and enhance interpretation of the quantitative findings. The mothers' descriptions of their stigma experiences were categorized according to source, basis, mechanism, response, and impact. Table 3 identifies dimensions according to frequency of report, along with mothers' comments. The majority of participants ($n = 52, 83\%$) were able to describe at least one stigma experience, with some relating multiple and varied experiences.

Sources of stigma. The mothers described their stigma experiences as arising from two sources — the general public or strangers (including professionals), and people known to them. The majority of participants ($n = 45, 87\%$) identified strangers, particularly “older people,” as key players in their stigma experiences and public transit as a common site for these experiences. Most of the participants were linked with some form of health or social services and more than one third ($n = 19, 37\%$) reported stigma experiences arising from contact with nurses, doctors, teachers, or social assistance counsellors. Few mothers identified family members ($n = 8, 15\%$) or friends ($n = 6, 12\%$) as sources of stigma.

Bases of stigma. Mothers most often identified their youth ($n = 29, 56\%$) as the reason for negative judgements about them, with some ($n = 14, 27\%$) making a link between their youth and the perception that they were not fit to be parents. Some mothers ($n = 11, 21\%$) said that they had been judged as immoral or deviant because they were unwed, had had sexual relations before marriage, and were presumed to use drugs or to shoplift. Finally, 15% ($n = 8$) of the mothers described irresponsibility or dependence on the welfare system as a reason for negative judgements about them.

Mechanisms of stigma. Stigma was experienced in three different forms: non-verbal expressions ($n = 30, 58\%$), such as “looks” or “glares”

Table 3 Stigma Experiences of Young Mothers (N = 52)

Dimension	Frequency	Examples
Sources		
Strangers	45	“One time when I was on the bus...it’s usually older people, and they were sitting behind me and talking ‘children having children,’ and I overheard them.”
Professionals	19	“The nurse called me out of the waiting room and said to me that she didn’t know what I expected them to do for me...and being me and pregnant, I just left.”
Family/friends	14	“My aunt...phoned me and said she wouldn’t have a shower for me as a 15-year-old having a baby is a tragedy, not a celebration.”
Bases		
Youth/poor parent	43	“Everybody thinks that because I’m young I’m just neglecting her...and that I don’t know how to take care of her.”
Immoral/deviant	11	“People see me with my baby [in public] and they are just, like, ‘gross, you had sex, you’re a pig’ kind of thing.”
Irresponsible/social dependency	8	“I just got my child support. I had tons of groceries with me. We were getting off the bus and a lady said, ‘Oh, welfare cheque day?...they just assumed I sit at home and that I’m on welfare.”
Mechanisms		
Non-verbal expressions	30	“When I’m out in public and people see that I’m a kid...then they just sort of give you a look like you’re disgusting, looks you don’t want to get, dirty looks.”
Verbal comments	26	“Older people...sometimes say things like, ‘I can’t believe you have a baby, you’re so young, you should have waited, it’s not good,’ kind of thing... They say it kind of mean too.”
Ill treatment	19	“One of the nurses was very curt with me, very abrupt and treating me like I couldn’t do it myself... They just seemed that they would rather help all the other mothers that were a little bit older.”

Responses		
Physical	20	<p>“When I’m walking down the street I’m, like, trying to hide.”</p> <p>“I will not dress my daughter in donated clothes. She always wears Gap...because I don’t want people to look down on me and stereotype me... If she’s in her play clothes people give me dirty looks. If she’s in her regular clothes they don’t even give me a second glance.”</p> <p>“It hurt my feelings a little bit, but everybody has their own opinion so it doesn’t really matter what everybody else thinks.”</p> <p>“It almost seems I am hard as a rock but I can get upset really easily and they may not see that, but as soon as they are out of sight and turn that corner, the tears are coming.”</p>
Cognitive	19	
Emotional	13	
Challenge		
Stigmatizers	10	<p>“...older people [on a bus] talking ‘children having children’, and I overheard them. I turned around and said, ‘I’m a 24-year-old, married, successful,’ and then they apologized and said my daughter looked like a happy, healthy baby.”</p> <p>“I’ve been out on my own for a year and a half just because I’m so hell bent on proving everybody wrong, that there are people out there my age who can do it and I can do it.”</p>
Self	5	
Impact		
Social isolation	31	<p>“It took me a long time, but now it’s just like I’ve kind of put up a wall.”</p> <p>“A lot of my friends who are the same age as me don’t have kids...so it’s like I can’t relate to half of my friends any more.”</p>
Emotional/mental health	27	<p>“Sometimes it affects my mental health because I worry about what other people think.”</p> <p>“Like my emotions went up and down... I was really down because of the looks that you got and the things the nurses would say, things that made you feel you were less than everybody else.”</p>
Positive life change	8	<p>“I’m a one hundred percent different person than I was the day before I found out I was pregnant. I changed totally... I just pretty much bettered my life from there.”</p>

conveying a judgement of inadequacy; verbal comments ($n = 26, 50\%$), such as insensitive questions or unsolicited advice; and ill treatment ($n = 19, 37\%$), such as rudeness, avoidance, or inappropriately intense monitoring.

Responses to stigma. The mothers described a variety of responses to these expressions of stigma. The majority attempted to conceal the stigma they felt by cognitively, emotionally, or physically distancing themselves. Few mothers chose to challenge either the perpetrators or themselves. Cognitive concealing, reported by 37% ($n = 19$) of the mothers, consisted of reframing their experience as unimportant, often by telling themselves that others' opinions "don't matter" or that they "don't care what other people think." Affective or emotional concealing, identified by one quarter ($n = 13$) of the mothers, involved either suppressing their emotions in public or protecting themselves from emotional harm and "not let it bother me." Physical concealing was the most frequent response identified by participants ($n = 20, 38\%$). The mothers described using strategies to avoid others and to fit in and be less visible in public. For example, several mothers said they dressed themselves and their children in better clothing in order to "blend in."

Only 20% ($n = 10$) of the mothers reported attempts to confront the stigma. Most of these challenged the people they perceived were judging them, by trying to explain themselves, by offering themselves as role models, or, in one instance, by lying about their age and marital status. A small group of mothers ($n = 5, 10\%$) described their stigma experience as an impetus to challenge themselves and make changes in their lives in order to prove those who would sit in judgement of them wrong.

Impact of stigma. The participants described their stigma experiences as affecting their health and their social relationships. However, they identified both positive and negative outcomes. The most striking negative outcome was social isolation. In attempting to minimize the stigma, the mothers often put up physical and emotional walls around themselves. The mothers' isolation stemmed from both their responses to stigma and their changing relationships with friends. Most of the participants described an asynchrony or poor fit between themselves and their old friends but attributed this to changes in their life course and a loss of common interests, rather than to negative judgements on the part of their friends. Half of the participants ($n = 27$) reported that stigma affected their emotional or mental health by increasing their feelings of stress or depression and eroding their self-confidence. Despite the negative impact of stigma on their emotional health and interpersonal relationships, several of the young mothers acknowledged that motherhood had its positive aspects, such as giving them an opportunity to dramatically change their lives for the better.

Discussion

Support for the relationship between health work and competence in health behaviour, operationalized as mothers' health promoting lifestyle practices, offers further validation for proposed relationships in the Developmental Model of Health and Nursing (DHMN) (Allen & Warner, 2002; Ford-Gilboe, 2002a). The positive relationship found in this study between family health work and mothers' health promoting lifestyle practices ($r = .52$) is consistent with findings from several previous studies with young families with children (Ford-Gilboe, 1997; Ford-Gilboe et al., 2000; Monteith & Ford-Gilboe, 2002), including two studies with single adolescent mothers of preschoolers (Black & Ford-Gilboe, in press; Sgarbossa & Ford-Gilboe, 2004). It has been suggested that health work, which includes broad problem-solving and goal-attainment activities, provides the foundation for helping family members develop and sustain a healthy lifestyle (Ford-Gilboe, 2002a). Consistent with this premise, research examining family management style in families with chronically ill children suggests that when families use proactive strategies and build on previous successes, members are more competent in self-care (Knafl, Breitmayer, Gallo, & Zoller, 1996). Similarly, findings of both quantitative and qualitative studies with single-parent families support the relationships between family processes of growth and change, testing of new health behaviours, and making healthy lifestyle choices (Duffy, 1984, 1986, 1994). Thus, in setting goals and working through problems, families and their members have the opportunity to develop effective health behaviours and thus healthier lifestyles. The adolescent mothers in the present study were in the early stages of learning to parent, and these experiences may have provided a context for considering goals and priorities and changing lifestyle practices as they incorporated the developmental tasks of mothering with those of adolescence.

The majority of mothers in the present study defined "family" broadly when responding to questions about health work. Thus, the pattern of health work captured in the study was primarily that of the family of origin and the social network rather than that of the emerging family of "procreation." The participants identified these same people — their own mother, friends, partners, and extended family members — as sources of support. Their extended family relationships may have encouraged them to develop patterns of health work by providing them with a reservoir of established problem-solving and goal-attainment means they could draw upon when faced with new challenges, such as parenting, education, or career-development issues. Previous research has shown that supportive extended-family relationships positively affect adolescent mothers' coping (Kelly, 1995) and facilitate the transition to motherhood (Mercer, 1986;

Panzarine, 1986). Extended family members may have also served as role models, not only for problem-solving but for developing healthy lifestyles. Parental role modelling of positive health behaviours has been found to be associated with healthy lifestyle practices among adolescents (Donovan et al., 1991; Gillis, 1997). Findings from this study suggest that, even in the context of developmental and situational challenges associated with adolescent parenting, family health work has a positive impact on the adoption and maintenance of healthy lifestyle practices.

The results of this study provide a basis for considering what role, if any, contextual factors such as felt stigma play in family health promotion. The complexity of and wide variation in the stigma experiences described by the adolescent mothers support the contention that this population is heterogeneous (Arenson, 1994). Most participants reported responding to feelings of stigma by concealing themselves through cognitive reframing, suppression of emotions, and physical distancing or social isolation, yet some challenged themselves to develop their potential as women and as mothers by setting goals and striving to meet them. However, qualitative analysis showed no consistent pattern of a relationship between their responses to stigma and health work when inspected across the analysis matrix. Thus, it is possible that no relationship exists between felt stigma and health work, that such a relationship exists only under certain conditions, or that such a relationship is manifested in other variables. It is also possible that the effect was too small to be detected or that the Stigma Scale, a brief, newer instrument, may not have adequately captured key dimensions of stigma experienced by adolescent mothers. Further research is needed in order to examine factors that mediate the relationship between stigma and health promotion efforts, such as self-esteem, resilience, and father involvement.

Although felt stigma was not directly related to health work or global health promoting lifestyle practices, father involvement was positively related to health work and negatively related to felt stigma, raising the possibility that felt stigma indirectly affects health work through father or partner involvement. Involvement of the children's fathers has been found to contribute to higher levels of self-esteem (Thompson & Peebles-Wilkins, 1992) and life satisfaction (Unger & Wandersman, 1988) in mothers, and to improved child development and behavioural outcomes (Unger & Cooley, 1992). Fathers of children are key players in providing functional and interpersonal support for adolescent mothers (Chen, Telleen, & Chen, 1995). It is possible that the presence of the children's father in the lives of participants lessened the perceived stigma, perhaps because it made them seem part of a nuclear family and transformed them from unwed mothers into "good girls" with a proper future (Addelson, 1999). Lower feelings of stigma may have caused the mothers

to be more open to assistance from the child's father and others, supporting the development of health work.

Both the qualitative findings of this study and the literature support the premise that stigma affects two personal strengths — self-esteem and resilience. Higher levels of stigma have been associated with lower levels of self-esteem in adolescents (Gershon et al., 1999; Westbrook et al., 1992). In this study, similarly, the adolescents who reported higher levels of felt stigma described themselves with less confidence than those who reported lower levels of felt stigma. Self-esteem has been found to be positively associated with parental competence (Sadler, Anderson, & Sabatelli, 2001) and coping strategies used by teen mothers in managing living arrangements, finances, and illnesses (Colletta, Hadler, & Gregg, 1981). Self-esteem is an internal strength that increases adolescent mothers' ability to manage normative life transitions associated with parenting. Thus, it is possible that self-esteem mediates the relationship between felt stigma and health work, ultimately resulting in positive parenting behaviours.

Resilience may also mediate the relationship between stigma and health work. Resilience is the capacity to adapt and grow in the face of adversity, and is associated with flexibility, self-reliance, determination, and the ability to derive meaning and satisfaction from life (Kadner, 1989; O'Leary, 1998, Wagnild & Young, 1990). In studies with single adolescent mothers (Black & Ford-Gilboe, in press) and single adult mothers (Ford-Gilboe et al., 2000), resilience has been found to positively affect both health work and healthy lifestyle practices. Felt stigma may cause distress (Scambler & Hopkins, 1986) and place those experiencing it at risk for negative outcomes, creating a context of adversity. Yet several participants in the present study reported that their stigma experiences, in conjunction with their new motherhood role, prompted them to change their life courses and better themselves, which suggests that stigma may engender resilience. The idea that parenting promotes positive transformations in adolescent mothers echoes the findings of other qualitative studies (Clemmens, 2003; Smith Battle, 1995), although not exclusively related to the perceived stigma of teen motherhood. Resilience may cause those mothers who possess it to take a greater interest in their health, in spite of adversity, and to strive towards healthy personal and family development.

The unanticipated finding of a direct positive relationship between felt stigma and health responsibility suggests that felt stigma may provide an impetus for young mothers to adopt health-seeking behaviours. Health responsibility is the most visible dimension of health promoting lifestyle, as it entails the seeking of health information or care from professionals in the public domain (Walker et al., 1987). Findings from qual-

itative studies suggest that young mothers are acutely aware of the sanctions associated with involvement with health or social service agencies, including the risk of having their children removed by child protection authorities (DeJonge, 2001; Hanna, 2001). Thus, felt stigma may serve to increase awareness of risk and cause the adolescent mothers to take proactive measures, such as seeking health services, in order to publicly demonstrate parental competence and responsibility. No such public action is associated with more personal health promotion practices, such as nutrition or stress management, none of which have been found to be related to felt stigma.

While the results of this study contribute to the knowledge base on the health promotion practices of adolescent single mothers, several limitations should be considered. Use of a correlational design precludes causal inferences, while the use of a small convenience sample of primarily Caucasian, English-speaking, educated mothers of preschool children, most of whom were connected with a variety of community service programs, limits the generalizability of the findings to those with similar characteristics. Further, the mothers most often defined their family broadly, so that their reported health work reflects patterns within their families of origin and social network, as opposed to within a nuclear family structure. Thus the relationship between health work and health promoting lifestyle practices, and the effects of felt stigma on these variables in the nuclear family, is not known. Although the DMHN holds that “family” should be defined by the person, varied definitions of family pose a challenge to the measurement of health work and interpretation of findings. Since the participants may have sought to portray themselves in the best light, self-report bias is possible. Finally, the qualitative findings related to stigma provide no more than a glimpse from the perspective — obtained during a single encounter — of adolescent mothers who were well connected with community services.

Conclusions and Implications

Consistent with a review of media stories (Kelly, 1996), the majority of participants described experiences with stigma in their everyday lives that affected their emotional and social health. Despite the apparent difficulty of living under continual scrutiny, the adolescent mothers participated in both family and individual health promotion activities at levels similar to those reported by older and/or more advantaged women and their families (Ford-Gilboe et al., 2000; Monteith & Ford-Gilboe, 2002). The participants rose to the challenge of their life circumstances by parenting while attending school or working, seeking assistance and support through a range of community services and promoting health by taking

responsibility for themselves and their children. These findings are consistent with the premise that adolescent motherhood can provide an opportunity for growth and positive change (Clemmens, 2003; Smith Battle, 2000). According to the DMHN (Allen & Warner, 2002), support for the development of health work may help both adolescent mothers and their families to make healthy lifestyle choices by providing them with opportunities to develop and engage in coping and goal-attainment processes.

Most of the participants reported experiences of stigma from various sources, including service providers. It is important that health-care professionals working with adolescent single mothers be cognizant of these feelings and perceptions. Attention to both verbal and non-verbal communication is essential, so that stigma is not perpetuated, resulting in further discrimination. Experiences of stigma may also contribute to the marginalization and social isolation of families headed by adolescent mothers. Nurses and other health-care professionals, particularly those working in public health, have a unique opportunity to identify these families and to support the development of connections within the community.

Nurses and other professionals must also advocate for adolescent mothers and their families on a broader scale in order to reduce barriers to effective services and dispel the negative stereotyping that pervades society. The present findings suggest that felt stigma may, in fact, motivate adolescent mothers to assume responsibility for health, but that stigma is a complex phenomenon and may affect other aspects of their lives. Further, this study was the first to explore stigma with regard to adolescent mothers and offers only a glimpse into its effects and its potential impact on health promotion. More in-depth or sophisticated schemas of the phenomenon may exist but were not discovered. More research aimed at describing the influence of stigma on the lives of families headed by adolescent mothers and identifying factors that buffer the effects of stigma on health outcomes is needed. As found in this study, relationships between stigma and family health promotion may be mediated by personal qualities such as self-esteem or resilience. Future studies should examine the interrelationships between these and other personal or family capacities on feelings of stigma and health promotion in families headed by adolescent mothers, including those experiencing varied contexts such as single-parenting, limited support networks, living with chronic illness, or families with older children. Additionally, longitudinal studies would be beneficial, in order to examine the evolution of health promotion in these families as both the mothers and their children grow and develop and in order to identify any association between changing resources and family strengths.

The results of this study contribute to an evolving knowledge base on health promotion in families headed by adolescent mothers and provide insight into the impact of contextual factors, such as felt stigma, on family health promotion efforts. A comprehensive understanding of factors that both enhance and hinder the health promotion efforts of these families is needed, to assist health and social service professionals to provide services that support, rather than undermine, the healthy development of adolescent mothers and their children.

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Comments or inquiries may be directed to Adrienne Fulford, West Elgin Community Health Centre, 153 Main Street, Box 761, West Lorne, Ontario N0L 2P0 Canada. Telephone: 519-768-1715, ext. 2211. E-mail: afulford@sympatico.ca

Adrienne Fulford, RN(EC), MScN, is Primary Health Care Nurse Practitioner, West Elgin Community Health Centre, West Lorne, Ontario, Canada. Marilyn Ford-Gilboe, RN, PhD, is Associate Professor and T. R. Meighen Family Foundation Community Nursing Professor, School of Nursing, University of Western Ontario, London, Ontario.