"Going Beyond the Call of Doula": A Grounded Theory Analysis of the Diverse Roles Community-Based Doulas Play in the Lives of Pregnant and Parenting Adolescent Mothers

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ABSTRACT

This article presents some of the most salient qualitative results from a larger program evaluation of pregnant and parenting adolescents who participated in a community-based doula program. Using grounded theory analysis, seven problem-solving strategies emerged that doulas apply in helping pregnant and parenting adolescents navigate multiple social and health settings that often serve as barriers to positive maternal- and child-health outcomes. The ethnographic findings of this study suggest that the doulas provide valuable assistance to pregnant and parenting adolescents by addressing social-psychological issues and socio-economic disparities. "Diverse role-taking" results in doulas helping pregnant adolescents navigate more successfully through fragmented social and health service systems that are less supportive of low-income adolescents, who are often perceived to be draining scarce resources. The findings have implications for the roles of community-based doulas assigned to low-income adolescents of color seeking to overcome obstacles and attain better educational and economic opportunities.

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By definition, a doula is a woman who is experienced in childbirth and provides support for an expectant mother and baby before, during, and after childbirth. This article examines how a community-based doula program in the State of Georgia addresses multiple issues in the lives of pregnant and parenting adolescents, including child- and maternal-health outcomes and social-structural problems. The findings of the study will help inform program enhancements for early-intervention programs for single adolescent mothers.

Although several studies have evaluated various aspects of early-intervention programs among adolescent mothers (Cherniss & Herzog, 1996; Harris & Franklin, 2009; Kuziel-Perri & Snarey, 1991), the value associated with community-based doulas working with adolescent mothers is not as well known. The effectiveness of doulas and childbirth educators in reducing medical interventions and improving maternal and infant outcomes in adult women is well-established in scientific journals (Campero et al., 1998; Deitrick & Draves, 2008; Schroeder & Bell, 2005). However, we found only one study that examined the perceptions of social support from the perspectives of pregnant and parenting adolescents using community-based doulas (Breedlove, 2005). This article seeks to contribute to the need for social scientific data pertaining to the relationship between doulas and pregnant or parenting adolescents.

The need for additional social and health services for pregnant and parenting adolescents is well documented. Birkeland, Thompson, and Phares (2005), for example, suggested adolescent mothers experience unique challenges during the postpartum because the roles of mother and adolescent conflict in ways that can manifest as clinical depression. They further argued that adolescent mothers lack the social support needed to address socioeconomic problems that are not necessarily unique to adolescent mothers but have more dire consequences for them because they lack problem-solving skills and access to resources. In particular, adolescent mothers experience restrictions in their social activities, interruptions in the educational process, unemployment and underemployment, and unstable intimate relationships with their children's fathers. The occurrence of such issues during pregnancy and postpartum highlight the need for adolescent mothers to have access to doulas who are committed to assisting them in addressing social, educational, and economic barriers as part of the service delivery model.

Brubaker (2007) provided a perspective on adolescent mothers concerning their interaction with the representatives of the formal health-care system whom they encounter during pregnancy. Specifically, some health-care providers' morally conservative views on adolescent sexuality in general sometimes result in tension and, in some cases, hostile exchanges between expecting adolescent mothers and their health-care providers. Also, some adolescents may choose to delay disclosing their pregnancy for fear of backlash when they reside in conservative families and communities. As Brubaker (2007) showed, such delays of disclosure and negative interactions with health-care providers may jeopardize the health of both mother and child.

Research that addresses adolescent-pregnancy intervention centers on the idea that, where there is concentrated poverty, there appears to be a related concentration of adolescent pregnancy of epidemic proportions in communities associated with having greater community social disorganization and, therein, limited educational and economic opportunities for young people (Beal, 2009). Generally, concentrated adolescent pregnancy is conceptualized as referring to U.S. states, counties, and zip codes that have adolescent pregnancy and birth rates of greater than 100 per 1,000 adolescents between the ages of 13 and 19 years old (Guttmacher Institute, 2010). Additional indicators of communities experiencing concentrated adolescent pregnancy include the following factors: large numbers of generational adolescent pregnancy (SmithBattle & Leonard, 2006); limited support and low expectations that adolescent mothers will remain in school during pregnancy or complete their education after giving birth (Barnet, Arroyo, Devoe, & Duggan, 2004; Pillow, 2006; Romo & Nadeem, 2007; Zachry, 2005); lack of comprehensive sex education programs (Kaiser & Hays, 2005; Kirby, 2007); high rates of substance abuse (McDonell, Limber, & Conner-Godbey, 2007); dating violence (Weisz & Black, 2009); unmet basic needs (T. Young, Turner, Denny, & M. Young, 2004); high rates of unemployment (Sarri & Phillips, 2004); and high per capita dependence on government-funded

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social and health benefits (An, Haveman, & Wolfe 1993; Duncan & Hoffman, 1990; Sarri & Phillips, 2004). Moreover, communities with high concentrations of adolescent pregnancy tend to socially-construct a discourse of social normalization around issues of adolescent pregnancy (SmithBattle, 2007). In this sense, becoming more intentional in approaches to communities where concentrated adolescent pregnancy exists has great potential for reducing the socioeconomic and health impacts associated with high rates of adolescent pregnancy. Thus, the need for relevant early interventions in communities where there is concentrated adolescent pregnancy is paramount because it relates to meeting vulnerable expectant mothers where they reside (Rains, Davies, & McKinnon, 2004).

The literature on early-intervention programs for pregnant and parenting adolescents highlights the strengths and challenges associated with addressing multi-systemic influences on maternal and infant outcomes (Barnet, Liu, & DeVoe, 2008; Corcoran, 2001; Gray, Sheeder, O'Brien, & Stevens-Simon, 2006; Shanok & Miller, 2007b). Several research articles have examined the extent to which adolescent mothers are impacted by experiences such as limited social support (Logsdon, Gagne, Hughes, Patterson, & Rakestraw, 2005), economic hardships (Young et al., 2004), and educational setbacks (Pillow, 2006; Zachry, 2005). Our review of the literature revealed, however, that there are very few programs implemented and evaluated that explore the effectiveness of community-based doulas assigned to pregnant and parenting adolescents (Breedlove, 2005; Barnet, Liu, Devoe, Alperovitz-Bichell, & Duggan, 2007). As a way to fill the gap in knowledge about the interactions of doulas and adolescent mothers, our ethnographic study used qualitative interviews to document adolescent mothers' experiences within a community-based doula program.

PURPOSE OF STUDY

Our study was designed to explore the services doulas provide for disadvantaged pregnant and parenting adolescents ($N = 30$) who received support from a community-based doula program in a large Southeastern urban area. Adolescent mothers participating in a qualitative evaluation of the program described several tasks that the doulas performed. The doulas' strategies can inform adolescent pregnancy interventions aimed at enhancing maternal and child outcomes and increasing opportunities for self-sufficiency.

COMMUNITY-BASED DOULA PROGRAM DESCRIPTION

The community-based doula program being evaluated as part of this study is implemented by the Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP), a state-level adolescent pregnancy prevention organization. The overall mission of G-CAPP is to eliminate adolescent pregnancy in Georgia by developing and supporting program innovations that build local and statewide capacity to promote the healthy development of adolescents. The community-based doula program represents one of several programs designed to achieve G-CAPP's mission. The specific program objective of the doula program is to provide community-based and culturally competent doula support to educate, counsel, and advocate for adolescent mothers and their babies during pregnancy, birth, and the weeks after birth. The program goal is to enhance health and social outcomes for mothers and their babies, and reduce the rate of repeat adolescent pregnancy among mothers in the program. The doula program trains its team of doulas to act as physical, emotional, and social support systems for adolescent mothers. Doulas conduct weekly home visits with expectant adolescent mothers, provide support during the labor and birthing processes, and assist with postpartum needs. Since its inception in 2002, the doula program has served a little over 300 pregnant and parenting adolescents. At the time of the evaluation, the program employed two full-time and two part-time doulas supported by a lead doula and two program coordinators.

G-CAPP partners with a local organization, Families First, Inc., to deliver the doula model in communities where adolescents are more vulnerable to unmet prenatal care and birthing support needs. The service delivery process begins with social service, education, and health providers referring pregnant adolescents to the community-based doula program. Pregnant adolescents are assigned to doulas based on cultural competency and geographical locations. Doulas conduct comprehensive assessments with each new program participant, which includes baseline data related to maternal-health indicators, social background, social support, and economic status. Program participants typically begin receiving weekly educational visits during the second trimester. Depending on

time of enrollment, prenatal educational visits can last up to nine weeks. Doulas attend births as part of the program, but based on the roles of other supporters and hospital rules, doulas may not always be present in the birthing room during the birth. Furthermore, after the adolescent gives birth, she receives up to three months of postpartum education and support. The program's core activities and intended outcomes are presented in Table 1.

THE ETHNOGRAPHIC INQUIRY

Ethnographic data provide a rich description of the roles doulas play in the lives of expecting and parenting adolescents. Ethnographic findings complement quantitative data collected on maternal- and child-health outcomes. The ethnographic evaluation design for the doula program consisted of in-depth interviews and direct observations.

Data Collection and Management Methods

Between May 2008 and September 2008, 30 ethnographic interviews and direct observations were conducted by two masters-level interviewers with expertise in child and maternal health. One interviewer was fluent in Spanish and interviewed the Latina adolescent mothers; the other was African American and interviewed the African American adolescent mothers. Both interviewers participated in ethnographic interview training under the leadership of an experienced qualitative health researcher. Their training consisted of motivational interview techniques, human subject protection, informed consent, data management, and data analysis. Prior to scheduling an interview, the interviewers contacted the doulas who had worked with the former program participants. Doulas provided updated information on former participants' last known address and phone number, as well as background on their relationship with the program participants. After debriefing with the doulas, interviewers called former program participants and scheduled to meet with them in person.

All consent forms, surveys, and direct observation forms were maintained in a field carrying case.

TABLE 1
The Doula Program's Activities and Intended Outcomes

Prenatal Home-based Education Series (Weeks 2–9)
W2: Get Ready for Birth
W3: Female Anatomy
W4: Signs of Labor, Warning Signs, and Introduce Birth Plan
W5: Complete Birth Plan
W6: Stages of Labor
W7: Hospital Procedures
W8: Breastfeeding
W9: Your Newborn

Labor and birth support

Postpartum Education Series (Weeks 1-12)
W1: Immediate Postpartum
W2: All About Your Baby
W3: Mom, You're Important Too
W4: Take It Slow
W5: Planning for the Future
W6: Putting It All Together
W7: Getting It Together
W8: Building Independence I
W9: Building Independence II
W10: Building Independence III
W11: Preparing for Discharge
W12: Week of Discharge

Follow-up postpartum services
Individualized support and advocacy activities

Enhanced Health Outcomes
☐ Healthy prenatal care among adolescent mothers
☐ Decreased cesarean births among adolescent mothers
☐ Increased breastfeeding rates
☐ Increased mother-child bonding
☐ Enhanced postpartum health among infants born to adolescent mothers
☐ Reduced repeat adolescent pregnancy rates

Enhanced Socioeconomic Outcomes
☐ Adolescent mothers with less than a high school education will return to school after giving birth
☐ Adolescent mothers will have adequate economic support after giving birth
☐ Adolescent mothers will have stable living situations after giving birth
☐ Adolescent mothers will have stable intimate-partner relationships after giving birth

Program Participant Satisfaction With Services
Program participants report overall efficacy of the program

Completed forms were returned to the evaluation team's main office and stored in a locked file cabinet. Digital-recorded interviews were stored on a shared drive and copied to a CD-ROM for back up.

Using purposive sampling and theoretical sampling, interviewers engaged 30 program participants who had completed the doula program within the last two years. Although adolescents and their guardians had given informed consent for data collection at the time of enrollment into the doula program, the evaluation team had the families complete an additional informed consent form that explained the purpose, time commitment, audio-recording, confidentiality, and voluntary aspects of the discussion. They were told that they could end the interview at anytime. Adolescent mothers received a $20 gift card for their time with the ethnographic interviewer.

Flexibility is a necessary component of ethnographic data collection in general. For our project, flexibility served the evaluators well since several of the adolescent mothers had different conditions under which they needed to schedule and complete the interviews about their experiences in the doula program. Although our evaluation design planned for all interviews to be conducted in person at the participant's preferred location, only 22 (73%) of the 30 interviews were conducted in this manner. Most in-person interviews were conducted in the participant's home, while a few were conducted at the home of another relative. One participant requested to meet in a local park. Eight interviews were conducted by phone due to scheduling conflicts or the participant's preference not to have the interview conducted at her home. Interviews ranged in timing from 20 minutes to 60 minutes. Interviews that ended earlier were primarily due to the mother's need to care for her infant.

Interviewers familiarized themselves with the ethnographic interview guide as a way to limit having to refer to the questions. Observation notes were completed immediately after the interviews, using a structured form for consistency. If the interviewer was unable to write her notes immediately after the interview, she used the digital recorder to capture her initial field impressions and then jotted her notes at a later time. Observation notes included the interviewer's perspectives on the environment, the participant's actions and feelings toward motherhood in general, and salient themes and quotes from a particular participant that were relevant to the evaluation questions.

Participant Demographics

Of the 30 participants who were interviewed, 16 were African Americans and 14 were Hispanic/Latina. The age range of the adolescents selected for ethnographic interviews was between 13 and 19 years old (mean age = 17 years) at the time of their entry into the doula program. Other demographics are presented in Table 2. At the time of this study, 314 of the 332 doula program participants had given birth. Therefore, birthing outcomes are only available for 314 adolescent mothers served. At the time of the evaluation, 293 of the 332 participants had completed the doula program's postpartum support phase. Thus, economic data at the time of program discharge are available for 293 of the 332 program participants.

Data Management

The ethnographic interviews were recorded as digital sound files and transcribed by the ethnographic interviewers. Copies of field notes and transcribed interviews were emailed to the evaluation data manager. The data manager checked and corrected every transcribed interview for accuracy.

Data Analysis

Two types of data coding schemes were used for our study. First, the transcriptions were coded using direct content analysis methods (Hsieh & Shannon, 2005). In this process, a coding scheme was structured according to the interview topics. The second coding technique was based on Strauss' (1987) grounded theory methodology, in which codes are sorted into four open codes answering the following questions:

1. *Conditions* – Under what conditions are pregnant adolescents entering the doula program?
2. *Interaction among actors* – In addition to the doula, what other supporters are involved in the everyday lives of pregnant and parenting adolescents?
3. *Strategies and tactics* – What are doulas "doing" on behalf of the pregnant and adolescent mothers?
4. *Consequences* – What are the consequences of adolescents' participation in the doula program?

The findings of our study are based on data analysis from the grounded theory coding techniques process in which an open coding indicator-concept model yields subcodes in each of the open codes. The open coding indicator-concept model is presented in Table 3.

TABLE 2
Study Participants' Demographics

	ETHNOGRAPHIC SUBSET ($N = 30$)			ALL PROGRAM PARTICIPANTS SERVED FROM 2002–2008 ($N = 332$)		
	African American	Hispanic/ Latina	Total/ Percent	African American	Hispanic/ Latina	Total/ Percent
School Attainment (at time of program discharge)						
Attending school or GED program	10 (33%)	3 (10%)	13 (43%)	128 (39%)	16 (4%)	144 (43%)
High school diploma or GED	4 (13%)	0 (0%)	4 (13%)	37 (12%)	11 (3%)	48 (15%)
Not enrolled in school	2 (7%)	11 (37%)	13 (44%)	40 (12%)	100 (30%)	140 (42%)
*Birthing Outcomes**					$n = 314$*	
Natural childbirth	9 (30%)	8 (27%)	17 (57%)	105 (33%)	69 (22%)	174 (55%)
Induced or assisted vaginal birth	4 (13%)	3 (10%)	7 (23%)	58 (19%)	29 (9%)	87 (28%)
Cesarean births	3 (10%)	3 (10%)	6 (20%)	44 (14%)	9 (3%)	53 (17%)
Skin-to-skin contact with newborn within 30 minutes of giving birth	8 (27%)	10 (33%)	18 (60%)	66 (21%)	58 (19%)	124 (40%)
Doulas attended birth	11 (37%)	8 (27%)	19 (64%)	106 (34%)	66 (21%)	172 (55%)
Initiated breastfeeding after giving birth	9 (30%)	11 (37%)	20 (67%)	102 (33%)	61 (19%)	163 (52%)
Medically classified as having a normal birth weight	13 (43%)	14 (47%)	27 (90%)	147 (47%)	95 (30%)	242 (77%)
*Economic Data**(at time of program discharge)*					$n = 293$**	
Employment	1 (3%)	0 (0%)	1 (3%)	29 (10%)	6 (2%)	35 (12%)
Receiving Temporary Assistance to Needy Families	4 (13%)	2 (7%)	6 (20%)	49 (17%)	3 (1%)	52 (18%)
Medicaid for mother	17 (57%)	3 (10%)	20 (67%)	189 (65%)	21 (7%)	210 (72%)
Medicaid for baby	16 (53%)	14 (47%)	30 (100%)	176 (60%)	100 (34%)	276 (94%)
Financial support from father	4 (13%)	9 (30%)	13 (43%)	41 (14%)	79 (27%)	120 (41%)
Receiving food stamps	8 (27%)	0 (0%)	8 (27%)	82 (28%)	2 (1%)	84 (29%)
*Risk Factors for Repeat Pregnancy**					$n = 293$**	
Self-reported using birth control at 12 weeks postpartum	5 (16%)	8 (27%)	13 (43%)	129 (44%)	69 (23%)	198 (67%)
Repeat pregnancies	2 (7%)	0 (0%)	2 (7%)	9 (3%)	1 (< .5%)	10 (3%)

Note. *At the time of the study, 314 of the 332 participants in the doula program had given birth; therefore, birthing outcomes are only available for 314 adolescent mothers served. ** At the time of the study, 293 of the 332 participants in the doula program had completed the program's postpartum support phase; thus, data at the time of discharge are available for 293 of the 332 program participants.

As suggested by Strauss (1987), an axial coding process was conducted whereby the researchers sought to make sense of the open codes by asking: "What conditions and situations are adolescent mothers facing that lead doulas to pursue specific problem-solving strategies?" After the open codes were reviewed extensively, each was examined in terms of how it related to the strategies and tactics used among the doulas when interacting with pregnant and parenting adolescents. There appeared to be a pattern in the problem-solving strategies, with seven categories of problem-solving strategies emerging. The resulting conceptualization of the problem-solving strategies included:

1. *Asking* – Program doulas used motivational interviewing techniques to ask participants questions that helped doulas determine the degree to which adolescent mothers were impacted by a particular subject or issue.
2. *Active listening* – The participants described the doula's active listening skills as "listening without judging." The participants seemed to be most appreciative of the opportunity to speak with a neutral third party about the details of their private lives. According to the adolescents, active listening typically was followed by either assuring words when the adolescents were

TABLE 3
The Open Coding Indicator-Concept Model

1 Conditions	2 Interaction Among Actors	3 Strategies and Tactics	4 Consequences
Under what conditions are pregnant adolescents entering the doula program?	In addition to the doula, what other supporters are involved in the everyday lives of pregnant and parenting adolescents?	What are doulas "doing" on behalf of the pregnant and adolescent mothers?	What are the consequences of adolescents' participation in the doula program?
a) Unplanned pregnancy	a) Mothers	a) Advising on parenting for toddlers	a) Remaining in touch with doula
b) Growing up in child protective custody	b) Fathers of the babies	b) Assisting with child wellness	b) Advocating for self
c) Babies' fathers incarcerated	c) Sisters/brothers (siblings of the teen)	c) Assisting with child development	c) Changing living arrangements
d) Repeat adolescent pregnancy	d) Stepfathers	d) Advocating at the doctor's office	d) Surprised that the doulas care
e) 5–7 months pregnant before prenatal care	e) Grandmothers of the adolescents	e) Buying gifts	e) Happy feelings about pregnancy and parenting
f) Strained relationship with babies' fathers	f) New boyfriends	f) Serving as life coaches	f) Having hope
g) New boyfriends	g) Teachers	g) Encouraging adolescents to attend school	g) Returning to school
h) Large family households	h) Fathers of the adolescents	h) Serving as a substitute mother	h) Not as depressed
i) Pregnant and friends		i) Relationship counseling	i) Having a doula for life
j) Depressed		j) Providing transportation	j) Receiving advice on parenting
k) Lack of support from fathers of babies		k) Talking to sad adolescents	k) Strained relations with father of child
l) Unstable living conditions		l) Providing job leads	l) Hopeful about the future
m) Loss of custody		m) Giving good advice	m) Unmet needs for professional counseling
n) Labeled as a problem child		n) Mentoring and supporting	n) Not attending school
o) Negative comments for getting pregnant		o) Helping find jobs	o) Repeat adolescent pregnancy
p) Mixed feelings about being pregnant		p) Helping find housing	p) New relationships
q) Denied being pregnant			
r) Ashamed of being pregnant			
s) Negative parental role models			
t) Fathers of babies denying paternity			
u) Breaking up with fathers of babies			
v) Living with others			
w) Missing relatives that are not able or willing to be involved in pregnancy			
x) Not attending school			
y) Doubting doulas could help			
z) Teachers being shocked			
aa) Unfit family environment			
bb) Childhood abuse and neglect			
cc) Self-doubt			

already on the right track or advice to address identified problems.
3. *Assuring* – When the doulas worked with adolescents who were facing compounding and complex conditions associated with their pregnancy and early parenting, doulas continually reassured the adolescents that everything was going to work out for them and their babies.
4. *Affirming* – Sometimes, the adolescent mothers had good insights and generally made sound decisions pertaining to mothering. In these instances, doulas affirmed the adolescent mothers' thought processes and decision-making abilities.
5. *Advising* – When some adolescents were making weaker choices or appeared to be unable to make choices, the doulas provided advice based on their knowledge about that particular issue or situation.
6. *Action taking* – Some conditions resulted in the doula having to take action on behalf of the participant. Taking action was typically the strategy used when doulas believed the young mothers did not have adequate information about child- and maternal-health resources in particular. As a way of modeling the proper behavior for taking action aimed at information gathering, doulas attempted to include participants in the conversations and action-planning steps, including giving them assignments to make phone calls during the information-seeking phase.
7. *Advocating* – When the doulas believed the adolescent mothers were being treated unfairly or were not given access to resources that should readily be available to them, the doulas would advocate for the adolescents within the social and health service systems.

In addition, our study examined the recurring situations or issues that led to the need for doulas to select one or more problem-solving strategies to assist program participants. Ten situations or issues met the criteria for ''recurring,'' which was defined as having been coded in at least 8 of the 30 interviews. For this publication, recurring themes were coded and identified for each ethnic group. However, the actual coded text was sorted in a Microsoft Excel spreadsheet, which allowed for cultural differences and patterns in the doulas' approaches to problem solving to be checked. Table 4 highlights the axial coding analytic scheme by ethnic group.

1. *Self-esteem and self-efficacy* – For the African American adolescents in particular, their pregnancies tended to be unplanned and they described themselves as ''being down'' on themselves as a result of their pregnancies. Doulas helped build the adolescents' self-esteem and self-efficacy to prepare them for taking positive self-actions during the pregnancy, birthing, and early-parenting processes.
2. *School* – Doulas advising adolescents who were in school at the time of their pregnancy to remain in school and return to school after the 6-week checkup was prevalent among African American adolescents. Advising Latina mothers to go to school was not as prevalent, primarily because most were not eligible at the time to attend school in the United States. However, advising Latina adolescents to enroll in classes where they could improve their English language skills was important because improved English proficiency was attached to gaining access to better jobs and schooling in the future.
3. *Health care* – Problem solving around health care included asking questions about doctor visits, advising adolescents about the importance of making and keeping appointments, taking action in helping adolescents make sense of medical information, and advocating for fair treatment within the health-care service system.
4. *Translation services* – Doulas working with Latina adolescents often had to take action in serving as translators at doctors' offices.
5. *Depression* – All doulas actively listened to adolescents who self-reported being depressed during and after pregnancy. Active listening was followed up by either assuring the adolescents that they would be alright or providing practical advice for addressing the issues that led to depression.
6. *Transportation* – Both Latina and African American adolescents needed assistance with transportation, primarily for rides to prenatal care visits, to the hospital for birth, and to pediatrician visits for the baby.
7. *Intimate-partner relationships* – Evidence of addressing the problems associated with intimate-partner relationships included asking, active listening, and advising. Despite reports among some adolescents of intimate-partner violence, it is important to note that taking action and advocating were not commonly used as problem-solving strategies in this area.

TABLE 4
Axial Coding Analytic Scheme

	1 Asking		2 Active Listening		3 Assuring		4 Affirming		5 Advising		6 Action Taking		7 Advocating	
	African American	Latina	African American	Latina	African American	Latina	African American	Latina	African American	Latina	African American	Latina	African American	Latina
1. Self-esteem and self-efficacy					x	x	x	x						
2. School									x					
3. Health care	x								x	x		x	x	
4. Translation services										x	x	x	x	x
5. Depression	x	x	x	x	x	x	x	x						
6. Transportation														
7. Intimate-partner relationships	x	x	x	x					x	x				
8. Father involvement and child support			x	x					x	x			x	
9. Birth control	x	x							x	x				
10. Future goal setting	x	x							x	x				

8. *Father involvement and child support* – In the early months of pregnancy, most adolescents believed that the fathers of their babies would be supportive emotionally and financially. However, many adolescents found that their ideal expectations for father involvement were not met, which resulted in doulas actively listening and giving situational advice. In a few instances, doulas took action to help adolescents gain access to child support or other means of economic support.
9. *Birth control* – Doulas asked the adolescents questions about their birth control preference and postpartum utilization. After listening to the adolescents' attitudes and beliefs about birth control, the doulas provided medically accurate advice on the various types of birth control.
10. *Future goal setting* – All doulas engaged in asking questions about the adolescents' future plans. After asking questions, doulas provided advice and assisted some adolescents in taking action toward preparing for the future. For pregnant and parenting adolescents, "the future" was defined as the next five years.

Toward a Theoretical Model

According to Strauss (1987), when open and axial coding activities are followed by selective coding techniques, a theoretical model typically emerges that explains the relationships between the codes. The selective coding process of our ethnographic study resulted in a theory of "additional role-taking and caregiving beyond the traditional job description of a doula." In essence, because the doulas supporting adolescent mothers are open to solving multiple and complex problems on behalf of adolescent mothers, they often perform work beyond the parameters of a doula's traditional role. The additional roles these doulas take on most often involve trying to help adolescent mothers address unmet social and socioeconomic needs. In this way, the doulas create a continuum of care that is atypical in service provision systems for pregnant and parenting adolescents. Doulas become "activists" as they confront systems of care that have marginalized pregnant and parenting adolescents, deeming them "moral, political, and economic undesirables." Even some dimensions of more liberal discourse on adolescent pregnancy suggest that pregnant adolescents have forfeited the ability to access educational and economic opportunities. As the work of doulas reminds us, adolescent pregnancy is not the cause of poverty and limited mobility, but in fact is a symptom of life in communities where adolescents are confronted with social and economic obstacles every day, even before they ever become pregnant.

As our theoretical model suggests, doulas recognize the unequal treatment pregnant and parenting adolescents experience in both public and private spaces. This disparity prompts doulas to take on additional roles to fill social, emotional, and economic voids in the adolescents' lives. Additional role-taking among doulas can be divided into three categories of role types: (1) family and friend, (2) social and health service provider and advocate, and (3) general life coach and counselor.

Taking on the roles of family and friends. During the interviews, adolescent mothers were quick to identify ways in which doulas took on socially supportive roles. Because most adolescents had never heard the term ''doula,'' it was important for them to find ways to think about what role a doula would play or replace in their lives. In the early weeks, many adolescents made sense of the doula's role by identifying her actions as performing the duties the adolescents associated with the roles that an ideal mother, older or ''big'' sister, or friend should play during her pregnancy, birth, and early-parenting phases.

Mother. The most identified role the adolescents perceived the doulas to be filling was that of ''another mother'' or the ''ideal mother.'' A closer examination of the data suggests that adolescent mothers appeared to have three different types of relationships with their birth mothers at the time of enrollment into the doula program: a close, but strained relationship; a dysfunctional or nonexistent relationship; and a limited or no relationship due to geographical separation. Some adolescents were close to their biological mothers, but felt strain in the relationship due to their pregnancy. Pregnant adolescents with previously close relationships with their mothers felt that their unplanned pregnancy had hurt their biological mothers. These adolescents welcomed the idea of having the doula take on a mothering role, albeit temporarily, since most biological mothers in this group eventually restored relationships with their daughters. One adolescent mother who felt she had hurt her family described her mother as crying and being disappointed when she found out the adolescent was pregnant. The adolescent was then connected with the doula through her school. What she remembers most is the doula telling her, ''It's not the end of the world.'' Another adolescent described her mother's reactions as more ''mad'' than ''sad'':

> *She was like, ''Why did you do this to me? I let you go out and your dad is going to kill me.'' She was sad, but then she was like, ''It's up to you if you want to keep it or not.''*

Over time, this adolescent's mother accepted the pregnancy, but in the interim the doula played the role of ''supportive mother.''

Another group of pregnant and parenting adolescents described their relationship with their mothers as dysfunctional or nonexistent:

> *My mom can't be depended on. She ain't been here since yesterday and she can't be depended on. I'm more mature than what she is. She just want to be loved. . .. She do things and don't worry about if it's going to embarrass me hanging with boys around my age. She drink. . .. Basically I raised myself.*

For these adolescents, having an ''ideal mother'' figure to replace years of self-described poor parenting by their own mothers was of great value.

Finally, many of the Latina adolescent mothers reported that their biological mothers were living in Mexico. For example, one Latina adolescent noted, ''[The doula] was real helpful for me because I am here alone in this country. I don't have my sister or mother.'' Many of these adolescents described themselves as living in the United States with their ''husbands,'' even though they were not legally married. Latina adolescent mothers were more likely to be living in larger households headed primarily by women from the families of their ''husbands'' or the fathers of their children. The doulas were able to balance maternal and parenting advice and correct misinformation that might be provided by the family. In this way, Latina adolescents welcomed the opportunity to have mother-figures in their lives who were unrelated to the fathers of their children.

Big sister. Several adolescent mothers viewed their doulas as a ''big sister.'' The big-sister role typically was reserved for when the adolescents needed to discuss intimate-partner relationships. The big-sister role became more important during the postpartum phase when adolescents discovered that the fathers were not playing the parenting or support roles the adolescent mothers had envisioned. For the African American adolescents, the fathers of their children were more likely to be in jail or have simply abandoned the relationship. For Latina adolescents, fathers were absent primarily due to working long hours or leaving to find work in other cities. As one adolescent described her experience, ''I went through postpartum depression because my baby daddy wasn't there, even though I had other support I needed. It's just something that everybody wants no matter who you are.'' Another

Doulas become "activists" as they confront systems of care that have marginalized pregnant and parenting adolescents, deeming them "moral, political, and economic undesirables."

adolescent confided a similar story: ''Me and my baby daddy we were a couple but something had happened and I felt very comfortable talking to [my doula].''

The adolescents discussed issues they were having with the biological fathers of their babies and, in some cases, with new boyfriends. A few adolescents confided in the doulas that their intimate-partner conflicts had become violent. According to one adolescent, she turned to her doula for help when ''he started being abusive.''

Friend. Several adolescents looked to their doulas as a friend. After the adolescents became pregnant, many found themselves having limited or no contact with their close adolescent friends. During interviews, they described how doulas filled these ''girlfriend'' roles. For example, as one adolescent mother said, ''[The doula] would come out and visit and talk with me about things.'' Another adolescent recalled her relationship with her doula: ''She would basically 'chill' with me like she was my friend.''

For the African American adolescents, loss of friendship was tied to not being in school. For Latina adolescents, limited friendship was tied to moving frequently and not being in one place long enough to establish close female bonds outside of their families. Some socially integrated African American adolescents stated that the parents of their friends were responsible for ending friendship ties. For example, one African American adolescent said, ''[My friend's mom] thinks I'm a bad influence on her because I was pregnant.''

Taking on the roles of social and health service provider and advocate. The doulas took on additional roles to assist adolescents in navigating fragile social and health systems. As adolescents described their social and health needs, the roles that doulas played in this area emerged.

Social worker. Doulas often took on the role of social worker, often defined as ''offering guidance and counseling to people in crises.'' From this perspective, a number of issues addressed by the doulas that the adolescents described through interviews indeed fell under the category of social work. One adolescent whose living conditions had become unbearable received assistance from her doula: ''[The doula] was trying to enroll me in this program that give you an apartment.''

Another adolescent, who was unable to establish consistent child support, learned from her doula how to access Temporary Assistance to Needy Families, a federal assistance program. The adolescent described how the doula took her to a session that helped her understand the pros and cons of seeking welfare benefits. Doulas also proved very helpful in assisting undocumented Latina adolescents in accessing resources specific to their undocumented status. Other social-work centered activities included helping adolescents get back into ''regular'' school or find appropriate alternatives such as GED programs or vocational training. In addition, doulas provided job leads and made recommendations for finding safe, affordable daycare providers.

Health-care advocate. Serving as a health-care advocate typically is included as part of the traditional duties and expectations for all doulas. However, for adolescent mothers, the role of health-care advocate takes on new dimensions. First, doulas often found themselves transporting adolescents to and from medical appointments. As one of the adolescents reported, ''Sometimes when I didn't have bus fare, [my doula] would take me to my doctor's appointment.''

In the health-care setting, doulas found themselves standing up for the adolescent mothers. In some cases, adolescents experienced negative interactions with doctors and nurses. For one adolescent, the treatment was so bad that the doula actually helped the adolescent change health-care providers altogether. These adolescents' experiences are consistent with research conducted by Breheny and Stephens (2007), who found that some health professionals' moral beliefs result in negative attitudes toward adolescent mothers.

Several adolescents reported feeling like the doctor was trying to ''trick'' them into certain procedures that were commonly related to the medical model, as opposed to natural childbirth. In such instances, the adolescents looked to the doulas to provide support for their decisions to have natural childbirths. Adolescents often recalled that, during the prenatal visits, it was common for them to sit for hours waiting to see the doctor. In these cases, doulas stepped in and advocated for adolescents to complete their doctor visits within a more reasonable time frame. One adolescent described the following experience in how her doula supported her in the health-care setting:

[The medical office staff] treated me a little unfairly and she [the doula] saw that and she would speak up on my behalf and I liked that because a lot of times I was going through stress and problems and I would take things a little too far, and she know how to say things the right way and calm the situation down.

At least three of the adolescents were no longer formally in the doula program, but they were still receiving assistance from doulas when they needed help getting their infants to pediatric appointments. One adolescent summed up the doulas' continued actions in this regard: ''I am not in the program anymore, but it's like I am still in the program because [the doula] take him to the doctor sometime.''

Education advocate. Advocating for adolescents to return to school emerged as a theme among the African American adolescents. A few of the African American adolescents had dropped out of school prior to becoming pregnant. For this subpopulation, doulas helped them find GED programs, return to school, or enroll in vocational training programs. The doulas' effort was especially important for adolescents who had gotten lost in multiple systems, including family, child protective services, and the public school system. As one adolescent reported:

I was in [Department of Family and Child Services] custody when I was younger. They transferred me from so many schools just my 12th-grade year alone. They lost a lot of my credits and I had a hard time trying to further myself. I wanted to get all these good jobs, but you can't really get a good job if you don't have a GED or diploma. A GED just wasn't enough for me. [The doula] gave me a lot of information about different programs I could go to.

Other adolescents had trouble finding the motivation to continue attending school during their pregnancy. Some doulas appealed to adolescents by associating their children's future as tied to the decisions the adolescent mothers make today pertaining to school. As one adolescent described, ''[The doula] told me 'don't stop going to school because if I stop then [the baby] will probably follow behind my footsteps.' '' Another adolescent recalled her doula motivating her to remain in school as a way to lower her dependency on others in the future: ''She said that when somebody isn't prepared for school that they would always be depending on someone else and they will not get anywhere.'' Another adolescent described how she needed almost daily encouragement to attend school:

I didn't even want to go to school, but [the doula] told me don't do that. ''You don't want your education to drop 'cause you are pregnant and don't feel like going.'' She said, ''You can stay out when you sick or don't feel well. If you go to school and you don't feel well, then you come home, but at least go for half the day.''

Sex educator. Providing information about birth control was a common theme among the doulas interacting with adolescents. Adolescents commented about the education they received on birth control and the prospects for repeat pregnancy. It is important to note that there were two repeat pregnancies among adolescents in this ethnographic subset. At the same time, several of the Latina adolescents indicated that birth control was not a goal because they wanted a large family. One Latina adolescent described why she was less motivated to use birth control: ''My thoughts were to have a big family like my mother. I want 12 children.''

Taking on the roles of general life coach and counselor. By the time the doulas began working with most of the adolescents, the adolescents had already experienced an excess of negative reactions to their pregnancies and faced conditions that put their health at risk. The adolescents' predicament resulted in the doulas initiating problem-solving strategies that fit into the category of ''general life coaching and counseling.'' The adolescents gave examples of how the doulas provided advice on a range of topics depending upon the adolescents' needs and interests. The topics included budgeting, child support, career coaching, parenting, mediating with extended family, and strategies for losing weight gained during pregnancy. In some cases, doulas provided information and, in other instances, life coaching took on an approach of modeling positive parenting techniques. One adolescent explained how the doula used general coaching and counseling techniques to help her sort through multiple issues:

I had a lot of situations when I just wanted to give up. I wanted to give up on school and I wanted to

give up on finding the baby daddy. She told me to stick in there. ''You going to get it. Don't just let it go.''

Other adolescents needed daily reminders to tune out negative messages from others in their lives. One adolescent recalled the doula coaching her on how to handle negativity: ''She was like, 'Don't listen to what people say if they try to down you and say stupid stuff.' ''

At least two adolescents simply did not know who the fathers of the children were. In these instances, the doulas applied general coaching as a way to inspire the adolescents not to give up on trying to figure out the identities of the fathers and to locate them.

Some of the adolescents needed the doulas to model maternal-infant bonding. According to one adolescent, the doula provided the following additional postpartum help: ''She would hold him and she would talk to him and feed him and change him. She did everything.'' Other adolescent mothers became frustrated when they did not know what to do for their babies' ''chronic crying.'' At these times, the doulas taught the adolescent mothers more productive ways of soothing and comforting their newborns, as well as dealing with their own frustrations.

Many of the adolescent mothers recalled reaching a breaking point in balancing their multiple identities, which included ''daughter, girlfriend, mother, student, adolescent, and worker,'' among others. Adolescents reported experiencing depression and self-doubt as a result of struggling to various degrees with role strain (within a particular role) and role conflict (between multiple roles). In response, doulas attempted to provide mental-health support. Several adolescents described how doulas continually gave them positive affirmations about ''keeping the faith, maintaining their strength, and maintaining high self-esteem.'' However, a few adolescents stated that they could have benefited more from professional counseling. One adolescent summarized the thoughts of several of her cohorts: ''I think that a professional counselor would be better because the doula try to do what she can so that we don't get depressed. But I think that a professional would be much better.''

General life counseling and coaching also extended to mediation between the adolescent mother and her family. This mediating role was particularly the case as adolescent mothers' became more confident in their parenting skills and decision-making abilities. Increases in confidence and skills sometimes brought adolescent mothers into conflict with their own mothers and grandmothers. Doulas, therefore, often invited the adolescents' mothers and grandmothers to join in on the educational sessions. Decisions about breastfeeding also seemed to require higher levels of mediation between the adolescent mother and other members of her household. For example, oftentimes other family members were not supportive of the adolescent's desire to breastfeed and, thus, conflicts arose.

After adolescent mothers were discharged from the doula program, many were left with limited support systems. Among the Latina adolescents, many relocated shortly after completing the program. However, among the Latina adolescents who remained in the area of the program, the doulas continued to maintain contact with them. Almost all of the African American adolescents reported continued contact with the doulas after they were discharged from the program. Although doulas had to add new program participants when adolescents ended their postpartum education visits, it was clear that doulas were adamant about not abandoning adolescents that needed continued support. Two adolescents summed up the sentiments of their cohorts: ''She said she my D4L—Doula for Life!'' and ''I really don't have a support system anymore, but I can always call [the doula] because she still comes around and helps me when I need her.''

DISCUSSION AND CONCLUSIONS

In our ethnographic study, we sought to examine parenting adolescents' perceptions of their experiences in a community-based doula program. The study's findings suggest that doulas give adolescent mothers valuable assistance by taking on various roles beyond traditional duties associated with being a doula. The program doulas filled social and economic voids, and they provided assistance well beyond the expectation of more positive maternal- and child-health outcomes. The doulas addressed issues such as stigma, shame, social isolation, and social structural issues faced by pregnant and parenting adolescents.

The doula approach to serving pregnant and parenting adolescents has implications for childbirth educators in general. The findings from our study imply that childbirth educators must be flexible in going beyond the role of ''educator'' when

serving mothers who may be members of multiple vulnerable populations. For example, younger adolescent mothers may need help working with multiple service providers in addition to guidance in how to develop respectful ways to communicate their maternal plans with their families. The need for extended help and guidance is especially the case when younger adolescent mothers desire to breastfeed. The findings also have implications for childbirth educators serving mothers who have a substance abuse history and may or may not be in treatment, incarcerated pregnant mothers, and mothers who are in violent partner and familial relationships. Ultimately, childbirth educators could be more effective and serve increasingly relevant roles in the lives of vulnerable mothers if they, like the program doulas in this study, incorporate strategies for addressing complex social and health issues into the childbirth education process.

Additionally, our study has implications for new program development and program enhancement for early-intervention programs targeting pregnant and parenting adolescents. Specifically, the study provides evidence that adolescents experiencing unplanned pregnancies benefit tremendously from having doulas to help stabilize some of the mental and physical aspects of their pregnancies, births, and postpartum experiences. However, community-based doula programs targeting adolescent mothers may need to consider extending the relationship from childbirth to child development in order to mentor adolescents through some of the more difficult transitions of adolescent motherhood. As adolescent mothers take postpartum action to return to school or work, they require social support from others experiencing similar daily routines. Although the doulas' dedication to their clients after they were discharged from the program is admirable, it is unrealistic to expect doulas to provide services to new adolescent mothers with the same frequency and intensity after they have become ''former'' program participants. Doula-led, weekly support-group sessions for former program participants may be an appropriate program enhancement.

As indicated in our study's data, adolescent mothers also have unmet mental-health needs that may require professional counseling, a finding that is consistent with previous larger studies of postpartum depression among adolescent mothers. For example, Sadler et al. (2007) found that about 33% of adolescent mothers in their study experienced mild to moderate depression. Shanok and Miller (2007a) found that feelings of shame and guilt and discouragement increased inner-city adolescent mothers' risk for depression. Eshbaugh (2006) found that race, ethnicity, and partner status predict depression among adolescent mothers, with partnered African Americans and non-partnered Latina mothers having higher rates of depression after giving birth. Finally, Yozwiak (2010) concluded that mental-health screening, treatment, and follow up are missing from health-care needs of pregnant and parenting adolescents and should be incorporated into existing models of care for this group. It is true that public support and financing of a comprehensive mental-health system of care for adolescent mothers may be problematic. However, the public's view may shift if provided with recent studies highlighting depression in adolescent mothers, which have found that adolescents experiencing untreated depression are more likely to have a rapid subsequent pregnancy, defined as pregnancy occurring within 24 months of a birth (Barnet et al., 2008).

In the absence of public support for increasing the resources available to adolescent mothers, maternal- and child-health advocates may want to build on the promising findings that doulas who are already serving adolescents have the ability to link program participants with clinical mental-health services. Given the trust that adolescent mothers indicate they have in doulas, training doulas on proper procedures for screening and providing referrals for clients with depression and signs of more severe mental illness may result in more adolescents accessing and appropriately interacting with mental-health counselors. Shanok & Miller (2007a) found that combining the Beck Depression Inventory and Edinburgh Postnatal Depression Scale results in a valid and reliable tool for screening for depression among pregnant and parenting adolescents in inner-city communities. Furthermore, Barnet et al. (2008) used the Center for Epidemiological Studies Depression Scale to screen for depressive symptoms among adolescent mothers. Incorporating one of the findings of these studies into the existing assessment process may be helpful as a first step in getting severely depressed adolescent mothers into clinical treatment.

Intimate-partner conflict or violence is another area where doulas may need specific training in order to assist adolescents in gaining access to appropriate domestic-violence counseling and resources. In

addition to formal training on intimate-partner violence, doula programs targeting adolescents may want to use a simplified version of the widely used Conflict Tactics Scale to screen for violence more effectively (Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Doulas have demonstrated that working with pregnant adolescents requires them to go beyond their assigned roles and duties in an effort to reach intended maternal and child outcomes. From a public-issues standpoint, the performance of multiple supportive roles by doulas serving adolescents has implications for a number of social problems. First, the actions of doulas must be viewed from the broader perspective of long-term child well-being. Also, the doulas' increased interventions with higher risk adolescent parents must be understood within the context of the types of parents who are more likely to be brought to the attention of Child Protective Services for neglect or abuse at some point during the parenting process. Following up on adolescent mothers, even when formal service ends, provides opportunities to assess their children for signs of neglect and abuse over a longer period of time. Moreover, the support that doulas provide to adolescents as they return to school, enter vocational training, or go to work has the potential to break cycles of poverty and welfare dependence among low-income adolescent mothers. The efforts of doulas committed to solving multiple and complex problems in the lives of their program participants show promise for enhancing educational and economic opportunities and outcomes for adolescent mothers.

Research Implications

Because our study was part of a program evaluation, we used theoretical sampling as a way to augment quantitative evaluation data with qualitative data in order to measure the personal impact of community-based doula programs from the participants' viewpoints. Moreover, narrative discussions helped shape a discourse on the difference doulas make in the lives of more vulnerable mothers and their infants. To that end, we strived to include study participants who needed more support as a result of becoming pregnant at 13 and 14 years old. However, only one of the three 13-year-old mothers and two of the twelve 14-year-old mothers who were previously enrolled in the program were successfully located. In addition, we recommend that future evaluations include interviews with the doulas to understand better their perspectives, how they select and apply problem-solving strategies, and how they manage their time and resources when servicing new program participants while maintaining relationships with previously served adolescent mothers.

We also recommend that additional aspects of program evaluation and future research include interviews with other key stakeholders in the adolescent mothers' social support network, including members of the adolescents' family, the fathers of the children, and the adolescents' new significant partners. Interviews can also be conducted with teachers, health-care providers, and other social-service providers to understand their beliefs and approaches to serving pregnant and parenting adolescents, which may serve as a first step in understanding and addressing the structural barriers to adolescent maternal and child health. These additional perspectives will also provide further evidence of the extent to which others who support adolescent mothers believe doulas are helping pregnant and parenting adolescents solve multiple and complex problems.

Study Strengths and Limitations

Our ethnographic study was designed to examine more deeply the lives and relationships of adolescent mothers who had participated in a community-based doula program with their program doulas. The demographics of the ethnographic study participants ($N = 30$) is similar enough to the program's larger sample of all program participants ($N = 332$) that it can be reasonably expected that other program participants had experiences similar to the study's sample. The sampling process was, however, biased by the interviewers' heavy dependence on the doulas for selecting and locating past program participants. As feminist researchers, however, we believe that this grounded theoretical approach and its generation of relevant knowledge about an unexplored dimension of the work of doulas far outweigh the study limitations.

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REFERENCES

An, C. B., Haveman, R., & Wolfe, B. (1993). Out-of wedlock births and welfare receipt: The role of childhood events and economic circumstances. *Review of Economics and Statistics*, *75*(2), 195–219.

Barnet, B., Arroyo, C., Devoe, M., & Duggan, A. K. (2004). Reduced school dropout rates among adolescent mothers receiving school-based prenatal care. *Archives of Pediatrics & Adolescent Medicine*, *158*, 262–268.

Barnet, B., Liu, J., & Devoe, M. (2008). Double jeopardy: Depressive symptoms and rapid subsequent pregnancy in adolescent mothers. *Archives of Pediatrics & Adolescent Medicine*, *162*(3), 246–252.

Barnet, B., Liu, J., Devoe, M., Alperovitz-Bichell, K., & Duggan, A. (2007). Home visiting for adolescent mothers: Effects on parenting, maternal life course, and primary care linkage. *Annals of Family Medicine*, *5*(3), 224–232.

Beal, J. (2009). Race, ethnicity, concentrated poverty, and low birth weight disparities. *The American Journal of Maternal/Child Nursing*, *34*(2), 134.

Breedlove, G. (2005). Perceptions of social support from pregnant and parenting adolescents using community-based doulas. *The Journal of Perinatal Education*, *14*(3), 15–22.

Breheny, M., & Stephens, C. (2007). Irreconcilable differences: Health professionals' constructions of adolescence and motherhood. *Social Science & Medicine*, *64*(1), 112–124.

Birkeland, R., Thompson, J., & Phares, V. (2005). Adolescent motherhood and postpartum depression. *Journal of Clinical Child and Adolescent Psychology*, *34*(2), 292–300.

Brubaker, S. J. (2007). Denied, embracing, and resisting medicalization: African American teen mothers' perceptions of formal pregnancy and childbirth care. *Gender & Society*, *21*(4), 528–552.

Campero, L., Garcia, C., Diaz, C., Ortiz, O., Reynoso, S., & Langer, A. (1998). Alone, I wouldn't have known what to do: A qualitative study of social support during labor and delivery in Mexico. *Social Science & Medicine*, *47*(3), 395–403.

Cherniss, C., & Herzog, E. (1996). Impact of home-based family therapy on maternal and child outcomes in disadvantaged adolescent mothers. *Family Relations*, *45*, 72–79.

Corcoran, J. (2001). Multi-systemic influences on the family functioning of teens attending pregnancy prevention programs. *Child & Adolescent Social Work Journal*, *18*(1), 37–49.

Deitrick, L. M., & Draves, P. R. (2008). Attitudes toward doula support during pregnancy by clients, doulas, and labor-and-delivery nurses: A case study from Tampa, Florida. *Human Organization*, *67*(4), 397–406.

Duncan, G. J., & Hoffman, S. D. (1990). Welfare benefits, economic opportunities, and out-of-wedlock births among black teenage girls. *Demography*, *27*(4), 519–535.

Eshbaugh, E. M. (2006). Predictors of depressive symptomatology among low-income adolescent mothers. *Archives of Women's Mental Health*, *9*, 339–342.

Gray, S., Sheeder, J., O'Brien, R., & Stevens-Simon, C. (2006). Having the best intentions is necessary but not sufficient: What would increase the efficacy of home visiting for preventing second teen pregnancies? *Prevention Science*, *7*, 389–395.

Guttmacher Institute. (2010, January). *U.S. teenage pregnancies, births and abortions: National and state trends and trends by race and ethnicity*. Retrieved from http://www.guttmacher.org/pubs/USTPtrends.pdf

Harris, M., & Franklin, C. (2009). Helping adolescent mothers to achieve in school: An evaluation of the taking charge group intervention. *Children & Schools*, *31*(1), 27–34.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Kaiser, M. M., & Hays, B. J. (2005). Health-risk behaviors in a sample of first-time pregnant adolescents. *Public Health Nursing (Boston, Mass.)*, *22*(6), 483–493.

Kirby, D. *Emerging answers: Research findings on programs to reduce teen pregnancy – Full report*. Washington, DC: The National Campaign to Prevent Adolescent and Unplanned Pregnancy.

Kuziel-Perri, P., & Snarey, J. (1991). Adolescent repeat pregnancies: An evaluation study of a comprehensive service program for pregnant and parenting black adolescents. *Family Relations*, *40*(4), 381–385.

Logsdon, C. M., Gagne, P., Hughes, T., Patterson, J., & Rakestraw, V. (2005). Social support during adolescent pregnancy: Piecing together a quilt. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *34*, 606–614.

McDonell, J. R., Limber, S. P., & Connor-Godbey, J. (2007). Pathways Teen Mother Support Project: Longitudinal findings. *Children and Youth Services Review*, *29*, 840–855.

Pillow, W. (2006). Teen pregnancy and education: Politics of knowledge, research, and practice. *Educational Policy*, *20*, 59–84.

Rains, P., Davies, L., & McKinnon, M. (2004). Social services construct the teen mother. *Families in Society*, *85*(1), 17–26.

Romo, L. F., & Nadeem, E. (2007). School connectedness, mental health, and well-being of adolescent mothers. *Theory Into Practice*, *46*(2), 130–137.

Sadler, L. S., Swartz, M. K., Ryan-Krause, P., Seitz, V., Meadows-Oliver, M., Grey, M., et al. (2007). Promising outcomes in teen mothers enrolled in a school-based parent support program and childcare center. *The Journal of School Health*, *77*(3), 121–130.

Sarri, R., & Phillips, A. (2004). Health and social services for pregnant and parenting high risk teens. *Children and Youth Services Review*, *26*, 537–560.

Schroeder, C., & Bell, J. (2005). Doula birth support for incarcerated pregnant women. *Public Health Nursing (Boston, Mass.)*, *22*(1), 53–58.

Shanok, A. F., & Miller, L. (2007a). Depression and treatment with inner city pregnant and parenting teens. *Archives of Women's Mental Health*, *10*(5), 199–210.

Shanok, A. F., & Miller, L. (2007b). Stepping up to motherhood among inner-city adolescents. *Psychology of Women Quarterly*, *31*(3), 252–261.

SmithBattle, L. (2007). Legacies of advantage and disadvantage: The case of teen mothers. *Public Health Nursing (Boston, Mass.)*, *24*(5), 409–420.

SmithBattle, L., & Leonard, V. W. (2006). Teen mothers and their teenaged children: The reciprocity of developmental trajectories. *ANS. Advances in Nursing Science*, *29*(4), 351–365.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, *17*, 283–316.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge, England: Cambridge University Press.

Weisz, A. N., & Black, B. M. (2009). Help-seeking and help-giving for teen dating violence. *Prevention Researcher*, *16*(1), 12–16.

Young, T., Turner, J., Denny, G., & Young, M. (2004). Examining external and internal poverty as antecedents of teen pregnancy. *American Journal of Health Behavior*, *28*(4), 361–373.

Yozwiak, J. A. (2010). Postpartum depression and adolescent mothers: A review of assessment and treatment approaches. *Journal of Pediatric and Adolescent Gynecology*, *23*, 172–178.

Zachry, E. (2005). Getting my education: Teen mothers' experiences in school before and after motherhood. *Teachers College Record*, *107*(12), 2566–2598.

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