

Family Therapy and Interpersonal Violence:
Targeting At-risk Adolescent Mothers

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Intimate partner violence and child maltreatment are both types of interpersonal violence that have been identified as public health problems (U.S. Department of Health and Human Services, 2000). With regards to intimate partner violence, national surveys estimate that a romantic partner has physically victimized approximately 11.6% of women during the past year. About one-third of these women reported experiencing severe violence from their partner (Straus & Gelles, 1990). Women, however, are not the only victims of interpersonal violence as accumulated evidence indicates that women use relationship violence at rates equivalent to or greater than men (Archer, 2000). Women also engage in power and control tactics that are similar to men and describe similar motives for engaging in their partner-directed violence (e.g., Babcock, Miller, & Siard, 2003; Graham-Kevan, this volume; Medeiros & Straus, this volume); although they are less likely than men to inflict physical injury as a result of their abuse (Cascardi, Langhinrichsen & Vivian, 1992).

These findings have led researchers to consider adoption of a gender-inclusive term for relationship abuse, namely “intimate partner violence”. The financial and emotional consequences due to intimate partner violence are substantial. Evidence shows that approximately 15% of the 1992 United States’ homicides were committed by an intimate partner (Bachman & Saltzman, 1995). Injury at the hands of an intimate partner is also common. About one-fourth of all intentional injuries examined in hospital emergency rooms were sustained as a result of intimate partner violence (Greenfeld et al., 1998).

A number of risk factors for intimate partner violence have been identified; although researchers have primarily considered what women’s risk factors are for receiving abuse from men’s violence and what men’s risk factors are for intimate violence perpetration. These risk factors include reduced levels of education, partner unemployment, living in poverty, and a history of experiencing emotional and verbal abuse in childhood, a condition known as the intergenerational transmission of violence (Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001).

Poverty, in particular, may be an important risk factor for both women and men’s perpetration of intimate partner violence and child maltreatment. For example, in a review article, Cunradi, Caetano, and Schafer (2002) reported that annual household income had the greatest relative influence on the probability of partner violence occurring. Similarly, in 1996, Aldarondo and Sugarman conducted a risk marker analysis of the cessation and persistence of wife assault. They reported that low SES was both associated with the occurrence and continuity of wife assault across time. Considering this risk factor from a systemic perspective, Brown (2002) wrote how poverty provides a culture of hopelessness, invisibility, shame, and disenfranchisement from power that significantly increases both the risk of intimate partner violence and child maltreatment. Raver and Leadbeater (1999) also described how poverty, and its associated hardships, could work to reduce feelings of competence about both maternal and familial roles. They then related lower maternal self-efficacy both to increased inter-parental conflict and to decreased child outcomes.

Consistent with this relational or dynamic perspective, other interpersonal or dyadic factors have been shown to increase the risk of intimate partner violence (e.g., high levels of belligerence in conflictual communications, poor communication and conflict management skills, problems with emotional regulation and stress management, e.g., Babcock, Waltz, Jacobson, & Gottman, 1993; Follingstad, Bradley, Helff, & Laughlin, 2002). Emotional and interactional deficits have been noted for both men and women in violent relationships. Violent and distressed couples have been shown to have a greater tendency to engage in patterns of

negative reciprocity during conflict than nonviolent/distressed or happy married couples (Cordova, Jacobson, Gottman, Rushe, & Cox, 1993).

Taken as a whole, these findings highlight that intimate partner violence can be conceptualized as occurring within a dynamic system, in which each person's actions influence and provide feedback for the behaviors that occur in the relationship. This conceptualization is consistent with evidence showing that intimate partner violence is more likely to be mutual or bi-directional than perpetrated by only one spouse (Vivian & Langhinrichsen-Rohling, 1994). These findings also lend credence to the position that family or relationship-oriented therapy, which is gender-inclusive rather than gender-specific, may be an appropriate treatment for some couples who are experiencing intimate partner violence (e.g., Green & Bogo, 2002; O'Leary, Heyman, & Neidig, 1999). A further benefit of this type of approach is that it may simultaneously reduce the incidence of other types of violence that frequently co-occur within the family system such as child maltreatment and psychological abuse and neglect. Systemic interventions may hold particular promise as a means to intervene in the intergenerational cycle of violence.

In the current chapter, we describe both parenting and relationship oriented interventions that have been directed toward undereducated teen mothers. We have identified adolescent mothers as an important target for gender inclusive violence interventions because they are more likely to live in poverty than adult mothers (Bissell, 2000); they tend to have lower educational and occupational attainment than older mothers (Furstenburg, 1991; Hockaday, Crase, Shelley, & Stockdale, 2000; Monahan, 2002; Moore & Brooks-Gunn, 2002); and they are also more likely to be financially dependent on welfare programs (Furstenburg, 1991). Thus, they demonstrate many risk factors for intimate partner violence. In fact, researchers have already documented a high rate of victimization from intimate partner violence among these women (Sussex & Corcoran, 2005). However, few investigators have considered the degree to which pregnant adolescent women or teenage mothers might be perpetrators of abuse in their intimate relationships, in addition to being victims.

Specifically, as shown in Figure 1, we assert that high-risk, low income, adolescent mothers are an important focus for family-based interventions because they often form a central element in the intergenerational transmission of interpersonal violence, as well as in the intergenerational transmission of pregnancy and poverty. Our contention is consistent with evidence demonstrating that teenage mothers are more likely than non-pregnant adolescent women to have experienced childhood sexual abuse, as well as other types of violence or neglect in their family-of-origin (Herrenkohl, Herrenkohl, Egolf, & Russo, 1998). Adolescent mothers are also more likely to have been raised by a mother who experienced a pregnancy in her own adolescence; raising the question, "What aspect of these experiences is transmitted through the generations?" (Langhinrichsen-Rohling, Hankla, & Stormberg, 2004).

However, even adolescents who did not experience family-of-origin violence may face a variety of intrapersonal challenges with the advent of a teen pregnancy that may be mollified with exposure to a family therapy based intervention. Both wanted and unwanted sexual experiences in adolescence have been broadly related to family dysfunction (Kellogg, Burge, & Taylor, 2000). For example, age at first pregnancy has been related both to the experience of physical violence in the family of origin and to having a family member with a drug or alcohol problem (Kellogg & Hoffman, 1999).

Additional developmental and family-of-origin issues often get raised as the adolescent mother simultaneously attempts to meet her own needs and the needs of her child, perhaps while

she is still residing in her parent's residence and feeling the tension between separation and individuation (Coren, Barlow, & Stewart-Brown, 2003). Difficulties occur because the adolescent mother is being asked to provide a secure base of attachment for her child, typically before her own adult identity is established, and perhaps while she is concurrently struggling with a less than secure attachment to her own mother, with whom she may be sharing baby care-giving responsibilities (Hess, Papas, & Black, 2002).

It may also be useful to target pregnant adolescents because these women may provide a point of contact with men who are at high risk for intimate partner violence and child abuse; yet, historically, these men have not willingly sought treatment for their abusive behavior. Research suggests that men who father babies with high-risk adolescent women are, on average significantly older than the mothers, are frequently undereducated, and often have financial stressors which increase the risk for relationship conflict and violence (Bolton, 1987). However, relatively little focus has been placed on understanding the father-child dyad or the surrogate father-child dyad and how it may be related to increased chances of family violence occurring in family's containing an adolescent mother (Osofsky & Thompson, 2000).

Family therapy or therapy that focuses on the interactional patterns between family members is also warranted for many high-risk adolescent mothers because the co-occurrence of intimate partner abuse and physical child abuse within families has been well documented (see review of 42 studies by Appel & Holden, 1998). While Appel and Holden (1998) reported a wide range of co-occurrence estimates (6% in community samples to 100% in some clinical samples); they suggested that a median co-occurrence rate of 40% could be anticipated. Several different models for co-occurrence were proposed; however, bi-directional violence models have received the most recent empirical support (e.g., Moore & Pepler, 1998). For example, McGuigan, Vuchinich, & Pratt (2000) recently argued that pre-existing domestic abuse increases the likelihood that parents of a newborn will perceive that child negatively. These negative perceptions will then increase the likelihood of co-occurring child abuse. Furthermore, recent evidence indicates that young maternal age, low education, low income, and lack of involvement in a religious community all significantly increase the risk for child maltreatment in the context of a domestically violent intimate partner relationship (Cox, Kotch, & Everson, 2003). These risk factors are relevant for adolescent mothers.

There are several pathways to establishing a negative parent-child relationship. Researchers have demonstrated that adolescent mothers are likely to have less appropriate developmental expectations and less knowledge of child development (Brooks-Gunn & Furstenberg, 1986; Vukelich & Kliman, 1985) which may contribute to a greater level of frustration for these mothers and place them at a higher risk for abusing or neglecting their children (Garbarino, 1976; Stern & Alvarez, 1992). Adolescent mothers may have also fewer emotional resources to offer their children. For example, Osofsky and Thompson (2000) found that interactions between teen mothers and their children were characterized by either an over-emphasis on negative affect or on misread affective cues between baby and mother.

In summary, adolescent parents are an important group to target for family-oriented prevention and intervention activities because of their high numbers, as well as the intergenerational family dynamics that have been shown to be associated with the occurrence of teenage pregnancy. Evidence shows the greater likelihood that the adolescent mother will have had unmet developmental needs, the increased risk that adolescent mothers will experience negative and/or violent events in either this or future interpersonal relationships; the increased likelihood that adolescent mothers will perpetrate child abuse; and the greater likelihood of a

variety of adverse consequences for adolescent mothers and the children they parent. These factors have been related, in part, to interactional patterns between these mothers and their children, these mothers and their partners, and these mothers and their own family-of-origin caregivers (e.g., Turner, Grindstaff, & Phillips, 1990).

To address these concerns, two main types of family interventions have historically been directed toward adolescent mothers: parenting interventions and relationship-oriented interventions. In the next section, we will review parenting interventions that have been designed to support the personal development and parenting skills of adolescent mothers and a case example will be described. In the next section, relationship-oriented interventions directed toward adolescent mothers will be briefly reviewed. We will then describe a newly developed, relationship-oriented intervention that has been created by these authors in order to intervene in the intergenerational cycle of family violence that frequently co-occurs with adolescent pregnancy. Finally, a case example will be offered that demonstrates issues related to administering this intervention with under-educated, high risk, adolescent mothers who are living in poverty.

Parenting Interventions with Adolescent Mothers

Adolescent parenting interventions vary significantly in their focus, particularly in terms of whether the goal is to improve the woman's chances of economic self-sufficiency by continuing her education or delaying future pregnancy, or whether the intervention is designed to enhance and improve her parenting practices. Across studies, there seems to be a consistent finding of improvements in these goals while adolescent mothers are enrolled in the study, but the evidence for long-term impact on either of these foci is mixed (Granger & Cytron, 1999).

For example, intervention programs aimed at supporting and improving parenting practices have reported improvements in parenting attitudes and knowledge (e.g., Fulton, Murphy, & Anderson, 1991; Unger & Wandersman, 1985) and behaviors (e.g., Heinicke, et al, 1999). Additionally, several parenting interventions have resulted in improvement in the child's development (e.g., Fewell & Wheedon, 1998; Field, Widmayer, Greenberg, & Stoller, 1982). Similarly, programs aimed at improving economic self-sufficiency have resulted in larger numbers of participants completing the GED and often improvements have been noted in employment and earnings (Granger & Cytron, 1999).

Consistent with the premise that relational or systemic factors may be an important component of the negative outcomes sometimes experienced by adolescent mothers and their children, parenting interventions that include a relationship-based component have been shown to have promise with this population. Specifically, a growing number of researchers and practitioners believe that the positive outcomes reported in home visitation parenting programs are due to the nurturing relationship established and maintained between the parent and the home visitor (Heinicke et al., 1999; Musick & Stott, 1990; Robinson, Emde, & Korfmacher, 1997). Korfmacher & Marchi (2002) theorize that a positive relationship is essential in interventions because the adolescent parent may be differentially responsive to information and guidance offered within the context of a trusting relationship. Heinicke et al. (1999) found that mothers participating in a relationship-based parenting intervention were more responsive to their infant's needs and expressed more positive affect toward their children than mothers in the control group. The researchers theorized that the support and understanding offered by the home visitors allowed the first-time mothers to express their feelings related to the challenges of parenthood.

Adolescent mothers may have more emotional resources to offer their children once their own personal and developmentally appropriate needs have been supported.

Similarly, Olds and colleagues report positive results from the Nurse Home Visitation Program Trials implemented in Elmira, New York and Memphis, Tennessee (Olds et al., 1999; Olds, Kitzman, Cole, & Robinson, 1997). They indicate that the formation of a therapeutic alliance between the mother and the intervener served as a “corrective experience” for the mothers, most of who reported that they had never received such consistent care and encouragement in their family of origin. It is possible that these interveners demonstrated the benefits of a securely attached and nurturing relationship, which then translated to better child outcomes and reduced levels of child maltreatment by the adolescent mothers. Thus, the research on parenting interventions has shown significant reductions in state-verified incidents of child abuse and neglect by supplying home-based, relationship-oriented interventions to high-risk women (e.g., low income, young age, high stress) during their pregnancy and continuing afterwards for two years (Olds, Henderson, & Kitzman, 1998).

The current authors of this chapter, in conjunction with Borkowski et al., 2005, employed a parenting intervention that focused on adolescent mothers and used volunteer mentors as an integral part of the program. Each participant in the intervention was paired with her own volunteer mentor, each of whom had received extensive training and support for the duration of the 11-month intervention. The goal was for the mentor to form a supportive relationship with the adolescent mother, to model positive relationship skills, to provide child development and childcare information, and to provide emotional support for the adolescent mother’s own concerns. Our findings indicate that throughout the parenting intervention program, mentors supported and encouraged the adolescent mothers both during and between sessions. Support provided by mentors varied from giving advice, providing food in emergencies, helping mothers’ access available resources for housing, utilities, and food, socializing, and teaching a mom to drive. A specific case example is described below.

Case #1: Parenting Intervention

Latonya, a 17-year old African-American female, enrolled in the parenting intervention when her son, Jerome, was three months old. At the time of delivery, she was an 11th grade student, unmarried and residing with her mother and stepfather. She reported to the intervention staff and to her mentor that she felt her pregnancy was a result of sexually coercive behavior perpetrated by her boyfriend. She was, however, still involved with this boyfriend and he did acknowledge Jerome as his son. The father’s involvement in the baby’s life consisted of providing limited financial support to Latonya and visiting Jerome on a weekly basis.

During the initial interview, Latonya appeared to project an outward demeanor of confidence and efficacy in her role as a parent. She had a tendency to talk more than the other participants and often would dominate the group discussions and interrupt while others were speaking. Both her mentor and project staff noted that Latonya appeared to overestimate her parenting skills and knowledge. She often seemed to be resistant to learning new concepts presented during the group sessions. This negativity particularly concerned her mentor who directly encouraged Latonya to be open to receiving new information and opinions regarding childcare and child development issues.

The approach the mentor used was to share with Latonya some of her own struggles with being a teenage mother. Through these interactions, the pair appeared to develop a trusting and reciprocal relationship, although the mentor continued to initiate the majority of both the telephone and in-person contacts that occurred both in and out of the parenting group format.

The outside group contacts included eating out, attending church, and going to high school football games. Additionally, getting a driver's license was a top priority for Latonya. Near the end of the formal intervention, Latonya sought out her mentor's assistance and asked her to teach her how to drive. The pair met on several occasions to work on Latonya's driving skills. One week prior to the culmination of the intervention, Latonya received her driving license.

Moreover, over the course of the program, both her mentor and the intervention staff observed that Latonya began interacting with her baby in a fundamentally different way. There was also evidence that she was implementing some of the strategies she had learned in the group sessions. In a self-report measure at the end of the intervention, Latonya reported that she placed great value on the importance of reading to, talking with, and verbally and emotionally interacting with Jerome. Reciprocity in the relationship was evident as well. Posttest measures of Jerome's language and cognitive development indicated that, by the end of the intervention, he was functioning at least at the norm for his age and about one-half a standard deviation above his performance at pretest. Additionally, although the intervention program formally ended, Latonya continued her contact with her mentor and with the intervention staff. For example, she routinely called with updates about herself and Jerome, and, with considerable pride, she invited her mentor and the intervention staff to her high school graduation. This occurred more than one year after her initial involvement with the program.

Intimate Partner Relationship Interventions with Adolescent Mothers

As stated previously, although intimate partner violence can occur in any relationship, it has consistently been shown to be more likely to occur in young, distressed, stressed, and low-income relationships (e.g., Hamel & Nicholls, this issue). Violent couples also have higher levels of expressed hostility, poorer methods of anger expression, and more rigid patterns of conflict management such as demand/withdrawal than do nonviolent couples (e.g., Babcock et al., 1993; Follingstad et al., 2002). Preventing relationship violence may thus be enhanced by preventing relationship distress and stress (such as that associated with the transition to parenthood; Langhinrichsen-Rohling, Heyman, Schlee, & O'Leary, 1997). Injury prevention and positive health outcomes can also be expected with improvements in relationship satisfaction, as researchers have demonstrated declines in immune functioning after relationship conflicts (Kiecolt-Glaser, Malarky, & Chee, 1993).

There is evidence that relatively brief couples-based skill-building interventions can be used successfully to prevent marital distress (e.g., EPL in Germany; PREP in the U.S.; Alexander, Holtzworth-Munroe, & Jameson, 1994; Hahlweg, et al., 1998; Markman, Floyd, Stanley, & Storaasli, 1988). The major premise of these programs is that relationship partners can, relatively quickly, learn the communication and conflict-management skills that are necessary to handle their issues safely and productively (Hahlweg et al., 1998). These communication skills should then lessen the probability of violence, as violence has been shown to be a tactic that partners use when they are in conflict with one another.

To date, however, there is little research on the effectiveness of these types of interventions with adolescent mothers. Typically, interventions directed at adolescent mothers have focused on changing risky sexual behavior, rather than explicitly targeting relationship behaviors and the potential for family violence in this population. Yet, the need to construct and implement a family systems approach to adolescent sexuality and teenage pregnancy has been called for repeatedly, as has the need to consider issues related to the father of the baby

(Chilman, 1989; Pistole, 1999; Robinson & Frank, 1994; Tuten, Jones, Tran & Svikis, 2004). The family therapy interventions that have been tried in this population have often targeted the adolescent mother and both her parents, or the teenage mother and just her mother (McFarland, 1997; Owens, Scofield, & Taylor, 2003). Evidence has accumulated that there are many barriers toward involving the families of pregnant adolescents in treatment (Hanson, 1992). In contrast, relatively few interventions have been designed to target the intimate partner relationship dynamics of adolescent mothers (see *Caring for My Family*, Michigan State University Extension, 2003). Even fewer, if any, researchers, have used systemic interventions that are gender-inclusive to tackle the intergenerational transmission of violence that often occurs in the families of adolescent mothers. To fill this gap, Langhinrichsen-Rohling, McGowan, and Turner (2004) developed the Building a Lasting Love relationship intervention.

The Building a Lasting Love Relationship Intervention

We designed the Building a Lasting Love intervention to include individual and dyadic goals in a brief four-session format. Theoretically, this program reflects an integration of a number of existing curriculum including Spouse Abuse: A Treatment Program for Couples (Neidig & Friedman, 1984); Communication and Conflict Management Skills in Intimate Relationships (e.g., Brown & Brown, 2002); Premarital Interpersonal Choices (PIC; Van Epp, 1999); PREP; (Markman, Blumberg, & Stanley, 1989; Markman, Jamieson, & Floyd, 1980; Markman, Renick, Floyd, Stanley, & Clements, 1993; Markman, Stanley, & Bloomberg, 1994); *Caring for My Family* (Michigan State University Extension, 2003); Family Preservation (Mantooth, Gefner, Franks, & Patrick, 1987); and Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993). The resulting B.A.L.L. curriculum draws extensively from the literature on evidence-based interventions to enhance couple functioning and communication strategies as well as from the literature on domestic violence interventions for couples.

Gender-inclusive couple-related strategies to reduce violence are aware that both male and female partners can engage in violence in a relationship. Therefore, it is important to help each partner recognize and take responsibility for their own behavior in the relationship. It is also important to teach each partner the skills they need to manage their anger, reduce their stress, increase their ability to communicate effectively, and resolve their conflicts with others to their satisfaction. Consequently, teaching teen mothers skills that will help prevent conflict escalation and enhance the likelihood of successful conflict resolution should provide some protection against the occurrence of violence- both within that specific intimate relationship and in their other dyadic contexts (e.g., in conflicts between the teen mother and her parents/relatives or in conflicts between the teen mother and her child). These skills should enhance communication and emotional regulation. Thus, the B.A.L.L. intervention, while conducted individually with teen mothers, is expected to have an impact on a variety of intergenerational relationships and to be systemic and family oriented in its focus.

The four sessions of the intervention will be briefly described here. Session One includes activities to help the adolescent mothers identify characteristics of healthy versus unhealthy, distressed, or violent relationships. Discussion centers on what is experienced after the baby is born when there is a shift from a romantic relationship to a relationship that includes both an intimate partner/romantic and a co-parenting/child-rearing component. Characteristics of healthy and unhealthy relationships are identified and debated. Emphasis is placed on the choices that are available to each participant. Actions that can be taken to nurture important relationships are

delineated as well as ways to avoid unhealthy relationship patterns. The participants are educated about what constitutes intimate violence, and how the program espouses violence-free relationships. The women discuss their beliefs about violence, and the violent or abusive behaviors that they believe are considered acceptable or unacceptable within their particular subculture. Efforts are made to help the women consider how their baby might interpret or respond to witnessing or experiencing violent or abusive behaviors within the dyadic relationship. Mothers are encouraged to make a safety plan for themselves and their babies and they consider when, or if, they would need to implement this type of plan. At the end of Session One, each mother chooses a specific family-focused or relationship-focused goal to work on for the remainder of the group.

In session two, we present the SCOPE model in which each participant is encouraged to evaluate themselves and their partners in terms of their relationship Skills, Choices, Old baggage, interaction Patterns, and ability to handle difficult Emotions such as anger, jealousy, and hurt. We begin to practice important interactional skills including how to manage anger, jealousy, hurt, and lack of trust (with baby, money, drug use). Skills that facilitate emotional regulation are emphasized. A frequently mentioned concern by the adolescent mother is her relationship with her mother “in-law”, who often initially denies that her son fathered the baby. Discussion also often centers on how the woman’s romantic relationship with the baby’s father is negatively affected by his friends.

The focus in session three is on learning what it takes to build L.A.S.T.ing and loving intimate relationships. In this session, the adolescent mothers learn that the building blocks of a healthy relationship include: continuing to Learn about each other and grow, as opposed to mind reading and stagnation; practicing good communication techniques particularly with regards to “hot” topics that generate Anger and violence rather than Aceptance. They also learn that long-lasting relationships ensue partly when both partners make a commitment to Stick together and work things out, regardless of the difficulties they will encounter. We talk about ways to foster Trust and Teamwork rather than engaging in win-lose strategies with your partner. Finally, we discuss the important of Sexual connection and intimacy in intimate relationships and how that might vary over time. The teen mothers often talk about how their sexuality has changed since they became pregnant. Much of this session centers on the verbal and nonverbal skills that are needed for productive communication (e.g., speaker/listener, I statements, congruence between verbal and nonverbal messages, ratio of positives to negatives, choose your battles). Interactive activities occur during which participants practice assertive requests and describe the differences among passive, assertive, and aggressive communication styles. They consider the pro’s and con’s of each type of communication.

The final session is focused on helping the participants identify methods to reduce their stress or increase their ability to cope with the stressors in their life while they are finding more ways to have fun with themselves, their families, their partners, and their babies. Discussion focuses how a high level of stress increases the risk of intense, violent, or dysfunctional conflict or poor communication with their partner. They evaluate how they currently handle stress and learn some new coping strategies. Particular focus is given to time management techniques and activities that are fun but not expensive. The session ends with participants reviewing what they have accomplished in the group and how they will continue to support themselves to have the kind of intimate relationships they want with their partner, their parents, their “in-laws”, and their child.

The Building a Lasting Love program is noteworthy for its brevity, its interpersonal focus, and its stance that all violence in relationships is detrimental, regardless of the gender of the perpetrator. There were several reasons we felt it was important to develop a brief intervention in spite of the gravity of the problems to be addressed by these high-risk teenage mothers and the number of issues that we wanted to consider. First, we knew that attendance to long-lasting interventions is inconsistent in this population. Second, we felt that the brevity of the intervention would be well suited to a population who struggles with transportation, childcare, and time-constraint issues. These factors continued to be concerns for the women in the group although the intervention staff provided childcare and transportation for the mothers, as needed. Third, participants who have a positive experience with a brief intervention are more likely to consider engaging in another intervention in the future. Fourth, the intervention was designed to include the main and overlapping elements of existing marital and domestic violence interventions that have been demonstrated to be effective; hopefully allowing us to demonstrate more change with less intervention effort.

Lastly, according to Prochaska's model of change, the most effective interventions are suited to participants' readiness to change (Prochaska, Norcross, & DiClemente, 1994). Prochaska describes readiness to change as fitting along a continuum from precontemplation (unaware of behavior that needs changing; individual is not convinced that change is needed now or later), through contemplation (have considered making a change but that is all), preparation (need help to change, plans are being made to change), to action (change process is begun), and then developing maintenance strategies for the new behavior.

A priori, we expected that a significant number of high-risk adolescent mothers would be in the precontemplation stage with regards to their perceptions of their risk for experiencing or perpetrating relationship violence or child maltreatment, as well as for their need to enhance their intergenerational relationship skills. Consequently, our intervention was designed with the goal of helping participants move toward a greater readiness to change by including exercises that should foster moving from precontemplation to contemplation (i.e., what are the pro's and con's associated with engaging in these behaviors) as well as from contemplation to preparation to action (i.e., making plans, discussing specific strategies for change). While these mothers may not engage in many different actions at the end of the brief intervention, they might be more ready to consider the part that they play in their intimate relationships and environments, in essence recognizing their role in the systemic interactions of their families.

Case #2: Relationship Intervention with Teenage Mothers with a High-Risk of Child Abuse: Breaking the Cycle of Family Violence

Tonya is a 19 year old high school senior. She is raising her two year old son, Cory, who was conceived with "Zack" when Tonya was 16 years old. Zack is a boy whom Tonya had dated for only a few months prior to the conception. Tonya describes Zack as a wild, drug using guy, with a bad group of friends. In the first session, she indicated that she always "went for" the trouble-makers, and wondered if that was because she liked excitement and got "bored" easily.

Zack was three years older than Tonya although he was only one grade ahead of her in school. He had repeated several grades and reportedly had difficulty reading. Shortly after their child was born, Zack dropped out of school for good. Since that time, he has had a difficult time keeping a job. According to Tonya, Zack had been fired for attendance problems, drug use on the job, and inappropriate displays of anger. Consequently, Zack provides only sporadic financial support for Cory. Tonya has gone back to court several times for financial assistance. This

occurs after Tonya learns, typically through mutual friends, that Zack is working again. Financial issues are a frequent point of conflict between the couple as Tonya is living independently from her family-of-origin. She was kicked out of her family home when she became pregnant and has little contact with her biological family. Tonya expressed a lot of anger over their treatment of her and her baby. Zack does have contact with Cory. He lives with his mother (his parents are divorced) and Zack and his mother keep Cory every other weekend.

Although they are no longer romantically involved, Tonya and Zack continue to have a conflict ridden and tumultuous relationship with one another. They see each other twice a month when they are exchanging Cory. These interactions included aggression several times in the six months before the relationship intervention group began. In one incident, Tonya kicked Zack and deliberately ran over some items in his driveway. Tonya and Zack are also in phone contact with one another. These calls can occur on an almost daily basis, and usually end with one or both of them yelling, swearing and hanging up without saying goodbye. Cory has overheard these verbal altercations on numerous occasions. He now uses swear words regularly in his play. In fact, the most recent fight between Tonya and Zack ensued when Cory called his father a swear word that he had heard Tonya use toward him on the phone. At the start of the intervention, Tonya reported that she found this “funny”. She also indicated that Zack was a jerk, and worse, and believed he was to blame for many of the negative behaviors she was seeing in Cory (i.e., hitting other children, refusing to share, biting, going to bed at midnight, waking up in the middle of the night and destroying his room, being kicked out of a playgroup, etc.). Tonya also indicated that Cory was a constant ball of energy and that no one she knew would baby-sit him for her.

Tonya was an active participant in group. In the first session, her comments were designed to illustrate how difficult it was for her to deal with Zack. She spoke with pride about how she had told Zack off on the phone and hung up on him. She also indicated that she thought violence, in the form of spanking repeatedly, was needed in order to discipline her son, who was out of control. When the group generated the pro’s and con’s of using violence in relationships, she indicated that she hadn’t really thought about what these actions were conveying to her son about what was acceptable. She also acknowledged that she perpetrated the majority of the violence in her relationship with Zack, but believed it was justified.

In contrast, by the end of the intervention, Tonya acknowledged that she had a problem controlling her quick temper and that it was interfering with all of her important relationships. She told the group that she was using strategies that she had learned in Session Two to help herself regulate her emotions and to stop and consider the situation from different vantage points. While assessment data did not show a change in her level of satisfaction with her relationship with Zack, there was a significant change in the amount of stress she was experiencing in that relationship (pre-intervention = 5 on a scale of 1 to 5; post-treatment, 1 on a scale of 1 to 5). Furthermore, Tonya reported that her romantic relationship with a new romantic partner was impacted such that both of them were using less insults and swear words with one another during conflicts. Assessment data also demonstrated that Tonya was considerably less irritable after the intervention, and that she felt more confident that she could handle her anger in a positive manner and express herself clearly and without fear. She gave the intervention high marks and indicated that the changes she had made in herself had resulted in more compliance and less aggression from her child (a behavioral observation that was shared by the intervention childcare staff) and more respect and hopefulness for their relationship from her new boyfriend. Most importantly, post-assessment data indicated that Tonya had not perpetrated any violence or engaged in any aggressive outbursts for the duration of the intervention.

Future Directions

As was typified by the case examples described previously, it is likely that there is considerable heterogeneity among adolescent mothers with regards to their risk factors for interpersonal violence and their potential responsiveness to a family-based intervention. This contention is consistent with work conducted by Larson (2004) which indicated about 30% of a sample of adolescent mothers experienced an episode of severe parenting stress at least one point across a two and one half year period. The experience of stress was found to be associated both with receiving criticism about their parenting from their own parent and with the experience of intimate partner violence. Additional research is needed to identify adolescent mothers who are at relatively higher risk for relationship difficulties (as we did with mothers at risk for child abuse). Specific barriers to interventions and particular motivations for participation within this subgroup also need to be determined.

Furthermore, as the literature clearly indicates, parenting and relationship issues co-occur in this population. Future research should focus on the development of a unified family intervention that specifically helps adolescent mothers generalize their relationship skills to different contexts (e.g., interactions with their mothers, the baby's father, a new relationship partner, their baby). An example of this type of intervention would be the CARRI program (Children at Risk: Resources and Intervention) that was developed in New Jersey. This program utilizes a home-based, multi-generational family therapy model with high-risk adolescent mothers (Carver & Herzog, 1993). While this program represents advances by: (1) the inclusion of the grandmother in the intervention process, (2) the explicit acknowledgement of the need to address communication processes between individuals, and (3) the inclusion of a developmental focus for the family as well as for the baby; we assert that future interventions may also require a direct focus on the adolescent mothers' romantic relationship patterns and their own potential for intimate partner violence.

Clearly, other family members have important contributions to the interpersonal processes that these mothers are describing. To date, our intervention, while systemic in conceptualization, is individual in implementation. Our preliminary efforts to engage adolescent fathers in treatment were largely unsuccessful, as has been found by others. Consequently, there is a need to understand the best way to motivate these men to become involved in a family oriented intervention. It is our contention that maintaining a gender-inclusive focus in our intervention, rather than a blaming stance, will be a vital element of the engagement process with these men.

Finally, intimate partner violence is associated with poverty. Individuals living in poverty have additional barriers to service delivery including difficulties with transportation, childcare, and scheduling conflicts. Successful interventions with poor individuals are likely to need to incorporate use of paraprofessionals as well as other interveners that can have long-term supportive relationships with high-risk individuals (Calzada et al., 2005). These new relationships should also be conceptualized in a systemic multi-generational fashion.

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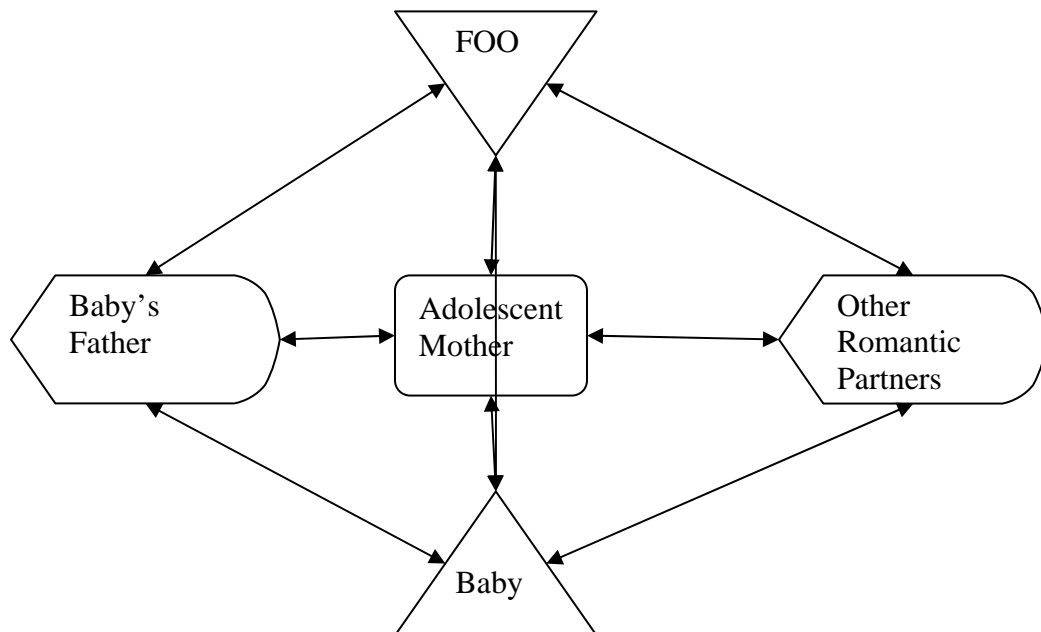
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Figure 1. A Model of the Intergenerational Dynamics Occurring with Adolescent Pregnancy



Note: FOO stands for Family-of-Origin.