Published in final edited form as:
Nurs Inq. 2013 September ; 20(3): 188–198. doi:10.1111/j.1440-1800.2012.00606.x.

Listening with care: Using narrative methods to cultivate nurses' responsive relationships in a home visiting intervention with teen mothers

Lee SmithBattle, RN, DNSc. [Professor], **Rebecca Lorenz, RN, PhD [Assistant Professor]**, and **Sheila Leander, RN, PhD [Assistant Professor]**
School of Nursing, Saint Louis University, Saint Louis, MO 63104

Abstract

Effective public health nursing relies on the development of responsive and collaborative relationships with families. While nurse-family relationships are endorsed by home visitation programs, training nurses to follow visit-to-visit protocols may unintentionally undermine these relationships and may also obscure nurses' clinical understanding and situated knowledge. With these issues in mind, we designed a home visiting intervention, titled *Listening with Care*, to cultivate nurses' relationships with teen mothers and nurses' clinical judgment and reasoning. Rather than using protocols, the training for the intervention introduced nurses to narrative methods and therapeutic tools. This mixed-method pilot study included a quasi-experimental design to examine the effect of the intervention on teen mothers' depressive symptoms, self-silencing, repeat pregnancy, and educational progress compared to teens who received usual care. Qualitative data was collected from the nurses to evaluate the feasibility and acceptability of the intervention and therapeutic tools. The nurses endorsed the therapeutic tools and expected to continue using them in their practice. Despite the lack of statistically significant differences in outcomes between groups, findings suggest that further study of the intervention is warranted. Future studies may have implications for strengthening hidden aspects of nursing that make a difference in the lives of teen mothers.

INTRODUCTION

Home visits have been a vital part of public health nursing since its inception (Wald 1915). They remain a key strategy of maternal child health programs in the U.S. and Europe and have been shown to be most effective with disadvantaged, first-time teen mothers (Howard and Brooks-Gunn 2009). As evidence of their benefits has accumulated, researchers have recommended that new services maintain fidelity to the protocols, theories, and staffing of tested programs (Sweet and Applebaum 2004; Donelan-McCall, Eckenrode and Olds 2009; Howard and Brooks-Gunn 2009). These recommendations may be premature since it is not yet clear how these complex programs contribute to positive outcomes (Stern 2006). For example, the researchers of the well-known Nurse-Family Partnership **(**NFP**)** report that protocols lack the specificity needed to respond to complex clinical situations, and they do not address the tension between following a protocol and developing a therapeutic alliance with disadvantaged teen mothers (Kitzman et al. 1997; Zeanah et al. 2006). This is a significant issue since home visiting programs routinely train staff in visit-to-visit protocols

Corresponding author: Lee SmithBattle, RN, DNSc., 3525 Caroline Mall, Saint Louis University School of Nursing, Saint Louis, MO 63104, Office number: 314-977-8980, Fax number: 314-977-8949, smithli@slu.edu.
smithli@slu.edu, lorenzra@slu.edu, leanders@slu.edu

The authors have no conflicts of interest.

even though expert nurses stray from protocols as they meld scientific knowledge with other forms of knowledge (James et al. 2010; Benner, Hooper-Kyriakidis and Stannard 2011; Porter, O'Halloran and Morrow 2011). Other forms of knowledge used by nurses include relational and ethical skills and patients' perspectives on their experiences, concerns, and preferences (Strøm, Kvernbekk and Fagermoen 2011). Much of this knowledge cannot be formalized in protocols because of its pragmatic and situated nature but is nevertheless key to effective care. To date, no known home visiting interventions have deliberately cultivated nurses' relational and ethical skills, and their practical and situated knowledge of clinical situations. Thus, the purpose of this pilot study was to determine the feasibility of a home visiting intervention, titled *Listening with Care* (LWC), to cultivate responsive relationships between public health nurses (PHNs) and teen mothers, using narrative methods. Secondarily, data was collected to assess whether the intervention promoted clinical understanding and improved selected maternal outcomes.

The Relational Core of Public Health Nursing Practice

The importance of developing trusting and collaborative relationships with families for providing effective care is well documented in the public health nursing literature (Wald, 1915; Paavilainen and Astedt-Kurki 1997; Jonsdottir, Litchfield and Pharris 2003; Porr, Drummond and Olson, 2012). Such relationships are also strongly endorsed by visited families (Aston et al. 2006; Finlay and Sandall 2009; Moules et al. 2010; Porr et al. 2012). Responsive relationships are a precondition for developing a mutually respectful relationship (Marcellus 2005; Moules et al. 2010) and for tailoring health and parenting education, emotional support, advocacy, and referrals to complex and changing clinical situations (SmithBattle, 2009a; Browne et al. 2010). Astute clinical judgments depend on contextualizing each person's strengths, concerns, and vulnerabilities and take priority over protocol-directed care (Benner et al 2011; Porter, O'Halloran and Morrow 2011).

Supporting Teen Mothers: Reexamining Risks, Losses, and Gains

Teen mothers are a stigmatized, vulnerable group of parents. They tend to be disadvantaged as children and drift into mothering as part of an accelerated life course (Burton 1990). Although associations between young maternal age and poor maternal-child outcomes are routinely reported in the literature, scholars increasingly agree that poor outcomes have been exaggerated by the failure to control for the background factors that predispose teens to pregnancy (Furstenberg 2007; Duncan, Edwards and Alexander 2010). As researchers have controlled for these factors, associations between poor outcomes and young maternal age have been greatly reduced or eliminated (Boden, Fergusson and Horwood 2008; Fletcher 2011; Webbink, Martin and Visscher 2011), and have led scholars to conclude that teen mothers do about as well as older childbearers from similar backgrounds (Furstenberg 2007; Duncan, Edwards and Alexander 2010).

Qualitative researchers have described how mothering offers some teens a turning point or a catalyst that redirects their lives in positive ways (Clemmens 2003; Spear and Lock 2003). Moving in a new direction includes their aspirations to pursue education, avoid risky situations, and be a good parent and positive example for their child (Hermann 2008; Rolfe 2008; Dornig et al. 2009). When their aspirations and strengths are supported, mothering facilitates the narrative repair of identity (Brubaker and Wright 2006; SmithBattle 2008). Others struggle to achieve their aspirations when they lack positive childhood experiences, emotional support, and educational or vocational opportunities (Kennedy 2005; SmithBattle 2007). Teen mothers' aspirations for themselves and their children can also be undermined by stereotypes, bureaucratic hurdles, flawed policies, and protocols that focus on risks and deficits (Furstenberg 2007; SmithBattle, 2012).

Depression is common among teen mothers (Reid and Meadows-Oliver 2007; Wang et al. 2011) and has been associated with exposure to violence (Kennedy and Bennett 2006). Depression is also associated with restricting one's thoughts and feelings in dismissive, controlling, or conflicted relationships, which Jack (1999) refers to as self-silencing. These and other factors have been identified as increasing the likelihood that a teen will drop out of school and become pregnant again quickly (Barnet, Liu and DeVoe 2008).

Teen mothers are also vulnerable to violations of dignity (Jacobson 2009) when they are dismissed, scorned, or silenced in relationships, and objectified in scientific discourse (Whitley and Kirmayer 2008; Yardley 2008). Stereotypes that they are unmotivated, irresponsible, and neglectful parents persist in media stories, public policies, and clinical literature (Lewis, Scarborough and Quirin 2007; Usdansky 2009), in spite of evidence describing their strengths, resilience, and aspirations (Duncan, Edwards and Alexander 2010; Easterbrooks et al. 2011). The emphasis on teen mothers' risks and deficits in clinical discourse and protocols may make it difficult for nurses to discern and capitalize on the growth promoting possibilities that teens identify as new mothers (Fessler 2003; Dodds 2009).

Nurses challenge stigmatizing views of teen mothers when they enter clinical situations with openness and curiosity (SmithBattle 2009a). This ethical and relational stance places nurses in a stronger position to cultivate the growth promoting opportunities available in parenting, while recognizing the daunting challenges faced by low-income mothers of any age. A number of researchers suggest that teen mothers reduce risk-taking and develop new habits of care for the self and baby when their strengths and aspirations are affirmed (Hermann 2008; Rolfe 2008). Trusting relationships may set in motion a positive chain of corrective and empowering experiences that repair childhood adversities and support personhood and parenting (Brubaker and Wright 2006; Kennedy et al. 2010).

In this article, we present an intervention study based on the importance of cultivating relationships in public health nursing and the first author's research with teen mothers (Jonsdottir, Litchfield and Pharris 2003; SmithBattle 2010; Porr et al, 2012). The underlying premise for this study is that therapeutic or responsive relationships between the PHN and teen mother promote dialogue and clinical understanding, and that improved understanding of the teen mother's situation guides and refines clinical reasoning so that nursing actions (e.g., health teaching, anticipatory guidance, counseling, referrals, advocacy) are tailored to a teen mother's strengths, aspirations, and challenges. Rather than training nurses in visit-to-visit protocols, we trained nurses in the use of narrative-based therapeutic tools to determine if such tools would facilitate nurse-teen mother relationships, improve nurses' clinical understanding and action, and enhance selected maternal outcomes.

METHODS

Research Design and Methods

This mixed-method pilot study included a quasi-experimental design to examine the effect of LWC on teen mothers' depressive symptoms, self-silencing, repeat pregnancy, and educational progress compared to teens who received usual care (UC). Quantitative data were collected for depressive symptoms, self-silencing, repeat pregnancy, and educational progress. Qualitative data were collected from the PHNs to determine the feasibility of the intervention and acceptability of the narrative-based therapeutic tools. Qualitative arms of intervention studies can improve knowledge of how interventions are implemented and tailored to specific individuals and complex clinical situations (Schumacher et al 2005). After PHNs were consented, teen mothers were recruited to participate in the UC group. Once the final, six month postpartum visits were completed with the UC group, the PHNs

participated in a two month training period for LWC. Teen mothers were then recruited to participate in the LWC intervention and were followed until six months postpartum. Teens in both groups participated from the third trimester until the baby reached six months of age; they received ten dollar gift certificates at the end of each visit. PHNs participated in the study for approximately three years and did not receive additional compensation.

Setting and Participants

The setting for this pilot study was a mid-western urban community with 319,234 residents (US Census Bureau 2011). PHNs were recruited from a local health department. The first author attended a PHN staff meeting to describe the study and the eligibility criteria for nurse participants. Because the intervention was designed to build upon their experience in maternal-child home visiting, only PHNs with more than one year of home visiting were eligible to participate. Pregnant teens referred to the PHN office were eligible to participate if they were 15 to 19 years of age, pregnant with a first child, single, living at home, and non-Latina African-American or white. Those who expressed interest were referred to the participating PHNs in the third trimester of pregnancy.

Human Subject Issues

Approval for the study was obtained from the university's institutional review board and the health department. The first author consented the PHNs who volunteered to participate in the study. After the PHNs completed the university-mandated credentialing process for consenting research participants, they began enrolling teens into the UC group. During the intake visit, PHNs obtained consent after informing interested teens of the risks, benefits, and alternatives of participation orally and in writing. The voluntary nature of the study was emphasized; each teen was told that she would continue to receive home visits if she did not wish to participate in the study.

Usual Care

Pregnant teens who were recruited into the UC group received usual care based on health department guidelines. Care involved two home visits in the third trimester, two visits within the first postpartum month and monthly visits for six months. Each visit was highly structured by a protocol that identified the assessments and health education to be completed at each visit. General information was provided on self-care, maternal and infant nutrition, family planning, infant safety and development, childcare, and community resources.

PHN Training for LWC

Once the teens in the UC group completed the six month postpartum visits, the PHNs received 18 hours of training in six sessions over a two-month period. The training fostered empathic listening by introducing PHNs to narrative methods and therapeutic tools based on views that we understand our lives in narrative terms; that identities are co-authored; and that sharing one's experience with a compassionate other is potentially validating and healing (Polkinghorne 1988; Taylor 1991; Risser 1997). Empathic listening also promotes narrative identity and its repair (Gilligan 1987; Pasupathi and Hoyt 2009). Each of the training sessions reinforced this narrative understanding of identity as PHNs were introduced to the therapeutic tools described below. The first author facilitated all the sessions; one session was co-facilitated by a mental health nurse with relevant experience.

Discussion of case studies—To promote clinical understanding of young mothers' lives, the first training session focused on detailed case studies from the first author's (2010) qualitative research. PHNs were asked to read published reports before the first meeting. Reports described varied patterns in teen and family care of an infant, including the

strengths, resources, challenges, and conflicts associated with each pattern. Discussions of these cases focused on the teen's strengths, aspirations, and struggles; how she learns the baby and projects herself into the future; and how families and partners shape her transition to parenting. As each case was discussed, PHNs were encouraged to develop an understanding of the teen and how her concerns, priorities, strengths, and struggles make sense of the possibilities, constraints, and contradictions of her situation. For example, cases stimulated discussion on how nursing care for a teen who struggles to care for her baby by rejecting her parents' example of poor parenting would necessarily differ from the care of a teen who draws on positive childhood experiences and family support. Discussions included how each teen's aspirations could be strengthened, and her challenges and vulnerabilities addressed with resources available in her family, school, or community. This approach promoted engaged reasoning with a case and avoided a narrow focus on the teens' risks and deficits (SmithBattle 2009b).

Clinical interviews—In the second training session, PHNs were trained to use clinical interviews during home visits to foster empathic listening and dialogue with the teen mother. Interview guides from the first author's previous studies were adapted for this purpose because they successfully elicited mothers' perspectives. As others have suggested (Gilligan 1987; Pasupathi and Hoyt 2009), eliciting a teen's experience can promote narrative identity when her hidden strengths, experiential learning, and hopes and plans for the future are validated. A teen's self-disclosure also enlarges the nurses' understanding of what needs to be done. PHNs also viewed three videotapes produced by the American Association for Marriage and Family Therapy Research and Education Foundation (1995) to observe examples of clinical interviewing that engage clients in a collaborative dialogue.

Speaking for the Baby—In this session, a doctorally-prepared mental health nurse trained the PHNs in *speaking for the baby* (Carter, Osofsky and Hann 1991), a process whereby the nurse infers and describes the baby's needs, preferences, and emerging capacities from observing mother-baby interactions. For example, a PHN can acknowledge a mother's skill in feeding her baby when she says, from the baby's perspective, "Mom, I love being cuddled as you feed me. It makes me feel special and loved. It's also the special way we learn about each other." *Speaking for the baby* can also be used to provide anticipatory guidance in a non-prescriptive manner: "Mom, I'll be able to learn to drink from a sippie cup soon. I'll enjoy throwing it and tipping it over before I can drink from it. It will be messy but it's the way I learn." In these examples, *speaking for the baby* supports the child's emerging capacities and the mother's learning from the baby. This technique was included to validate, support, and build on the mother's experiential learning.

Baby book journal—Responsive care and clinical judgment were also fostered through the use of a baby book journal that was introduced in the fifth training session. Developed from prior research (SmithBattle, Pohlman and Broeder 2004), *All About Me* is similar to commercial baby books with monthly text pages arranged according to the baby's chronological age. Unlike commercially produced baby books, the text of this book was written from the baby's perspective at a fifth grade level with the baby speaking directly to "mom." For example, the one-month-old baby announced from the page, "I'm learning so much and so are you! I notice that when you're happy and calm—the world seems so bright. When you're feeling low or stressed out, the world seems a bit less secure. And you notice what my days are like too. That's how we learn to know each other." Another unique feature of this baby book was the inclusion of monthly journal pages that encouraged the mother to write about what she was learning from her baby and about herself. For example, after every monthly text page, the first journal page, titled "All About Me", invited the mother to write a paragraph in response to each of the following prompts: Tell me what I am like at this age;

Tell me about the new things I am learning; and Tell me about my likes and dislikes and what I enjoy doing! “All About Mom” pages followed each journal page for the baby and asked the mom to “Tell me about yourself mom. Consider writing about your growing up, what your day was like, or things you want to share with me as I get older.” PHNs were instructed to give the baby book to teens upon enrolling in LWC and requested that they read each monthly text page and journal about the baby and themselves. Teens were also told at that time that they would be asked to share their written entries with the nurse if they were willing to do so.

Therapeutic letter writing (TLW)—The final training session introduced PHNs to TLW, which was based on research describing the therapeutic value of letters written by professionals (Freed et al. 2010). Therapeutic letters are typically written to individuals between clinical encounters to validate their suffering and courage; to reinforce clinical progress; and to remind them of recommendations or referrals. Examples of letters were reviewed and discussed as a tool for building rapport and validating teens’ strengths, priorities, and achievements. PHNs were asked to write and mail letters to teen mothers after the first and fifth month postpartum visits, or more often if the situation warranted additional support.

In summary, the training and therapeutic tools were designed to enhance teen mothers’ self-disclosure and PHNs’ clinical understanding and engaged reasoning characteristic of excellent nursing practice (Benner et al. 2011). Careful listening to each teen was considered indispensable for developing responsive relationships, making astute clinical judgments, and promoting teen mothers’ strengths, aspirations, and reduced risk-taking.

Baseline and Outcome Measures

Demographic characteristics, depressive symptoms, and self-silencing were used to describe the groups at intake, during the third trimester of the teen’s pregnancy. Outcomes included the teen’s self-reported pregnancy status, educational progress, depressive symptoms, and self-silencing, or the tendency to dismiss one’s thoughts and feelings in dismissive, controlling, or conflicted relationships. Teen mothers of both groups also rated their relationship with their nurse, using the Nurse-Client Relationship Inventory, at six months postpartum. Nurses completed a tracking form for each family and an encounter form after every home visit. The encounter form provided documentation of clinical data (e.g. infant weight, immunizations, recommended health visits) and a checklist that covered the content of visits (e.g. assessments, nutrition education, parenting issues, social support, referrals, family relationships, return to school/work, use of therapeutic tools). Study instruments are described below.

The Center for Epidemiologic Studies-Depression Scale (CES-D)—The CES–D (Radloff 1977) is 20- item scale that assesses the presence and severity of depressive symptoms during the previous week. The range of possible scores is 0 to 60 with higher scores indicating more depressive symptoms. A cut-off score of 16 is associated with possible depression in community samples. Internal consistency for the CES-D has been shown to be .85 for the general population (Radloff 1977). The tool has been used extensively with teen mothers and has shown alphas as high as .92 (Reid and Meadows-Oliver 2007). Cronbach’s alpha in this study was .90.

Silencing the Self Scale (STSS)—The STSS reflects a process of dismissing or silencing the self that often leads to depression as girls and women respond to non-supportive relationships and societal expectations (Jack and Dill 1992). Items include “I find it harder to be myself when I am in a close relationship than when I am on my own,” and “I

don't speak my feelings in an intimate relationship when I know they will cause disagreement." The thirty-one item tool uses a five point Likert scale with responses ranging from strongly disagree (1) to strongly agree (5). Higher scores reflect greater self-silencing. Cronbach's alpha ranged from .86 to .94 in previous studies (Jack and Dill 1992) and was . 80 in this study.

Nurse-Client Relationship Inventory (NCRI)—The NCRI was used to assess teen mothers' perception of the quality of the relationship with their nurse. The instrument is a 27 item, 5-point Likert scale (Agree Strongly to Disagree Strongly) with lower scores indicating more positive relationships (Barnard 1998). Cronbach's alpha was 0.96 in a previous study by Korfmacher and colleagues (2007) and 0.94 for this study.

PHN Research Meetings

The first author held team meetings with the PHNs to collect qualitative data every two- to three-months as LWC was delivered over 16 months. The six two-hour meetings were tape recorded, professionally transcribed, and corrected for accuracy. A semi-structured interview guide was used at each meeting to obtain a full description of how the PHNs used the therapeutic tools, how the tools shaped their clinical understanding and nursing care, and how the teens responded to the visits from the nurses' perspectives. To capture PHNs' clinical reasoning and relational skills, they were also asked at each meeting to discuss two cases: one teen who was relatively easy to engage and a teen who was more difficult to engage in visits. Because PHNs were encouraged to respond to each other's comments with their own thoughts and questions, group interviews offered the advantage of stimulating a lively conversation among the participants (Benner et al., 2011).

Analytic Strategy

Descriptive statistics provided sample characteristics. Quantitative measures of depression and self-silencing were examined for group differences and trends over time; educational attainment, pregnancy status, and the nurse-client relationship were evaluated for group differences at six months. Transcripts of the six team meetings were analyzed using qualitative description (Sandelowski 2000), a "low-inference" (385) approach that summarizes participants' perceptions of events in everyday language. Transcripts of team meetings were read, and text was coded by the first author with terms that remained close to the data. Coded data was validated with the PHNs and summarized to determine the feasibility and acceptability of the intervention and therapeutic tools.

RESULTS

Sample Characteristics

Six PHNs volunteered for the study; four were black and two were white. One PHN had one year of PHN experience; the remaining nurses had a minimum of seven years of home visiting experience. Twenty-seven teen mothers signed the consent form. One dropped out early in the study and seven were lost to follow up. The final sample of 19 teen mothers included ten in the UC group and nine in the LWC group. At baseline, the ages of the teen mothers ranged from 15 to 19 years, with the mean age in the LWC group being younger (M= 16.7; SD, 1.5; range 15-19 years) compared to the UC group (M=17.3; SD, 1.5; range 16-19 years). Ethnicity of all teen mothers was black. Three of the ten teens in the UC group had graduated from high school before the study began; the remaining seven teens were attending school. Only one of the nine teens in the LWC group had graduated from high school at intake, and three teens had dropped out before the study began. Seven of the nine teens in the LWC group resided in households with incomes less than $10,000, compared to

four of the ten teens in the UC group, indicating that the LWC group was more socially disadvantaged than the UC group.

Intervention Outcomes

No statistically significant differences were found between groups on maternal outcomes. At baseline, the mean CES-D score for the LWC group was 18.1 (SD, 11.9) compared to 18.8 (SD, 11.5) for the UC group, indicating that both groups had a level of depressive symptoms within the last week that exceeded the cutoff score (of 16) for possible depression. At six months, depressive symptoms had declined in the LWC group (M=16.1; SD, 12.5) and in the UC group (M=15.3; SD, 11.4) with the UC group having a slightly larger but not statistically different decrease in depressive symptoms (Mann-Whitney U test, p=0.94). Similarly, at baseline the teen mothers in the LWC group had a higher mean score on the Silencing the Self questionnaire (M=69.8; SD, 15.0) compared to the UC group (M=67.5; SD, 15.7) indicating a slightly higher level of feeling dismissed or silenced. However, this difference was not statistically significant (Mann-Whitney U Test, p=.59). At six months, silencing had declined in the LWC group (M=66.8; SD, 11.3) and the UC group (M=66.8; SD, 14.9) with both groups now at similar levels (Mann-Whitney U Test, p=.89). The Nurse-Client Relationship Inventory (NCRI) was used to examine the relationship between the PHN and the teen mother at six months. While the NCRI scores in the LWC group (M=37.3; SD, 14.7) indicated a stronger relationship between the teen mother and the nurse compared to the UC group (M=42.3; SD, 13.1), this difference was not statistically different (Mann-Whitney U Test, p=.43).

By six months postpartum, one pregnancy had occurred in the UC group but none in the LWC group. Three of the ten teens in the UC group had graduated from high school before the study began; the remaining seven teens were attending school at six months. Of the nine teens in the LWC group, one teen had graduated and three had dropped out before intake. Among the five remaining teens, two had dropped out and three remained in school at six months.

Finally, we calculated a standardized effect size by dividing the difference between the mean change of the LWC and UC group by the pooled SD for the two groups on the CESD. Based on these pilot data, a randomized controlled trial would need 70 subjects per group to provide statistical power of 80% at 5% level of significance to detect an effect size of 0.5 using a two-sided t-test.

Intervention Feasibility and Acceptability

The qualitative component of the study addressed the feasibility of the intervention and the acceptability of the therapeutic tools from the perspectives of the participating nurses. PHNs reported that clinical interviews were helpful in promoting teens' self-disclosure. One PHN commented that active listening contributed to "a real productive visit. I learned a lot about the teen, more so than I had learned before." Another nurse concurred: "During our visits (prior to LWC training), it was me, the nurse, coming in to teach her. And because of the [clinical interview] questions I was able to get her to really talk." PHNs commented that a fruitful dialogue with teens broadened the scope and breadth of nursing care (beyond risk factors and deficits) as they became aware of teens' strengths and "red flags" regarding teens' relationships with boyfriends and family members.

Teens' written entries in the baby book journal provided another opportunity for the nurses to understand and respond to the teen's joys, difficulties, and what the teen was learning from the baby. PHNs asked teens to share their written entries with them during home visits. None directly refused, but two teens never shared their entries. PHNs stated that reading and

discussing teens' journal entries helped them uncover "what's really on the teens' minds and in their hearts." One PHN noted that journaling provided an "emotional outlet" for teens and offered "a bridge" for her to understand their concerns. Another described the baby book entries this way:

> When I look at what she's written, that helps me to bring out more of her social [situation]. I don't always think of it right off hand because I'm so concerned with her health. When I read her entries…that helps me bring up other issues…. The background things. I don't think I would have gotten that without the book.

Nurses also reported that some teens wrote at length and requested additional journal pages.

Several nurses reported that *speaking for the baby* became natural for them during home visits. All the nurses endorsed the value of therapeutic letters in building rapport with teens and reinforcing what had been discussed during visits. The nurses agreed with one PHN who said that the letters "reaffirmed the teen, boosted them up, and gave them encouragement." They also reported that teens appreciated receiving the letters. Here is an excerpt from one letter:

> I know that although this has been a very special time in your life, it must also be stressful adjusting to the baby and being a mother. I'm sure that at times you have had mixed feelings about being a mother, returning to school, sorting out feelings about the baby's father and how your relationship is changing with your mother. Your thoughts and feelings about the changes in your life are very important to me and how you are taking steps towards a good future for you and your baby….

In summary, PHNs endorsed the therapeutic tools and found them easy to use. At the last meeting, they volunteered that they would continue to write therapeutic letters in their practice. They also requested additional copies of the baby book to distribute to pregnant clients on their caseloads. Transcripts of team meetings also revealed that nurses identified teens' strengths, achievements, and their persistence in coping with difficult situations or "setbacks." Their comments further suggested that the therapeutic tools helped to broaden interventions beyond a risk and problem focus and to tailor nursing care to a teen's experiences, preferences, and situation.

DISCUSSION

To our knowledge, this is the first known study that employed narrative methods to strengthen responsive relationships and clinical understanding of teen mothers' strengths, aspirations, and challenges. Prior studies suggest that teen mothers aspire to improve their education and their lives and yearn to be good parents and role models for their children but have difficulty achieving these goals without supportive relationships and access to community resources (Hermann 2008; Rolfe 2008). Qualitative evidence from group meetings suggested that the intervention was feasible and well accepted by PHNs and that the training and therapeutic tools encouraged them to listen more and talk less with teens. PHNs' feedback further suggested that the therapeutic tools promoted teens' self-disclosure and broadened the nurses' understanding of the fabric of teens' lives. Having a fuller picture of the teen's situation provided the specificity that is lacking in visit-to-visit protocols so that nursing care is tailored to teen mothers' complex realities. Our findings are consistent with a report by Zeanah and colleagues (2006) who discovered that nurses involved in the Nurse Family Partnership program shifted from a narrow focus on medical risks to broader psychosocial concerns, and strayed from protocols to do what the situation required.

We applaud the diffusion of home visiting programs in the U.S. and elsewhere (Howard and Brooks-Gunn 2009) but we agree with Stern (2006) that not enough attention has been

devoted to understanding what makes them effective. While therapeutic relationships are often endorsed in these programs, their role remains theoretically undeveloped, and the inherent tension between following a protocol, developing a therapeutic relationship, and responding to the particularities of a clinical situation is rarely addressed (SmithBattle 2009a). The push for staff to maintain fidelity to highly structured visit protocols (Sweet and Appelbaum 2004; Donelan-McCall, Eckenrode and Olds 2009) belies a conundrum since nursing care, at its very best, is a complex social process that melds scientific findings with a great deal of "tacit, submerged, routine, and taken for granted" knowledge (Pawson 2012). This hidden knowledge is particularistic, contextual, and typically develops in practice as nurses gain clinical experience with a population and develop the relational and ethical skills that home in on relevant aspects of a clinical situation (Benner et al. 2011; Porter, O'Halloran and Morrow 2011; Strøm, Kvernbekk, and Fagermoen 2011). These practical skills and clinical knowledge are especially crucial when "objective" forms of knowledge emphasize teen mothers' risks, deficits, and poor outcomes while disregarding their strengths and resilience, and the comparable outcomes between teen and older mothers from similar backgrounds (Duncan, Edwards and Alexander 2010). In an era of evidence-based care, validating the diverse forms of (theoretical and practical) knowledge that allow nurses to do the right thing, in the right way, at the right time, and for the right person (Aristotle 1984) is complex and well worth investigating, given that this knowledge may help to explain the effectiveness of interventions.

Based on this study, we recommend that intervention research include qualitative components to understand how nurses implement visit-to-visit protocols, and how and when they veer away from protocols. Systematic analysis of such data would enrich our understanding of clinical praxis in all its messiness and would address major gaps in the literature on clinical trials, namely: how interventions are implemented in concrete situations rather than as intended (which may reflect nurses' practical and relational knowledge); what factors contribute to their effectiveness, with whom, and under what circumstances; and how nurses respond to variations in mothers' concerns, aspirations, challenges, and contexts. These variations in the practice world are a source of complexity that resist standardized protocols. Articulating how nurses respond to these variations and the circumstances of each mother has an important role to play in narrowing the practice-theory gap, deepening our understanding of clinical judgment, and improving the evidence-base for practice (Shumacher et al 2005).

Although PHNs in this study endorsed the therapeutic tools and expected to continue using them in their practice, statistically significant differences in maternal outcomes were not found. Teens in the LWC group were younger, showed higher rates of dropping out of school, and were more economically disadvantaged than teens in the UC group. These disparities at intake may help to explain the finding that two teens in the LWC group had dropped out of school by the end of the program while teens in the UC group who had not already graduated remained in school. One pregnancy occurred in the UC group by the sixth month home visit, while no repeat pregnancies occurred in the LWC group. While there was no statistical difference between groups in ratings of the nurse-teen mother relationship as measured by the NRSI, the higher ratings of nurses by teens in the LWC group appear to converge with qualitative data suggesting that the nurses' rapport-building and clinical understanding may have been enhanced by the training.

Limitations of the Study

The original plan included a second clinical agency with a PHN program but their withdrawal immediately before the study began, and the lack of alternative agencies in the metropolitan area, contributed to the small sample. As a result, this pilot study did not have sufficient power to detect statistically significant differences or clinically meaningful

changes in maternal outcomes between groups. Other researchers suggest that short or less intensive interventions targeting disadvantaged mothers are rarely sufficient to demonstrate statistically significant differences (Howard and Brooks-Gunn 2009; Nievar, VanEgeren and Pollard 2010). Because randomization was not employed, groups were not equivalent on background factors at intake. The LWC group of teens was more educationally and socially disadvantaged than the UC group and these factors are associated with poorer maternal outcomes. We relied on PHNs' self-reported use of therapeutic tools, and did not directly observe home visits. We recommend that future studies include randomization, that feedback is obtained from mothers, and that visits are recorded.

CONCLUSION

"The new mother needs and wants to be 'held,' valued, appreciated, aided, and given structure by a benign, more experienced woman who is unequivocally on her side" (Stern 1995). Teen mothers are unlikely to receive the attentive care described by Stern (1995) as long as home visiting interventions emphasize fidelity to protocols over openness to the diverse forms of knowledge that make it possible for nurses to respond with compassion, skill, and flexibility to the complexities of each clinical situation (Benner et al. 2011). The study's findings suggested that the therapeutic tools used in this intervention cultivated nurses' relational skills and clinical understanding with narrative methods. PHNs' feedback also indicated that the therapeutic tools were well accepted and promoted dialogue and clinical understanding. The lack of statistically different findings reflects the small sample size, the relatively short intervention period, and non-equivalent groups at intake. Future studies should include randomized groups with a sample size that is adequate to detect clinically meaningful and statistically significant treatment effects. Feedback from teen mothers and PHNs should be obtained to account for what works, for whom, and under what circumstances. Findings may have implications for understanding and strengthening hidden aspects of nursing that make a difference in the lives of vulnerable teen mothers and their children.

Acknowledgments

We are grateful to the nurses and teen mothers who participated in this study; to Kathy Borcherding for research assistance; and Chakra Budhathoki, PhD, for statistical consultation. This research was funded by the National Institute of Nursing Research (NR04700 R29).

References

American Association for Marriage and Family Therapy Foundation. Listening to families: Exploring family strengths. Research and Education Foundation; Washington, DC: 1995.

Aristotle. Aristotle's Nichomedian ethics, trans. HG Apostle. Peripatetic Press; Grinnell, IA: 1984.

Aston M, Meagher-Stewart D, Sheppard-Lemoine D, Vukic A, Chircop A. Family health nursing and empowering relationships. Pediatric Nursing. 2006; 32:61–7. [PubMed: 16572540]

Barnet B, Liu J, DeVoe M. Double jeopardy: Depressive symptoms and rapid subsequent pregnancy in adolescent mothers. Archives of Pediatrics & Adolescent Medicine. 2008; 162:246–52. [PubMed: 18316662]

Benner, P.; Hooper-Kyriakidis, P.; Stannard, D. Clinical wisdom and interventions in acute and critical care: A thinking-in-action approach. 2nd edn. Springer; New York: 2011.

Boden JM, Fergusson DM, Horwood J. Early motherhood and subsequent life outcomes. Journal of Child Psychology and Psychiatry. 2008; 49:151–60. [PubMed: 18093114]

Browne AJ, Doane GH, Reimer J, MacLeod ML, McLellan E. Public health nursing practice with 'high priority' families: The significance of contextualizing 'risk'. Nursing Inquiry. 2010; 17:27–38. [PubMed: 20137028]

Brubaker SJ, Wright C. Identity transformation and family caregiving: Narratives of African American teen mothers. Journal of Marriage and Family. 2006; 68:1214–28.

Burton LM. Teenage childbearing as an alternative life-course strategy in multigenerational black families. Human Nature. 1990; 1:123–43.

Carter SL, Osofsky JD, Hann DM. Speaking for the baby: A therapeutic intervention with adolescent mothers and their children. Infant Mental Health Journal. 1991; 12:291–301.

Clemmens DA. Adolescent motherhood: A meta-synthesis of qualitative studies. MCN, American Journal of Maternal Child Nursing. 2003; 28:93–9.

Dodds A. Families 'at risk' and the family nurse partnership: The intrusion of risk into social exclusion policy. Journal of Social Policy. 2009; 38:499–514.

Donelan-McCall N, Eckenrode J, Olds D. Home visiting for the prevention of child maltreatment: Lessons learned during the past 20 years. Pediatric Clinics of North America. 2009; 56:389–403. [PubMed: 19358923]

Dornig K, Koniak-Griffin D, Lesser J, Gonzalez-Figueroa E, Luna MC, Anderson NLR, Corea-London B. You gotta start thinking like a parent": Hopes, dreams, and concerns of ethnic minority adolescent parents. Families in Society. 2009; 99:51–60.

Duncan, S.; Edwards, R.; Alexander, C., editors. Teenage parenthood: What's the problem?. Tufnell Press; London: 2010.

Easterbrooks MA, Chaudhuri JH, Bartlett JD, Copeman A. Resilience in parenting among young mothers: Family and ecological risks and opportunities. Children and Youth Services Review. 2011; 33:42–50.

Fessler KB. Social outcomes of early childbearing: Important considerations for the provision of clinical care. Journal of Midwifery & Women's Health. 2003; 48:178–85.

Finlay S, Sandall J. Someone's rooting for you": Continuity, advocacy and street-level bureaucracy in UK maternal healthcare. Social Science & Medicine. 2009; 69:1128–35.

Fletcher JM. The effects of teenage childbearing on the short and long-term health behaviors of mothers. Journal of Population Economics. 2011; 25:201–18.

Freed PE, McLaughlin DE, SmithBattle L, Leander S, Westhus N. It's the little things that count": The value in receiving therapeutic letters. Issues in Mental Health Nursing. 2010; 31:265–72. [PubMed: 20218770]

Furstenberg, FF, Jr.. Destinies of the disadvantaged: The politics of teenage childbearing. Russell Sage Foundation; New York: 2007.

Gilligan C. Adolescent development reconsidered. New Directions for Child Development. 1987; 54:63–91. [PubMed: 3454426]

Hermann JW. Adolescent perceptions of teen births. Journal of Obstetric, Gynecologic, & Neonatal Nursing. 2008; 37:42–50.

Howard KS, Brooks-Gunn J. The role of home visiting programs in preventing child abuse and neglect. The Future of Children. 2009; 19:119–46. [PubMed: 19719025]

Jack, DC. Silencing the self: Inner dialogues and outer realities. In: Joiner, TE.; Coyne, JC., editors. The interactional nature of depression: Advances in interpersonal approaches. American Psychological Association; Washington, DC: 1999.

Jack DC, Dill D. Silencing the self scale: Schemas of intimacy associated with depression in women. Psychology of Women Quarterly. 1992; 16:97–106.

Jacobson N. Dignity violation in health care. Qualitative Health Research. 2009; 19:1536–47. [PubMed: 19797155]

James I, Andershed B, Gustavsson B, Ternestedt B-M. Knowledge constructions in nursing practice: Understanding and integrating different forms of knowledge. Qualitative Health Research. 2010; 20:1500–18. [PubMed: 20562250]

Jonsdottir H, Litchfield M, Pharris MD. The relational core of nursing practice as partnership. Journal of Advanced Nursing. 2003; 47:241–50. [PubMed: 15238117]

Kennedy AC. Resilience among urban adolescent mothers living with violence: Listening to their stories. Violence Against Women. 2005; 11:1490–1514. [PubMed: 16247113]

Kennedy AC, Agbenyiga DL, Kasiborski N, Gladden J. Risk chains over the life course among homeless urban adolescent mothers: Altering their trajectories through formal support. Children and Youth Services Review. 2010; 32:1740–49.

Kennedy AC, Bennett L. Urban adolescent mothers exposed to community, family, and partner violence. Journal of Interpersonal Violence. 2006; 21:750–73. [PubMed: 16672740]

Kitzman HJ, Yoos HL, Cole R, Kormacher J, Hanks C. Prenatal and early childhood home-visitation program processes: A case illustration. Journal of Community Psychology. 1997; 25:27–45.

Korfmacher J, Green B, Spellmann M, Thornburg KR KR. The helping relationship and program participation in early childhood home visiting. Infant Mental Health Journal. 2007; 28:459–80.

Lewis CM, Scarborough M, Rose C, Quirin KB KB. Fighting stigma: An adolescent mother takes action. Journal of Women and Social Work. 2007; 22:302–6.

Marcellus L. The ethics of relation: Public health nurses and child protection clients. Journal of Advanced Nursing. 2005; 51:414–20. [PubMed: 16086810]

Moules NJ, MacLeod MLP, Thirsk LM, Hanlon N. And then you'll see her in the grocery store": The working relationships of public health nurses and high-priority families in northern Canadian communities. Journal of Pediatric Nursing. 2010; 25:327–34. [PubMed: 20816554]

Nievar MA, VanEgeren LA, Pollard S. A meta-analysis of home visiting programs: Moderators of improvements in maternal behavior. Infant Mental Health Journal. 2010; 31:499–520.

Paavilainen E, Astedt-Kurki P. The client-nurse relationship as experienced by public health nurses: Toward better collaboration. Public Health Nursing. 1997; 14:137–42. [PubMed: 9203837]

Pasupathi M, Hoyt T. The development of narrative identity in late adolescence and emergent adulthood: The continued importance of listeners. Developmental Psychology. 2009; 45:558–74. [PubMed: 19271839]

Pawson R. Realist thoughts on Cinderella, Alice in Wonderland and health care interventions. Nursing Inquiry. 2012; 19:4–5. [PubMed: 22212365]

Polkinghorne, DE. Narrative knowing and the human sciences. State University of New York press; New York: 1988.

Porr C, Drummond J, Olson K. Establishing therapeutic relationships with vulnerable and potentially stigmatized clients. Qualitative Health Research. 2012; 22:384–96. [PubMed: 21890718]

Porter S, O'Halloran P, Morrow E. Bringing values back into evidence-based nursing. The role of patients in resisting empiricism. Advances in Nursing Science. 2011; 34:106–18. [PubMed: 21427560]

Radloff LS. The CES—D Scale: A self-report depression scale for research in the general population. Applied Psychological Measurement. 1977; 1:385–401.

Reid V, Meadows-Oliver M. Postpartum depression in adolescent mothers: An integrative review of the literature. Journal of Pediatric Health Care. 2007; 21:289–98. [PubMed: 17825726]

Risser, J. Hermeneutic and the voice of the other: Rereading Gadamer's philosophical hermeneutics. State University of New York Press; Albany, NY: 1997.

Rolfe A. You've got to grow up when you've got a kid': Marginalized young women's accounts of motherhood. Journal of Community & Applied Social Psychology. 2008; 18:299–314.

Sandelowski M. Whatever happened to qualitative description? Research in Nursing & Health. 2000; 23:207–18.

Schumacher KL, Koresawa S, West C, Dodd M, Paul SV, Tripathy D, Koo P, Miakowski C. Qualitative resarch contribution to a randomized clinical trial. Research in Nursing & Health. 2005; 28:268–80. [PubMed: 15884025]

SmithBattle L. Legacies of advantage and disadvantage: The case of teen mothers. Public Health Nursing. 2007; 24:409–20. [PubMed: 17714225]

SmithBattle L. Gaining ground from a cultural tradition: A teen mother's story of repairing the world. Family Process. 2008; 47:521–35. [PubMed: 19130791]

SmithBattle L. Pregnant with possibilities: Drawing on hermeneutic thought to reframe home-visiting programs for young mothers. Nursing Inquiry. 2009a; 16:191–200. [PubMed: 19689646]

SmithBattle L. Reframing the risks and losses of teen mothering. MCN American Journal of Maternal Child Nursing. 2009b; 34:122–8.

SmithBattle, L. Listening with care to teen mothers and their families. In: Chan, G.; Brykczynski, K.; Malone, R.; Benner, P., editors. Interpretive phenomenology in health care research. Sigma Theta Tau International; Indianapolis, IN: 2010. p. 217-241.

SmithBattle L. Moving policies upstream to mitigate the social determinants of early childbearing. Public Health Nursing. 2012

SmithBattle L, Pohlman S, Broeder J. Listening to the baby: The development of a baby book journal. Journal of Family Nursing. 2004; 10:173–89.

Spear HJ, Lock S. Qualitative research on adolescent pregnancy: A descriptive review and analysis. Journal of Pediatric Nursing. 2003; 18:397–408. [PubMed: 15058536]

Stern, DN. The motherhood constellation: A unified view of parent-infant psychotherapy. Basic Books; New Yorrk: 1995.

Stern DN. Introduction to the special issue on early preventive intervention and home visiting. Infant Mental Health Journal. 2006; 27:1–4.

Strøm A, Kvernbekk T, Fagermoen MS. Parity: (im)possible? Interplay of knowledge forms in patient education. Nursing Inquiry. 2011; 18:94–101. [PubMed: 21564390]

Sweet MA, Appelbaum MI. Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. Child Development. 2004; 75:1435–56. [PubMed: 15369524]

Taylor, C.; Hiley, DR.; Bohman, JF.; Shusterman, R. The interpretive turn: Philosophy, science, culture. Cornell University Press; Ithaca, NY: 1991. The dialogical self; p. 304-314.

US Census Bureau. 2010 Census Data. US Government Printing Office; Washington DC: 2011.

Usdansky ML. A weak embrace: Popular and scholarly depictions of single-parent families, 1900-1998. Journal of Marriage and Family. 2009; 71:209–25.

Wald, L. The house on Henry Street. Hen Holt & Co; New York: 1915.

Wang L, Wu T, Anderson JL, Florence JE. Prevalence and risk factors of maternal depression during the first three years of child rearing. Journal of Women's Health. 2011; 20:711–8.

Webbink D, Martin NG, Visscher PM. Does teenage childbearing reduce investment in human capital? Journal of Population Economic. 2011; 24:701–730.

Whitley R, Kirmayer LJ. Perceived stigmatisation of young mothers: An exploratory study of psychological and social experience. Social Science & Medicine. 2008; 66:339–348. [PubMed: 17983698]

Yardley E. Teenage mothers' experiences of stigma. Journal of Youth Studies. 2008; 11:671–684.

Zeanah PD, Larrieu JA, Boris NW, Nagle G. Nurse home visiting: Perspectives from nurses. Infant Mental Health Journal. 2006; 27:41–54.