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Mental Health Utilization Among Former Pregnant and Parenting Teen Mothers

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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by

Chana Campbell

MPhil, Walden University 2019

MA, Argosy University, 2015

BS, Regent University 2010

Dissertation Submitted in Partial Fulfillment

of Requirements for the Degree of

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Abstract

Teen pregnancy and parenting at an early age can create numerous emotional stressors. Despite the documented need for mental health services among pregnant and parenting mothers, utilization rates of mental health services remain low. The purpose of this generic qualitative study was to explore the experiences of pregnant and parenting mothers who utilized mental health services. Bandura's social learning theory was used to explore how the experiences, perceptions, learned behaviors, thoughts, and beliefs surrounding mental health services impacted teen mothers' experiences with mental health utilization. One-on-one interviews were conducted with eight teen mothers or other young mothers who had given birth or were pregnant while utilizing mental health services. Open coding was used to analyze interview transcripts and sort material into codes, categories, and themes. The study results included six themes regarding parenting and mental health services. Results confirmed that pregnancy and parenting coincided with mental health issues such as depression, anxiety, and stress, creating a need for mental health services, also found in the existing literature. Participants were not discouraged from obtaining services due to a lack of support from family, friends, or negative stigmas associated with mental health. As a result, a greater understanding of pregnant and parenting teen and young mother's experiences was obtained. In addition, some of the specialized needs of pregnant and parenting mothers were identified and provide insight into how to best serve and advocate for the identified demographic. This may help mothers and practitioners obtain a better understanding of the mental health challenges of teen mothers and how to support those challenges and needs.

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Dedication

I give all praise and thanks to God for allowing me to have this moment. Accomplishing this goal has been a lifelong dream. I thank him for the love, grace, strength, and support extended to me daily as I traveled this path.

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Chapter 1: Introduction to the Study

Adolescent pregnancy is defined as the status of a teenage girl who becomes pregnant between the ages of 13 and 19 (Cahyaningtyasa et al., 2020). Over the past 30 years, there has been a decrease in teen pregnancies in the United States (Nutty, 2019). Despite the 8% decline in teen pregnancy rates from 2014–2015, teen pregnancy in the United States remains high compared to other countries (Harrison, 2017; Taylor et al., 2019; Yee et al., 2019). Annually, 400,000 teens give birth in the United States, continuing to make teen pregnancy a public health concern (Fernandes-Aleantara, 2018; Logdson, 2018). Several negative implications correlate with teen pregnancy, such as social, emotional, educational, financial, potential dependency on government agencies and mental health challenges (Kawaii-Bogue et al., 2017; Logdson, 2018; Taylor et al., 2019; Tanner & Tanner, 2020).

Despite the documented need for mental health services among pregnant and parenting mothers, utilization rates remain low (Fripp 2017; Harrison, 2017). Teen parenting mental health issues are associated with adverse long-term mental health issues if left untreated (Reardon et al., 2017). Within a year, 10–20% of adolescents may experience mental health issues such as depression, anxiety, and potential suicide attempts (Sapthiang & Shonin, 2019). Teen pregnancy and parenting can create emotional distress for young mothers as they deal with isolation, teen parenting stigma, and discrimination (Sapthiang, & Shonin, 2019; Tanner & Tanner, 2020).

Teen mothers are often marginalized, and their experiences with mental health utilization are underrepresented in the research literature (Harrison et al., 2017; Lucas,

2019). This study explored the perceptions and experiences former pregnant and parenting teen mothers faced while utilizing mental health services. Working professionals can use the information provided to aid pregnant and parenting teen mothers in safely and effectively navigating the mental health services system while understanding their specialized needs.

In this chapter, I will discuss background information on teen pregnancy and mental health. The conceptual framework, nature of the study, and the problem will be explored. The problem statement, assumptions, scope, delimitations, and limitations of the study will be provided.

Background

Teen pregnancy has been an area of concern in the United States since the 1950s and is considered a major public health concern (Paton & Wright, 2017). Annually, teen pregnancy and parenting have cost taxpayers over 11 billion dollars due to a greater need for health care, utilization of government-funded services, education costs, and an increased need for programs such as foster care (Barker et al., 2018; see also Yee et al., 2019). Understanding teen pregnancy is necessary to decrease teen pregnancy rates (Maness et al., 2016). Social determinants, geographic, environmental, and socioeconomic status contribute to high teen pregnancy rates (Dobbins et al., 2016; Marseille et al., 2018). Teen mothers have lower high school graduation rates, and fewer teen mothers attend college in comparison to their non-parenting peers (Dee et al., 2017; Holeness, 2015).

Teen parenting and pregnancy has been shown to negatively impact the teen parent's emotional well-being (Freed & Lee, 2016). The years a mother is parenting could become a critical period as it relates to mental health (Laurenzi, 2020). Mental health concerns such as depression and anxiety often arise during the teenage years, and adolescent mothers suffering from these conditions have the added stress of pregnancy and parenting, which can further complicate mental health concerns (Fife et al., 2020). Teen mothers residing in low socioeconomic status environments during pregnancy showed elevated comorbidity rates between depression and pregnancy (Sahrakorpi et al., 2017). Teen mothers are at higher risk for antenatal and postpartum depression than non-parenting teens (Harrison et al., 2017). Teen mothers reported elevated levels of psychological stress and a greater need for social support (Freed & Lee, 2016). Adolescent parenting has been associated with adverse long-term effects such as ongoing mental health issues and a reported decrease in life satisfaction (Reardon et al., 2017). The research establishes that numerous areas of an individual's life are impacted by mental health concerns (Akella et al., 2015; Corcoran, 2016; Hudgins et al., 2014; Sahrakorpi et al., 2017).

Once the need for mental health services has been identified, seeking treatment may become an additional area of concern (Ali et al., 2018). Pregnant and parenting teens may experience transportation issues, lack of insurance, socioeconomic health disparities, and negative health care experiences, which may serve as barriers to obtaining mental health services (Aguirre Velasco et al., 2020; Ali et al., 2018; Nutty, 2019). Multiple services are provided through local and state programs to assist with and provide mental

health services. But the number of individuals in this demographic seeking treatment remains low (Felder et al., 2017). To enhance the current body of literature, a better understanding of pregnant and parenting teens and help-seeking behaviors is needed (Aguirre Velasco et al., 2020).

Problem Statement

Despite the decline in teen pregnancy rates, the issue of teen parenting and pregnancy remains a public health concern (Kawaii-Bogue er al., 2017; Lindberg et al., 2017). For young mothers who experience pregnancy, their lives can become permanently altered as they deal with psychological, physical, social, emotional, and economic changes (Jones et al., 2019; Smith et al., 2018). Less than 50% of teen mothers obtain their high school diploma by the age of 22 (Yee et al., 2019). Teen pregnancy may impact mothers later in life as they may have fewer career options, live in low socioeconomic status environments, and have higher poverty rates (Yee et al., 2019).

Maternal mental health has become a growing concern for teen mothers (Jones et al., 2019). During adolescence, teens often begin to deal with mental health concerns, and parenting can exacerbate these issues (Harrison et al., 2017; Reardon et al., 2017). Teen pregnancy issues can further complicate existing mental health concerns (Burrus, 2018). Adolescents have higher rates of mental health issues than other age demographics, and adolescent mothers report more mental health concerns than other teens their age who are not parenting (Aguirre Velasco et al., 2020; Ashby et al., 2019). The adolescent demographic reports higher rates of anxiety, depression, and trauma in comparison to other age groups (Aguirre Velasco et al., 2020).

Despite current knowledge regarding barriers to treatment-seeking, and interventions created to aid in eliminating the identified barriers, teen mothers continue to underutilize mental health services (Lucas et al., 2019). Though the literature provides pertinent information regarding teenage pregnancy and mental health, additional research exploring the reasons for the underutilization of mental health resources is needed (Kawaii-Bogue et al., 2017; Laurenzi, 2020; Lucas et al., 2019). This research focused on understanding the collective experiences of pregnant and parenting teens and young mothers.

Purpose of the Study

The purpose of this study was to examine the perceptions and experiences of former teen and parenting teen mothers on the utilization of mental health services during their pregnancy and parenting years. Teen and young mothers were the focus of the study due to the high number of teen pregnancies and low rates for mental health utilization among this population. Research examining teen mothers' experiences and the utilization of mental health services is needed (Ashby et al., Harrison, 2017; Rouleau, 2017). The teen mother demographic is often marginalized and underrepresented in the current literature body (Harrison et al., 2017).

Research Question

How do former pregnant or parenting teen and young mothers describe their experiences of utilizing mental health services?

Conceptual Framework

The theoretical framework for this study is Bandura's (1963) social learning theory (SLT). I used the theory to explore how the experiences and perceptions of mental health services impacted teen mothers' choices as it relates to mental health utilization. Bandura's SLT is a vital resource when examining and explaining adolescent behavior (Akella, 2015). The theory states that individuals learn through observing what is happening in their environments, then the behaviors are emulated and modeled (Horsburgh & Ippolito 2017). This theory frames the existing relationship between human behavior, cognition, and environment (Jones et al., 2019). The most powerful influences for adolescent learning are identified as the family, peer groups, teachers, and legal guardians (Connolly, 2016). These individuals serve as role models and play a vital role in teens' lives due to the observational learning that occurs during the adolescent years of development (Aschenbrener & Johnson, 2017).

Social learning plays a role in help-seeking behaviors related to mental health services (Benjamin et al., 2015; Kawaii-Bougee et al., 2017). Learned and observed behaviors are important to understand since they can be transferred from generation to generation (Chang et al., 2016; Graves, 2017). Observed coping strategies utilized by parents for managing mental health issues can be learned and modeled by adolescents (Apsley & Padilla-Walker, 2020). Negative generational perspectives on mental health issues and help-seeking practices can serve as a barrier to seeking help (Ashby et al., 2019; Graves, 2017). Stigmas voiced by an individual's support system role model or

community surrounding therapeutic services can prevent teens from enlisting mental health professionals (Ashby et al., 2019; Chang et al., 2016).

Nature of the Study

The nature of the study is a generic qualitative approach. The qualitative approach is appropriate because it helps with analyzing subjective experiences through the interpretation of the data obtained as a means of gaining knowledge and insight (Akella et al., 2015). The interview process allows researchers to better understand the study participants' motives, opinions and focuses on their individualized experiences (Kennedy, 2016; Killebrew et al., 2014). Through this research, a greater understanding of the mother's experiences was obtained, with greater insight on how to best advocate for this population. Mothers ages 18–30 with treatment seeking experiences while pregnant and parenting were interviewed. The study involved semi-structured interviews as the primary data collection method for the target population. The informal, conversational approach was used to aid in the promotion of interactive conversation. Open-ended questions were used so that participants were presented with the opportunity to include their feelings and attitudes.

Definitions

Adolescent pregnancy: A pregnant female between the ages of 13–19.

Mental health treatment: The treatment of a mental health illness.

Pregnant teens: Teenage females between the ages of 13–19 who are pregnant.

Parenting mothers: A female between the ages of 18–30 parenting a child.

Teen pregnancy: Teen pregnancy is defined as the status of a teenage girl who becomes pregnant between the ages of 13–19.

Assumptions

An assumption made regarding the study was that participants were open, honest, and willing to talk about their perceptions and experiences. Unlike quantitative studies, the information provided by study participants is not quantifiable. This generic qualitative study was exploratory in nature and dependent upon the participants' subjective and lived experiences. Honesty was necessary for the groundwork of the study. It was assumed that the data found in the study will be applicable to a larger population. The presence of personal biases of the interviewer is an additional assumption. Journaling, member checking, and a peer review of my findings were utilized to eliminate biases within the study. The assumption was that participants would be willing to answer the questions honestly due to the protection of their personal and identifying information.

Scope and Delimitations

The scope of this generic qualitative study was to examine the perceptions and experiences of former pregnant or parenting teen mothers with utilizing mental health services as teenagers. The topic was selected because studies show there is an underutilization of mental health services for teenagers and the need for more studies documenting pregnant and parenting teen mothers (Kawaii-Bogue et al., 2017; Laurenzi, 2020). There is a gap in the literature regarding teen mothers' experiences as it relates to mental health. The study focused on the experiences and perspectives of mothers seeking mental health services while they were either pregnant or parenting. The scope of the

study focused only on experiences related to mental health utilization experienced by the demographic. The study did not focus on barriers such as financial issues, childcare, or availability/access to mental health programs.

Delimitations in qualitative research are within the researcher's control and explain the researcher's choices regarding the study (Theofanidis et al., 2018). Purposive sampling was the selected sampling strategy, meaning participants had to meet a specific criterion to participate in the study. Participants had to be between 18 and 30 and must have received mental health services while pregnant or parenting. Initially, I wanted to interview teen mothers who were utilizing mental health services. Due to recruitment issues, the age group was increased from 18–24 to 18–30. Participants must also be proficient in speaking English. Due to the subjective nature of qualitative studies, replication can be difficult. However, transferability will be achieved through variation in the participant selection process (Amankwaa, 2016; Theofanidis et al., 2019). Generalization of the study can be applied to pregnant and parenting teen mothers within the same age demographic.

Limitations

Elements of the study not under the researcher's control are known as limitations (Theofanidis et al., 2018). It is important to identify limitations because they can impact research findings (Theofanidis et al., 2018). Identified limitations of the current study included researcher and participant biases. My experiences as a mental health clinician and working with teen and young mothers could produce biases. I used bracketing, journaling, member checking, and a peer review of the study findings to help control

personal biases within the study (Birt et al., 2016). Sampling method concerns and confirmability issues were also considered limitations. The data provided by the study participants were self-reported. There were no medical records required to confirm the need for mental health services or confirmation of mental health treatment while pregnant or parenting. An additional limitation was that no in-person interviews were conducted due to COVID-19; all interviews were conducted online or via phone. As the interviewer, I ensured that I was in a private setting. Participants were asked to interview in an area with no distractions or interruptions. The importance of being in a quiet, secure location without distractions was discussed as part of maintaining confidentiality. However, I had no control over distractions that may occur in the participants' setting.

Significance

The study is significant for the field of mental health because it may aid in identifying how former pregnant and parenting teen mothers describe their experiences with the utilization of mental health services. The current mental health system provides vital services related to the mothers' mental health needs; however, underutilization still occurs among the demographic (Ashby et al., 2016). The study is unique because it fills a gap in the literature by exploring former pregnant and parenting teen and young mothers' experiences and perceptions. The study is significant to add new knowledge to the body of literature that has not been explored in this demographic.

Summary

In Chapter 1, teen pregnancy challenges and the impact of pregnancy on mental health among teen mothers were introduced. Background information on teen pregnancy

and underutilization of mental health were also discussed. The purpose of the study was provided, along with an introduction to the research question. I also outlined the social implications, limitations, scope, and delimitations as well as the conceptual framework of the study, Bandura's SLT. Chapter 2 will provide an in-depth literature review exploring teen parenting and mental health.

Chapter 2: Literature Review

Although teen pregnancy rates have declined over the past two decades, teen pregnancy and parenting rates remain high (Smith et al., 2018; Taylor et al., 2019). Teen pregnancy and adolescent parenting pose a significant issue for teens in the United States (Akella & Jordan, 2015; Fernandes-Alcantara, 2018). Teen pregnancy has life-long implications for young mothers (Smith et al., 2018), creating financial, academic, and social challenges for teen parents (Cox et al., 2019; Radcliff, 2018; Whitworth, 2017). Among pregnant and parenting mothers, there is a documented need for mental health services (Ashby et al., 2016; Harrison et al., 2016; Haynes et al., 2017). Mental health issues often emerge during pregnancy and are associated with multiple adverse mental health outcomes (Cocoran, 2016; Hodkinson et al., 2013). Despite the need for mental health services among pregnant and parenting mothers, utilization rates remain low among all demographics (Fripp 2017; Harrison, 2017; Kawaii-Bogue et al., 2017). There is a need for research examining the experiences among pregnant and parenting teens and young mothers utilizing mental health services (Ashby et al., 2016; Harrison, 2017; Rouleau, 2017).

Previous studies have focused on teen pregnancy, prevention measures, and reduction of subsequent pregnancies (Cox et al., 2019; Hudgins et al., 2014). But there is a lack of research on perceptions of teen and parenting mothers and their utilization of mental health services (Harrison et al., 2017). The current body of literature must be inclusive of the teen mother's experience (Burris, 2018; Ofonedu et al., 2017). This study aids in identifying teen and young mothers who utilized mental health services during

their parenting years and will help provide an understanding of their perceptions of and experiences with mental health treatment utilization. The study is necessary due to the underrepresentation of teen and young mothers' perspectives in the current body of literature (Harrison et al., 2017; Stokar, 2017).

Literature Search Strategy

A literature review is an analysis of previously researched information that is synthesized by scholars; new journal articles created add insight and meaningful content while filling any gaps found in the current body of literature (Dodgson, 2017). The research of peer-reviewed journal articles began in August of 2018. The time period of the articles ranges from 2014–2022. The Walden University online library included journal searches conducted by topics and multidisciplinary databases. Databases used for the literature review research included Psych Articles, Sage Journals, EBSC O Host, and ProQuest. Keyword searches included the verbiage of teen mothers, teen parenting, teen pregnancy, adolescent pregnancy, adolescent parenting, mental health, mental health and adolescent pregnancy, and adolescent parenting and mental health.

Google Scholar was also a resource used to locate open access articles. The search included mental health, mental health utilization, teen mothers, adolescent teen mothers, underutilization of mental health and teen mothers, maternal mental health, disadvantages for teen mothers, and adolescent teen pregnancies. To maximize search results, term variations conducted in all databases allowed for criteria inclusion. A review of the literature includes the stated problems of teen pregnancy, mental health in the teen

parenting community, and the utilization of mental health services in the pregnant and teen and young mother population.

Conceptual Framework

Teenage years are an essential time of cognitive development (Akealla et al., 2017). The conceptual framework utilized for the study is Bandura's (1963) SLT (see also Akella & Jordan, 2015). The theory explains how learned behaviors develop and their impact on behavior and decision making (Bandura, 1963; Killebrew et al., 2014). SLT has become a vital resource in understanding and examining adolescents' behavior and is utilized in multiple studies (Akella & Jordan, 2015, Akella et al., 2017; Killebrew et al., 2014).

This study used SLT as the framework to explore how the life experiences of former teen and young mothers impacted their decision to participate in mental health services while parenting. Traditionally, many teens do not seek mental health services due to numerous barriers. However, there is a demographic of teen mothers that seek mental health services while parenting. The SLT was essential to the current study. The theory frames the existing relationship between human behavior, cognition, and one's environment (Jones et al., 2019). According to Bandura's work during the 1960s and 1970s, social learning occurs through watching, imitating, and modeling observed behavior (Killebrew et al., 2014). Once the information has been modeled and coded into one's cognitive framework, the modeled behavior becomes a blueprint for future actions (Benjamin & Carolissen, 2015). Those who model behaviors in the lives of mothers impact their beliefs, attitudes, and decisions. Among adolescents' parental units, primary

caretakers and peers are influential in determining what is socially acceptable (Butler-Barnes et al., 2018). Social learning impacts the therapeutic experience as others learn from the personal past experiences of individuals in their lives and become aware of what is culturally acceptable from their role models as it relates to the therapeutic process (Ashby et al., 2017; Graves, 2017). Thus, the SLT's fundamental concepts may help provide a better understanding of the choice to participate in therapy and gain insight into these young mothers' perspectives and experiences while utilizing therapeutic services.

Literature Review Related to Key Concepts

Teen Pregnancy Defined

Teen pregnancy is defined as the status of a teenage girl between the ages of 13–19 who becomes pregnant (Akella & Jordan, 2015). The term originated in the 1950s and gained popularity as scholars began to research the topic in the 1970s, citing teen pregnancy as a social concern connected to dire consequences (Winters & Winters, 2012). In 1975, one out of 10 girls in the United States (aged 15–19) reported pregnancies (Kost & Winters, 2014). A rise in teen pregnancy continued into the 1980s (Kost et al., 2014). In 2013, 300,000 teens ages 15–19 reported births in the United States (Marseille et al., 2018).

Teen pregnancy rates have steadily declined over the past decade (Holeness, 2015). From 1991–2015, a decrease in teen pregnancy was reported for the 15–19-year age demographic, with rates declining from 61.8 to 24.2 per thousand and reaching a record low in 2009 from the previously recorded ten-year time period (Dee et al., 2017). Potential reasons for the decline in pregnancy rates include a higher number of teens

opting not to have sexual intercourse and more knowledgeable use of contraceptives (Ahern & Bramlett, 2016). An increase in preventive measures such as sexual education, contraceptive use, and abstinence education further contributed to the decline in pregnancy rates (Dee et al., 2017; Holeness, 2015).

Multiple factors contribute to teen pregnancy statistics. Geographical location has shown to have an impact on teen pregnancy rates (Danawi et al., 2016). For instance, residents of southern states such as Georgia, which has the third-highest teen pregnancy rate in the country, report elevated incidents of teen pregnancy in comparison to northern states (Ahren & Bramlett, 2016; Hudgins et al., 2014). Culture, preventive measures, and educational opportunities regarding sexual education vary between the two regions and have shown to impact thoughts and ideologies regarding teen pregnancy **(**Danawi et al., 2016, Erickson & Walker, 2014).

Impact of Teen Parenting

Teenage parenting is a transformative experience for young women (Fernandes-Alcantara, 2018; Zanchi et al., 2016). Researchers have documented the adverse outcomes associated with teen parenting (Hodgkinson et al., 2014; Katz & McKinney, 2018; Taylor et al., 2019). The impact of young parenting is often far-reaching (Cox et al., 2019). Pregnant and parenting mothers are at a higher risk for poor health outcomes, lower educational attainment, increased unemployment, financial hardships, and less than favorable economic outcomes (Gubrima et al., 2016; Radcliff et al., 2018; Romero et al., 2016). Risk factors such as poverty, race, lower parental educational achievement levels, divorce, being raised in a single-parent household, exposure to trauma, or experiences of

family disruption that a person has during their formative years increase the probability rate of becoming a teen parent (Combs et al., 2018).

Despite the decline in teen pregnancy rates over the past 10 years, the African American community continues to experience higher teen pregnancy rates than other demographics (Romero, 2016). In comparison to White teens in the age demographic of 15–17, African American teen pregnancy rates are double the rates of their White counterparts (Dee et al., 2017). There are several contributing factors to higher teen pregnancy rates in the African American community. These factors include lower socioeconomic status, multiple pregnancies, and family cycles of teen parenting (Akela et al., 2015; Dee et al., 2017).

Becoming a teen parent creates challenges in vital areas of a teen's life. Emotionally, socially, culturally, and financially, teen parents must face increased responsibilities that developmentally they may be ill-prepared for (Zanchi et al., 2016). Teen parents may also face stigma as teen pregnancy deviates from cultural and social norms (Katz & McKinney, 2018). Stigma is a shame, negative mark, attitude, or stereotype that may be associated with a group of individuals (Butler-Barnes et al., 2018). Negative stigmas are often associated with parenting as a teenager (Katz et al., 2018), such as the perception of being impure, undesirable, or unwanted (Katz et al., 2018). Stigmatization makes it a challenge to be accepted by society (Jones et al., 2019). Feelings of stigmatization can lead to isolation due to perceived or actual negative views that teen mothers experience (Katz & Mckinney, 2018).

Culture has an impact on teen parenting experiences. Cultural issues continue to arise as teen mothers report a loss of community, changes in friendship dynamics, social isolation, and stigmatization once they became parents (Radcliff et al., 2018; Tang et al., 2014). Adolescent mothers report elevated incidents of isolation and exclusion from peer groups (Ashby et al., 2016; Katz & Mckinney, 2018). The negative impact of teen parenting can decrease when the teen has access to needed resources along with social and emotional support (Radcliff, 2018; Whitworth, 2017). Having the support of family and friends during one's formative years is a vital component of healthy emotional well-being and overcoming obstacles faced by teen parents (Radcliff, 2018).

Having a child is the primary reason adolescent females do not finish high school (Gul & Russo, 2016). Only 50% of teen mothers will graduate from high school in comparison to 90% of their non parenting peers (Gul et al., 2016). Adolescent mothers have lower rates of school attendance and experience lower educational attainment (Dowden et al., 2018; Radcliff et al., 2018). Adolescent parenting is also associated with a loss of educational opportunities in the future, such as college or career training opportunities post-high school (Tanner & Tanner, 2020). Teen parents report a decrease in academic aspirations after becoming parents (Schulkind & Sandler, 2019; Tanner et al., 2020). Teen parenting decreases the likelihood of attending college, and less than 2% of teen mothers will complete their college education before the age of 30 (Combs et al., 2018).

The United States Supreme Court recognizes the importance of state and local education agencies in providing educational protection for pregnant and parenting teens

under Title IX of the Education Amendments of 1972 (Tanner et al., 2020). Teen parents' rights to education must be acknowledged, and proper support systems should be put in place to help parent students succeed (Tanner et al., 2017; Whitworth, 2017). When provided with appropriate educational resources and a reliable support system, teen mothers showed an increase in graduation rates (Rose et al., 2017). A reliable support system helps students who excelled pre-pregnancy maintain their academic performance level; as Erdmands and Black (2015) found, these students have higher rates of high school completion.

Teen parenting creates economic costs for taxpayers. Not only does teen pregnancy impact society, but it creates economic hardships for the teen parent as well (Schulkind & Sandler, 2019). 60% of adolescent mothers will utilize government assistance to provide for their children within their first year of life (Fernandes-Alcantara, 2018). Many teens do not possess the skill set to produce an income that will offset the cost of parenting.

A strong correlation between adolescent parenting and economic hardships exists (Schulkind et al., 2019). Teen mothers living in low socioeconomic status environments face financial hardships (Schulkind & Sandler, 2019; Smith et al., 2018). Creating a substantial income may be difficult due to the economic strain associated with parenting and nonexistent or low-income wages of teen mothers (Dobbins et al., 2016). Mothers whose income is either at or below the poverty level and who reside in low-income areas experience family instability, higher crime rates, exposure to trauma, and are at a higher

risk for subsequent pregnancies, which creates further economic distress (Smith et al., 2018).

When teens become parents, fiscal responsibility is usually taken on by others. Because of the difficulty in supporting themselves, teen parents often find themselves financially dependent on their families (Carlson, 2016; Zanchi et al., 2016). Financial support is critical during the transition from teen parenting to adulthood because most teens do not possess the skill set to obtain employment (Combs et al., 2018; Romero et al., 2016). Findings from one study showed that 63% of teens who did not live with their parents lived in poverty as opposed to 34% of those who lived with and received financial support from their families (Combs et al., 2018).

Financial assistance is available for parents in need. Government programs are available to teen mothers but carry a negative connotation in the community due to the perception that it may foster a dependency on government assistance (Combs et al., 2018; Tanner et al., 2020). Becoming dependent on government housing and other assistance may force teen parents to live in low socioeconomic status environments (Smith et al., 2018). Within the first year of teens becoming parents, more than 60% of these individuals will receive government assistance (Tanner et al., 2020).

Mental Health and Teen Parenting

The need for mental health services and associated costs has continuously increased over the past five years (Piers et al., 2013). In 2009 the Institute of Medicine estimated cost associated with mental health at 247 billion dollars (Schurer et al., 2017). Over a 12-month period, more than 61.5 million Americans experience mental health

concerns, with less than half of these individuals following through with treatment (Kim et al., 2017). Disparities among ethnic and racial groups exist as it pertains to mental health concerns and help-seeking behaviors (Kim, 2017).

Mental health-related issues among teenagers in the United States is a growing public health concern. One out of five youth in the United States has a diagnosable mental health disorder (Graves, 2017). For youth aged 10-19, depression is one of the top disabilities in the United States, and suicide is the third major cause of death (Lu, 2019; Woods-Giscombe et al., 2016). Teen pregnancy issues further complicate mental health concerns. Reported levels of trauma, depression, and anxiety are higher for parenting teens (Ashby et al., 2016). Adolescent mothers report more incidents of mental health concerns than other teens their age who are not parenting (Ashby et al., 2016). Because young mothers are a vulnerable and often underserved population in need of specialized interventions created by the impact of teen parenting, mental health is an area of vital concern regarding teen pregnancy (Breslau et al., 2017; Burrus, 2018).

Parenting teens have unique mental health needs. From a medical and psychological perspective, this demographic's needs vary and are more complicated as they experience biopsychosocial and biological changes along with the added stress of pregnancy and parenting (Ashby et al., 2019; Fernandes, 2017). During adolescent pregnancy, screenings for depression and other mental health disorders are standard practice and can become an issue for the teen parent if left untreated (Ahern & Bramlett, 2016). More than 400,000 teens give birth in the United States, and more than half of these individuals show signs of depression (Logsdon et al., 2018). Teen mothers have

shown a higher incidence of both antenatal and postpartum depression (Harrison et al., 2017).

A correlation between adolescent pregnancy, parenting, poverty, and mental health also exists. Individuals who reside in poverty for extended periods are more likely to experience mental health issues, are less likely to seek assistance, and may encounter barriers when attempting to access services. (Chang et al., 2016; Graves, 2017; Radcliff, 2018; Smith et al., 2018). The income level of families is associated with specific mental health diagnoses, such as higher rates of depression, social withdrawal, and attention deficit hyperactive disorder (Graves, 2017). Of individuals referred for mental health services, less than 25% sought the recommended treatment or further evaluation of the condition (Logsdon et al., 2018).

Adolescents from all demographics continue to show low utilization rates of mental health services (Richardson et al., 2016). The underutilization of mental health services in the community is well documented (Chang et al., 2016; Shepherd et al., 2018). Overall, mental health underutilization rates remain high (Hatcher et al., 2017). Despite strides in mental health, pregnant and parenting mothers are still experiencing challenges when it comes to obtaining services (Richardson et al., 2016). Teens often feel as if their mental health needs are not understood or go unmet (Muzik et al., 2016).

Barriers to Mental Health Services During Parenting

Obtaining necessary mental health services can be challenging (Ashby et al., 2019; Shepherd et al., 2018). Disparities in mental health utilization continue to persist in the United States (Brewer & Williams, 2019). Several recurring themes serve as barriers

to individuals seeking mental health treatment in the African American community (Anderson et al., 2018; Chang et al., 2016; Fripp et al., 2017). These barriers include racial disparities, transportation, stigma regarding mental health treatment, religious and spiritual views, availability of services, geographical location, support of the family, community, competency of the therapist, and mistrust of mental health professionals (Campbell-Grossman et al., 2016; Chang et al., 2016; Fripp et al., 2017; Planey et al., 2019). Young mothers have the responsibility of parenting while trying to overcome these barriers.

Teens who enroll in mental health services report lower attendance rates when it comes to mental health counseling and other associated services (Ashby et al., 2019). If appointments are not offered later in the afternoon once they have left school or on the weekends, the likely hood of attending sessions decreased (Ofonedu et al., 2017). Negative personal past experiences or knowledge of someone else's negative experiences associated with the therapeutic process served as barriers to help-seeking behaviors (Ashby et al., 2017). Negative past experiences of parents, other family members, and friends have shown to have an impact on how individuals view mental health services (Graves, 2017).

Financial concerns can serve as a barrier to treatment. African Americans living in low-socioeconomic status environments are less likely than European American, middle-class individuals to seek mental health services (Ofonedu et al., 2017). Financial concerns correlate with low levels of mental health utilization (Burrus, 2018). Mental health services and associated out-of-pocket costs can create financial strain (Graves,

2017). Not having insurance or being underinsured is a recurring theme in the teen mother demographic (Graves, 2017). Due to financial issues, teens of families residing in low-income areas report lower mental health utilization rates (Alzate et al., 2018; Burrus, 2018). Teen mothers may have access to necessary mental health services in their areas, but income barriers serve as a deterrent (Graves, 2017).

Stigmas surrounding mental health services prevent individuals in need from enlisting the assistance of mental health professionals (Ashby et al., 2019; Chang et al., 2016). Participation in services can be associated with weakness in the African American community (Neely-Fairbanks et al., 2018). Additional reasons as to why African Americans teens do not participate in mental health services include humiliation amongst peer groups or the fear of bringing shame to their family due to the negative association with mental health participation (Neely-Fairbanks et al., 2018). Creating an environment that addresses shame and negative attitudes can help to normalize the counseling experiences for teens and potentially increase utilization rates (Chang et al., 2016; Neely-Fairbanks et al., 2018).

Cultural beliefs, such as religion and spirituality, have a substantial impact on an individual's decision to seek mental health services (Neely-Fairbanks et al., 2018). Mothers need reliable support systems. Religious communities are significant because they can provide additional social support for teen mothers by creating bonds through socializing with the church community and other youth group participants (Makanui et al., 2018). Bonding with church members has shown to increase positive interaction that can help to support youth members during times of difficulties or life challenges

(Makanui et al., 2018). There is a strong correlation between good mental health and individuals who implemented spiritual practices or used related religious support as a part of the mental health process (Neely-Fairbanks et al., 2018). For teens who may be suffering from social isolating due to parenting, their church community is a haven (Makanui et al., 2018).

The relationship between the health care professional and the client is essential. Minorities report mistrust with government entities and doubt their cultural competency (Ashby et al., 2016). Teens report a distrust of those in authoritative positions such as healthcare, government, and social service providers; the fear was a barrier to teens participating in mental health services (Muzik et al., 2016). Building a sense of trust is vital in the therapeutic relationship when dealing with minorities (Ashby et al., 2019).

The concern of confidentiality breaches create fear and serves as a barrier to seeking help (Shepherd et al., 2018). Fear of being reported to government entities such as the Department of Family and Children Services can create a sense of fear when discussing personal issues during therapy. This fear can come from experiences from their friends or other family members had with government employees. Mental health professionals, such as caseworkers and counselors, are considered a part of this network. Fears of mandated reporting practices by clinicians and repeated negative mental health experiences, that individuals had themselves or the experiences of someone they know present as barriers to the therapeutic process (Ofonedu et al., 2017)**.**

Some mothers report feeling judged, felt a lack of support, and perceived ambivalence from their doctors and other health care professionals (Ashby et al., 2018;

Ofonedu et al., 2017). Patients' wanted health professionals to treat them with compassion and respect and for their providers to remain attentive throughout their appointment (Cuevas et al., 2017; Harrison et al., 2017). Patients may not return for additional services if these conditions are not met. Patients are also less likely to return to dominant or less patient-centered healthcare providers (Cuevas et al., 2017; Harrison et al., 2017). Therefore, it is necessary to understand the client and their experiences during the therapeutic process (Cuevas et al., 2017).

Summary

Young mothers have unique needs from a psychological perspective, and treatment can be complicated (Ashby, 2016; Hatcher et al., 2017). Teen mothers are a vulnerable and often underserved population in need of specialized interventions due to the emotional, social, and economic impact of teen parenting (Alzate et al., 2018; Burrus, 2018; Fernandes et al., 2017). The literature review provided valuable insights regarding teen pregnancy issues and the underutilization of mental health services among teen mothers. Mental health services are available to young mothers, but many mothers do not utilize or underutilize services. However, there is a demographic of teen mothers who overcame barriers and challenges to obtain mental health services while parenting. The current research seeks to understand the experiences of mothers who overcame numerous barriers to obtaining vital mental health services while parenting.

A gap in the literature exists as it relates to understanding the experiences of mothers seeking mental health services, and more studies are needed to document their experiences. This study is significant to the field of mental health. It seeks to identify

how teen and young mothers describe their experiences with the utilization of mental health services while parenting and how these experiences impact mental healthcare services utilization. By understanding this specialized demographic's experiences, professionals can begin to offer the type of care that is needed.

A review of the current literature confirmed a significant underuse of mental health services. During the parenting years, there is an increased need for mental health services due to the stressors of becoming a parent. One of the major themes identified was the numerous barriers mothers must overcome to participate in mental health services. This study sought to explore the experiences of mothers who participated in mental health treatment services during their teen years to add to the current body of literature.

Chapter 3: Research Method

This generic qualitative study explored the perception and experiences of pregnant and parenting teen and young mothers as it relates to the utilization of mental health services. The existing body of literature indicated that low utilization rates exist among teen mothers despite the documented need for mental health services (Dumas et al., 2018; Kawaii-Bogue, 2017; Laurenzi et al., 2020; Lucas et al., 2019). Discussion of the research design and the rationale for the study is included in Chapter 3. The chapter also discussed the research methodology, participants, sampling, data collection procedures, and analyses. Trustworthiness and ethical procedures are also reviewed.

Research Design and Rationale

The nature of the study was a generic qualitative approach because it aids in identifying and analyzing subjective experiences through data interpretation (Akella & Jordan, 2015). Qualitative research is appropriate for understanding how individuals give meaning to their experiences and how they construct their world (Kahlke, 2014). Qualitative studies are conducted to gain insight and knowledge about subjective experiences, attitudes, perceptions, or phenomena, which allowed the research question to be answered from the interviewee's vantage point (DeJonckheere & Vaughn, 2019; Kalman, 2019; Sutton, 2015). The following research question served as a basis for the study: How do former pregnant or parenting teen and young mothers describe their experiences of utilizing mental health services? Understanding others' historical experiences made the generic qualitative method an appropriate methodology for exploring the topic (Percy et al., 2015). Qualitative descriptive studies are most often

used to answer questions related to health care services (Kim et al., 2017). Understanding the impact of those experiences and using this knowledge to explain participants' subjective experiences is vital to the qualitative research approach (Kim et al., 2017; Teherani et al., 2015).

Additional designs considered for the study included phenomenological, narrative, case study, and grounded theory. Phenomenological studies are used to understand others' lived experiences (Teherani et al., 2015). The difference between the generic qualitative and phenomenological studies is that the objective of phenomenological studies is to gain insight into the participants' shared experiences. In contrast, generic qualitative studies focus on the participants' individualized experiences (Kennedy, 2016). In terms of generalizability, phenomenological studies can be challenging to replicate in larger populations (Teherani et al., 2015).

Narrative and case studies share similarities in understanding others' experiences by analyzing stories (Percy et al., 2015). Narrative studies examine the personal life stories of participants to gain insight (Butina, 2015). Like phenomenological studies, narrative and case studies focus on the individual (Roberts et al., 2019). Narrative and case studies have a smaller number of participants (Butina, 2015). A case study can have a single participant (Percy et al., 2015).

Grounded theory is used when the amount of information on a particular topic is limited, and the researcher seeks to develop a hypothesis or theory (Kennedy, 2016; McCrae & Purssell, 2016). This approach allows for the development of theoretical models (McCrae & Purssell, 2016). Though there is a need for additional research

regarding the lived experiences of pregnant and parenting teens related to mental health, the body of literature is vast. The current study did not seek to develop a new hypothesis or theory. The generic qualitative model was a better selection for attempting to understand the experiences of teen and young mothers.

Role of the Researcher

My personal experience working in mental health and with teen mothers led to my interest in this topic area. I am a licensed professional counselor, and I have experience working as a group facilitator for at-risk teens in several school systems in Georgia. Through my various roles in the mental health field and school systems, I observed the challenges many teens faced, such as access to mental health care services, financial, academic, and emotional issues. Numerous teens I encountered expressed a need or a desire for mental health services. Due to barriers, some teens mothers were unable to obtain services. Identified barriers included negative past experiences with counselors, location of services, availability of hours to accommodate the needs of teen parents, religious beliefs, and cultural competency concerns of mental health service providers (Chang et al., 2016; Graves, 2017; Radcliff 2018; Smith et al., 2018). I wanted to further explore this topic to better understand how individual experiences can influence one's decision to seek mental health counseling during their teen parenting years.

The role of the researcher is critical in qualitative studies (Attia & Edge, 2017). The researcher conducting the study is considered the primary instrument since they are responsible for conducting the interviews and analyzing data (Clark & Veale' et al., 2018). The researcher's additional tasks included collecting and interpreting data,

performing the analysis, and identifying and managing one's personal beliefs and values systems (Karagiozois, 2018). Part of my role as the researcher was to work directly with the study participants during the individual semi-structured interviews (Attia & Edge, 2017). Researchers are assigned the tasks of constructing interview questions (Fleet et al., 2018). The questions' design allows for reanalyzing as needed (Clark & Veale' et al., 2018). As the researcher in the study, I had more than one role. My tasks included constructing the interview questions, conducting the interviews, and analyzing the data. There were no personal or professional relationship between me and the study participants.

Researcher Bias

When an individual has more than one role in a research study, this can create ethical concerns (Clark & Veale, 2018). Since I conducted the interviews, I needed to be aware of my biases. Primary concerns of dual roles in research include researcher biases and discrimination (Fleet et al., 2016; Karagiozois, 2018). Several types of discrimination can lead to biases based on age, color, culture, physical or mental disabilities, gender, and spirituality (Attia & Edge, 2017; Karagiozois, 2018). Awareness of biases is necessary during the research process (Clark & Veale, 2018). If the researcher realizes biases are present, they should be continuously challenged during the process (Baksh, 2018). Biases need acknowledgment and processing to prevent potential discrimination within the study (Karagiozois, 2018). Bracketing is a way of acknowledging persona biases about the research topic (Baksh, 2018). I used a journal during the interview process and during the 10-minute reflection following the interview to write down any biases that may have

come up. To control for biases, member checking, a peer review of my findings, and a field test by having my chair review the initial interview transcript and audio was conducted.

To decrease biases, I also focused on the client, and biased wording was not utilized (Thurairajah & Przeglad, 2019). Due to the potentially sensitive nature of interview questions associated with qualitative interviews, each participant was treated professionally, showing kindness, empathy, compassion, and respect (DeJonckheere & Vaughn, 2018). The participant's best interest needs to be considered during the research and interview processes (Thurairajah & Przeglad, 2019). I did not ask leading questions during the interviews. Researchers should not look for information to confirm their personal beliefs during the interview process to prevent confirmation bias (Fleet et al., 2016). I also did not deviate from the preapproved questions during the interview process to maintain the model's fidelity and eliminate biases (DeJonckheee & Vaughn, 2019). An additional part of conducting an unbiased study includes setting healthy boundaries and maintaining these boundaries throughout the research and interview process (Thurairajah & Przeglad, 2019).

Methodology

Participation Logic

The target population for this study was formerly pregnant or parenting teen mothers. Participants had to be fluent in English and residents of the United States. As part of the inclusion criteria, participants must have treatment-seeking experiences while pregnant or parenting as a teen. Former teen mothers between the ages of 18–24 was

selected as the study's focus due to the high number of teen pregnancies and low mental health utilization rates. Teen mothers under the age of 18 were excluded from the study. When considering the age criteria, it was assumed that women within this age demographic could provide meaningful content by describing their experiences as teen mothers (Weis & Willems, 2017). There is a period of transition from the teen years into young adulthood (Jones, Whitfield, Seymour & Hayter, 2019). Extending the age demographic to 24 allows young adult mothers to recall and describe their experiences in a meaningful and reflective manner (Weis & Willems, 2017). The age demographic reflects the mothers' racial and ethnic diversity (Weis & Willems, 2017). However, after several months of attempting to recruit participants, I asked the IRB for permission to change the age criteria. At this point, permission was granted, and the age demographic was changed to mothers between 18–30.

Sampling Strategy

Study participants were recruited through social media platforms. Purposive (or purposeful) and snowball sampling were the selected recruitment strategies. In qualitative research, when studying a particular phenomenon or area of interest, purposive sampling is frequently utilized based on the researcher's ability to select participants who have had experiences related to a particular subject matter (Palinkas, 2015). For this reason, the sampling strategy is also referred to as judgment sampling since the researcher decides which participants will be selected to participate in the study (Palinkas, 2015). In purposive sampling, the participants must be willing to participate in the study, be open, and be forthcoming. The demographic must possess the ability to articulate their

experiences and feelings expressively (Pelikas et al., 2015). The sampling method increases validity and efficiency (Pelikas et al., 2015). Reflexively was used to identify the phenomenon's similarities and differences.

Sample Size

Multiple participants were needed for the study to achieve saturation (Kim et al., 2017). Studies suggest that saturation is more likely to occur when a larger group of participants (Roberts et al., 2019). The current study allowed for six–12 participants, serving as the reason narrative and case studies were not the best options. The typical group size for grounded studies can range from 20 to 60 participants (McCrae & Purssell, 2016). A population of this size is too large for the current study. Sample sizes used for qualitative studies are smaller than those of quantitative studies **(**Korstjens & Moser, 2018). In the selected study design, a smaller number of participants is adequate to obtain vital information due to the personalized nature of the interview style and detailed information obtained through the interview process (Vasileiou et al., 2018). However, sample sizes must include enough participants to examine the phenomenon (Morse, 2015). The study's sample size was intended have a minimum of eight participants, with a maximum limit of 12 or until saturation was achieved (Roberts et al., 2019). Saturation was achieved at eight participants. Replication of information or themes begin to reoccur within the interview process once saturation has been reached (Rijnsoever, 2017). The identifying of recurring themes helps the researcher gain insight and understanding of the phenomenon (Morse, 2015).

Instrumentation

Semi-structured interviews were the primary data collection method for the study. I developed the interview protocol. This interview process provided essential insights and gives voice to the experiences of former teen mothers. The informal conversational approach is used to aid in engaging participants in the conversation. Open-ended questions were used to promote interactive conversations. The structure of open-ended questions presents participants with the opportunity to discuss their feelings and attitudes. Through open-ended questions, additional data, insight, and details are obtained, and response error decreases (DeJonckheere & Vaughn, 2019; Fleet et al., 2016). In the semi-structured interview format, the researcher must possess the ability to make the interviewee feel comfortable enough to divulge personal information while keeping them on task during the process (Rijnsoever, 2017).

Data Collection

Approval from the IRB must be obtained before the research process can begin to maintain compliance with Walden University's ethics and regulations. Once approval from the IRB and Walden committee was granted (approval no. 10-29-21-0592842), the recruitment process began. The study's desired population were recruited via promotional flyers (see Appendix B) and ads posted on Facebook, Instagram, and LinkedIn. Public groups on social media platforms, including the participant demographic, were contacted through their administrator. I obtained permission to post the flyers in their group as part of the recruitment process. My contact information was provided to the interested parties. Additional recruitment methods for participants included snowball sampling. Interested

parties participated in a prescreening survey conducted online. The screening process was used to help identify the eligibility of interested study participants.

During the recruitment process, I adhered to informed consent practices. Study participants were provided with and asked to sign written informed consent in which they were advised in writing about any potential risks and benefits of participating in the study (Nusbaum et al., 2016). Participants must have provided consent for audio and video recordings. The interviews were recorded with the knowledge and written consent of participation. Once eligibility was confirmed, the informed consent forms were provided for the participants via email. After the consent forms were signed and returned to me, the interviews were scheduled. A one-time interview of 60-90 minutes on Zoom video conferencing or phone interview was conducted. A transcribed pdf copy of the interview was provided to the participants for member checking and verification.

The researcher's interviewing skills will directly impact the quality of the data (McMahon & Winch, 2018). The duration of each interview required a minimum of 60 minutes but did not exceed 90 minutes. An audio recording device was utilized in the data collection process. During the interview, I worked to establish a rapport with the participant. The demographic questionnaire was completed during this time. I did not deviate from the preapproved interview questions. After the interview was complete, any follow-up questions were answered. This process was repeated for each participant. If the number of study participants was too low, then the recruitment process was repeated until saturation was achieved.

Before closing out the interview, a wellness check was conducted. If the participant was experiencing any emotional distress, information for low-cost follow- up counseling services was provided. I provided a Word Document containing a list of clinicians in the area that offer low-cost services. I also provided participants with the website information to Psychology Today. Through utilizing Psychology Today, the participants can select a clinician of their choice if they would not like to use a clinician on the preprinted list. The participant had the option of choosing a therapist that provides low-cost sessions from the Psychology Today website.

Due to recent concerns related to Covid-19, virtual interviews were conducted via Zoom. To ensure confidentiality, I conducted the interview in a private location while videoconferencing. Participants were required to utilize a private location, as well. Flexibility was provided with dates and times considering the barriers participants may face regarding childcare or other parenting responsibilities. To ensure confidentiality, participants were provided with a code and referred to as Respondent 1, 2, 3, etc.

Debriefing After the Interview

Once the interview process was complete, the debriefing process began. Debriefing is an essential component of the research process (McMahon & Winch, 2018). I reviewed the intended purpose of the study. Participants were allowed to express their feelings and ask questions during the process (McMahon & Winch, 2018). Participation in qualitative research interviews can potentially cause problematic, upsetting, or confusing emotions (Nusbaum et al., 2016).

If the participant experienced any negative emotions, referrals for licensed mental health professionals offering sliding scale pricing options was available. Providing professional counseling references allowed participants to seek professional help once the interview process is complete if needed. To thank each participant for their participation, a $10.00 gift card was provided upon completing the interview. My chair was provided with an audio recording and transcription of the first interview as a field test for accuracy.

Transcription

The interview was audio recorded via the use of a handheld recorder. Once the interviews were complete, the audio recordings were used to transcribe the interviews. Copies of the transcripts were available for committee members and study participants. Member checking was utilized to ensure the trustworthiness and validity of the transcribed information (Amankwaa, 2016).

The pandemic presented challenges with the interview process. Before the pandemic, the interviews were going to be conducted face-to-face in a secure office setting. Due to safety concerns, the interview format was changed to an online platform or phone interview. This format presented its own unique challenges. Privacy concerns regarding the participant's selected interview space served as a challenge. The participants needed to ensure they were in a private area, free from distractions. Internet connection speed was another area of concern. Poor internet connections caused the video to disconnect, lag time, or freeze during the interview. This is an area that I addressed before beginning the interview. If the participant was disconnected from the call, they were instructed to log in again to complete the interview. No video recording

was taken via Zoom. I obtained consent for audio recording prior to the start of the interview via informed consent.

Each participant was allowed to review, confirm, clarify, or make corrections to the transcript's information within a 72-hour time period**.** Participants were emailed a password-protected interview transcript via pdf. Hard copies of the transcripts, along with audio recordings, will be kept on a password-protected external hard drive. The hard drive will be locked in a safe for a period of 5 years. The values coding method was utilized to analyze the data.

Data Analysis Plan

After the respondents confirmed the transcribed data's accuracy, the organization of the information and data analysis began. Preliminary coding was used to identify broad themes in the data using Colazzi's method. Seven steps have been outlined using the approach (Wirihana et al.,2018). Due to the nature of the study, using standard methods of data analysis were not appropriate since measurements, such as beliefs, rationale, opinions, and meaning, are explored through the qualitative research design and are not quantifiable (Kalman 2019).

The data obtained from the interview were further interpreted using line-by-line coding and reviewed for recurring patterns and themes, salient themes, and similarities in verbiage (Fleet et al., 2016; Kalman, 2019). These themes were coded and organized into categories and subcategories (Fleet et al., 2016; Williams & Moser, 2019). Placing the data into categories allowed for the identification of themes (Kalman 2019). The data was

placed into a Microsoft Excel spreadsheet and categorized according to the common themes, codes, and similar patterns.

Issues of Trustworthiness

Trustworthiness is used to ensure the quality or validity of a study (Connelly, 2016). Lincoln and Guba's framework is used as a guide to establish trustworthiness within the study (Korstjens & Moser, 2018). Per Lincoln and Guba's framework, credibility, transferability, dependability, confirmability, and reflexivity standards need to be met (Amankwaa, 2016; Connelly, 2016). The participant's original data interpretation must be accurate and truthful (Korstjens & Moser, 2018). When working to ensure trustworthiness, credibility must be considered (Connelly, 2016). Continuous observation and member checking was used to establish credibility.

Credibility

Credibility is equivalent to internal validity in quantitative studies and seeks to identify if research findings are accurate and truthful (Korstjens & Moser, 2018). To ensure validity, credibility, and transferability, member checking was implemented (Amankwaa, 2016). Member checking, also known as respondent validation, is utilized in qualitative research to verify the provided data (Birt et al., 2016). Continuous observation and member checking was used to establish credibility. During the interview process, I paraphrased, restated, or summarized the provided information (Amankwaa, 2016; Korstjens & Moser, 2018). Summarizing the information allows the participant to correct, agree, disagree, or clarify the provided information that allows for quality control (Korstjens & Moser, 2018). The transcripts were presented to the study participants as a

Microsoft Word document via email. Participants were allotted 72 hours to make corrections to the transcribed information.

Transferability

Transferability occurs when the study findings can be applied to individuals or groups in different settings. The process aids in identifying if the study findings yield an accurate representation of the explored phenomenon (Connelly, 2016). Transferability is achieved through the variation in the participant selection (Amankwaa, 2016). I accomplished transferability by providing a thick, rich description of the study participants, the setting, and their experiences (Korstjens & Moser, 2018). Providing a detailed description of the study participants, the environment, and their experiences allowed for accurate replication of the study.

Dependability

Dependability is achieved when the study findings are consistent and trustworthy (Korstjens & Moser, 2018). When a study is dependable, researchers should be able to replicate the study and find similar data (Birt et al., 2016). When working to establish dependability, the researcher's accuracy is imperative throughout the qualitative process (McMahon & Winch, 2018). During the analysis process, I clearly described the interview process. Regarding the data, I outlined the development process of the codes and categories. An audit trail was developed to ensure each step of the research process is accurately documented. Detailed information via the audit trail allowed for more accurate replication of the study (Korstjens & Moser, 2018).

Confirmability

Confirmability occurs when other researchers can confirm research findings (Birt et al., 2016). Research findings cannot be derived from the researcher's interpretation but must be grounded in the data (Birt et al., 2016; Korstjens & Moser, 2018). As part of the quality control process, member checking helps establish confirmability (Birt et al., 2016). Other methods of establishing confirmability may include prolonged exposure with the audit trail's data and production, persistent observation, triangulation, and member checking (Korstjens & Moser, 2018). To establish confirmability, I used member checking and an audit trail. As part of the audit trail, when working to identify themes, raw quotes were provided to establish confirmability, credibility, and authenticity during the data interpretation process.

Reflexivity

Reflexivity examines how the researcher's biases could potentially impact the study or how it will impact the researcher (Fleet et al., 2016). Researchers use reflexivity to ensure that the study outcomes are not inadvertently impacted by the researcher's thoughts, beliefs, or personal biases (Thurairajah et al., 2019). A 10-minute break was taken after each interview to prevent reflexivity. This process allows the researcher the opportunity to journal. Journaling strategies were used as a form of debriefing and can be utilized as a prospective or retrospective reflexivity activity (Attia & Edge, 2017; Fleet et al., 2016). In addition to journaling, bracketing is an additional method of eliminating biases in a study, the impact of any preconceived notions, and personal ideologies held by

the researcher (Baksh, 2018). A hard copy journal was available immediately following the interviews, data transcription, and analysis processes.

Ethical Procedures

Approval from my Walden University dissertation committee and the Walden IRB were obtained before conducting any portion of the research. The primary function of the IRB is to regulate scientific research on human subjects and to ensure the protection of their rights (Slovin & Semenec, 2019). The researcher's responsibility is to outline how the research will be executed and specific measures to ensure the participants' ethical treatment of the participants (Slovin & Semenec, 2019).

The interviews took place via Zoom Videoconferencing or via phone. Before the interview transpired, signed informed consent was obtained and reviewed. Participants were advised that some questions may be personal or may lead to an emotional response. Participants were advised of their right to decline to answer or come back to answer questions later in the interview, without consequence. Upon completion of the interview, I debriefed each participant. Contact information for licensed mental health professionals was readily available for all participants. Some individuals may have needed assistance in processing their emotions once the interview is complete. A therapist within the community who charges on a sliding scale was included on the list to ensure that financial status was not a deterrent for assistance.

Several measures ensured that the use of technology did not compromise the protection of the participant's personal information. Participants were provided with a code and referred to as Respondent, 1, 2, 3, etc. Storage of the coding information was on

an encrypted external hard drive. All supporting research documentation will remain in a secured filing cabinet via lock and key when not in use. Storage of the information will be for a 5-year time period upon completion of the dissertation. After the 5 years, the information will be destroyed. All paper records will be destroyed via use of a shredder. Files stored on the hard drive will be deleted via the drive-wiping software program called CBL Data Shredder.

Summary

Chapter 3 outlined the research and design rationale used for the study, the researcher's role, and its ethical considerations. The chapter also included the methodology and data collection. Analysis of the data, identification of recurring themes and patterns will help understand the experiences of the mothers who utilized mental health services. Chapter 4 will provide an analysis of the interview results.

Chapter 4: Results

The purpose of the study was to explore the perception and experiences of pregnant and parenting mothers regarding the utilization of mental health services, which the research question was designed to answer. Utilization rates for this demographic remain low despite the documented need for assistance. Parenting as a teen or young mother can have long-term psychological, social, physical, and economic effects. SLT was used as the framework for the research. A generic qualitative approach was used to conduct the study. The experiences of young mothers were explored through one-on-one personal interviews. There was a total of eight participants in the study. Chapter 4 will explore the setting, demographics, data collection, and analysis process, the results, and a summary.

Setting

Due to COVID-19, no face-to-face interviews were administered. Instead, the interviews were conducted via phone or Zoom. The Zoom platform was not used for any audio or visual recordings. However, all interviews were audio recorded via a handheld recorder with the participant's consent for data transcribing and coding purposes. I conducted the interviews in a closed office, free from distractions. Before the start of the interview, the participants were encouraged to select a quiet and secure location. Based on the interview order, the participants were referred to as Participants 1, 2, 3, etc.

A four-question presurvey was used to ensure participant qualification and is located in the demographic section of Appendix A. The actual interview contained 17 questions that the IRB preapproved. Probing questions were asked as needed. I would

repeat the content provided by the participant to ensure clarity. The final question was open-ended, allowing the participant to divulge any additional information about their experiences that would have been pertinent to the study.

Unforeseen conditions may have influenced the participants' experience during the interviews. For example, unanticipated interruptions in the participant setting were noted during two of the interviews. The interruptions included the baby of the participant crying and a family member entering the space to ask a question. Another noted disruption was a momentary pause due to technical difficulties with the Internet connection.

Demographics

While dealing with a marginalized population, the recruitment process was challenging. The age demographic for the study was initially 18–24. Another qualifying participation factor included mental health services while pregnant or parenting. Due to recruiting challenges, the IRB granted me permission to adjust the age demographic. At that time, the qualifying age limit for the study was increased from 24 to 30. Despite the difference in the initial age requirement, the input provided by the older mothers regarding their experience was a vital component of the study. They provided critical information about their experiences with mental health services, clinician relationships, and barriers to obtaining services. Purposive sampling was used as part of the recruiting process. Once participants were recruited, the snowballing method was utilized to find additional interviewees.

All the study participants were African American females residing in the state of Georgia. Three out of the eight participants attended therapy while pregnant. Two out of the eight mothers began services after the premature births of their children. Five of the study participants attended therapy while parenting. Two participants were pregnant as teens, but one of them did not participate in treatment until she was in her early 20s. Each participant was either pregnant or only had one child during treatment. The participant demographics are outlined in Table 1.

Table 1

Interviewee Demographic Age, Ethnicity, and Pregnant or Parenting Status

Participants	Ethnicity	Age	Number of Children	Pregnant or parenting during therapy
Participant 1	African American	19	1	Pregnant
Participant 2	African American	24	0	Pregnant
Participant 3	African American	27	1	Parenting
Participant 4	African American	25	1	Parenting
Participant 5	African American	22	1	Parenting
Participant 6	African American	20	1	Parenting
Participant 7	African American	23	1	Parenting
Participant 8	African American	28	1	Pregnant

Data Collection

Besides changing the initial age requirement for participation, additional changes were made to the recruitment process. A poster was created and posted to the social media outlets LinkedIn, Facebook, and Instagram. Approval was obtained from the IRB to reach out to local parenting organizations. I asked the agency director to share the flyers on their social media outlets to help with recruitment. I did not ask the agencies to encourage participation in the study. The use of the app, Next Door was approved as an

additional recruiting method. There were no other noted variations in the data collection process.

The final number of participants in the study was eight. Each participant answered prescreening questions to ensure qualifications for study participation. Informed consent was reviewed at this time. Consent forms were emailed to the participants before the start of the interview. Once the documentation was read, participants responded to the email with the words “I accept” to take the place of a physical signature due to COVID restrictions. Any questions about the interview or research process were answered during the initial call. Each participant was provided with the name of a therapist in case their participation in the study created any emotional distress. In addition, the information for a clinician offering a sliding scale was provided to help alleviate any concerns related to the cost of therapy.

Per IRB compliance, the interviews were audio recorded only. A handheld recording device was utilized. The data was transcribed and placed in a Microsoft Word document. Upon completion, the audio recording was replayed. The transcripts were reread to ensure accuracy. Once this process was complete, the transcripts were sent to the participants via email. Once the transcripts were received, the participants were allowed to make necessary adjustments within 72 hours. Participants were instructed to email any needed changes to me. The length of time for each interview ranged from 20 to 35 minutes. The committee chair reviewed the first and second interviews to ensure accuracy and provide feedback.

Data Analysis

A file was created for each participant. The documentation was added to each file upon receipt. The informed consent documentation was placed in each corresponding file and the email consenting to participation. Next, the interview questions were added to the file, along with the answers obtained from the demographics section. After each interview, I reviewed the audio recording, and notes were created. The notes reflected how the interview process went, thoughts and feelings about the interview, and what was learned or observed during the interview process. Finally, the audio recordings, notes, and transcripts were added to the participant's file. Upon completion of this process, I worked on coding the transcribed data for each participant.

Colaizzi's seven-step method was used to code the data. First, the transcripts were read a minimum of two times to ensure a clear understanding of the content. Next, the statements, sentences, and relevant phrases provided by the participant, which had significant meaning to the research question, were extracted and placed in a table created using Microsoft Excel. Direct quotes from the participants were used in the coding process to help ensure accuracy and trustworthiness. Once this process was complete, the data was compiled and placed in categories.

The second iteration of coding was completed to ensure accuracy. The standard codes among participants were placed in a primary chart created using Microsoft Excel. A list was created for each participant to document the number of times a particular code was used. The frequency with which each code was used across all interviews was assessed and entered into the table to help with theme development. Standard connections

that answered the research question were identified while developing themes. Six codes emerged during the analysis process. The last step included a discussion with my chair and a presentation of the coded data before theme development. Common themes found among study participants are presented in Table 2.

Table 2

Codes, Categories, and Themes

Code	Definition	Category	Theme
Unintended pregnancy.	Pregnancy was not planned.	Reasons for entering therapy/treatment.	1.Unintended pregnancy and expression with finding out about pregnancy are reasons for seeking mental health services.
Depression when finding out about pregnancy.	Showing signs of depression when finding out about being pregnant.	Reasons for entering therapy/treatment.	
Emotional changes during pregnancy or while parenting.	Emotional and hormonal changes during pregnancy or while parenting.	Anxiety, stress, health concerns, and need for emotional support during pregnancy or while parenting.	2.Stress, anxiety, illnesses, and coping with stress are types of support sought through therapy.
Stressors and complications during pregnancy.	Preterm labor, potential birth defects, illnesses, and morning sickness.	Anxiety, stress, health concerns, and need for emotional support during pregnancy or while parenting.	
Anxiety during pregnancy.	Anxiety about caring for and/or financially supporting a child, becoming a new mother.	Anxiety, stress, health concerns, and need for emotional support during pregnancy or while parenting.	
Encouraging support system.	Family, friends, spouse, and therapist support the therapeutic process.	Support	3.Family, friends, and therapist are a part of the support network.
Normalization of therapy.	It is ok or normal to go to therapy.	Support	
Challenges finding a therapist.	Participants describe a barrier locating a therapist and finding one that was a good fit for their needs.	Barriers	4. Barriers to treatment include finding a therapist, insurance, finance, time, work schedule, health concerns, parenting, and understanding therapist qualifications.
Insurance and financial concerns.	Participants describe financial and insurance barriers to treatment.	Barriers	
Time/Work Bar	Participants describe barriers to treatment related to work schedule and timing.	Barriers	

(table continues)

Code	Definition	Category	Theme
Not understanding therapist qualifications.	Participants describe barriers to treatment related to understanding how qualified the therapist were. Some participants did not understand the post-nominal letters and how they related to the qualifications of the therapist.	Barriers	
Coping with change.	Participants entered therapy to cope with the changes brought on by parenting and/or becoming a mother.	Anxiety, stress, health concerns, and need for emotional support during pregnancy or while parenting.	
The positive impact of services in the areas of parenting and personal wellness.	Participants reported feeling that therapy helped them to become happier and better parents and increased overall happiness in their personal lives.	Positive outcomes from therapy in the areas of parenting and daily life.	5. Additional positive outcomes were seen as mothers felt they were becoming healthier, happier, better parents, and happier on an individual level.
Positive impact of mental health services post pregnancy.	Positive effects spread beyond just the pregnancy and into other aspects of her lives.	Positive outcomes from therapy in the areas of parenting and daily life	
Resources provided by therapist.	Parenting classes, interventions, support groups, financial resources, and interventions were provided by the therapist.	Positive experiences with resources/supplements provided by the therapist and the therapeutic relationship	6. Additional resources provided by the therapist and having an open relationship with the therapist were vital to the overall success of the participant.
Relationship with therapist.	Relationship with therapist described as open and trusting.	Positive experiences with resources/supplements provided by the therapist and the therapeutic relationship	

Evidence of Trustworthiness

Credibility

Credibility is used to determine if the study findings are accurate and true (Forero et al.2018). During the interview process, one method utilized to work on ensuring credibility was to paraphrase the information provided during the interview process. Paraphrasing allows the participant to correct or disagree with any information the interviewer may have misinterpreted. Member checking was an additional component that was used to ensure credibility. Member checking allows the 53 participants to verify the data and findings interpreted by the researcher (Stahl & King, 2020). All participants were emailed and asked to read through their copy of the transcribed data to ensure accuracy of the provided information. Additionally, saturation was achieved after the fifth interview. Saturation occurs when no new data are found (Fofana et al., 2020). Three additional interviews were conducted to help solidify the study findings.

Transferability

Transferability is defined as the ability of a research finding to be applied to a different setting or context (Forero et al., 2018). The findings of the study can be generalized and applied to diverse groups or individuals (Levitt, 2021). I conducted an audit trail. A thick description of the data collection and coding process was written. Details of the interviewing process, coding, and analysis were recorded through journal writing. Noting the step-by-step process allows other researchers to replicate the study more accurately. In the future, researchers can utilize the detailed methodology to replicate the study in similar research settings.

Reflexivity

Reflexivity allows the researcher to identify biases that could potentially impact the study (Forero et al., 2018). I used the reflexive journaling method to help with reflexivity (Levitt, 2021). After each interview, I took a 10-minute break to journal. This process allowed me the opportunity to reflect on the data. Any personal biases or beliefs noted during the interview process were documented. In addition, the journal included procedural notes and documentation on how and why certain decisions were made regarding the interview process and coding strategies. This served as an additional measure to ensure that proper steps were taken regarding the ethical treatment of the study participants.

Dependability

Dependability refers to the ability of a study's finding to remain consistent over time (Tuval-Mashiach, 2021). This also includes the documentation of the research procedures (Tuval-Mashiach, 2021). One method used as part of the dependability process was the code-recode method. To begin the process, the data provided was coded. After 2 weeks had passed, I would then recode the data. This process allowed me to see if the same conclusions would be reached after an extended period. As a result, consistency was found in the data recordings. In addition, after each interview, I reviewed the audio recording, and notes regarding the interview were created. The notes reflected how the interview process went, thoughts and feelings about the interview, and what was learned or observed during the interview process. Finally, the member-checking process and establishing an audit trail aided in establishing dependability.

Confirmability

Confirmability allows other researchers to confirm the information that was provided in the original study through interpretation of the data findings ((Tuval-Mashiach, 2021). Confirmability ensures that the information concluded in the study is (Forero et al., 2018). The audio recordings were transcribed verbatim and sent to each participant within 48 hours of their interview. Participants were instructed to review the data to ensure accuracy. If the participants felt the need to make any changes, a 72-hour time period was provided for them to email me for correction. Additional measures taken during the data analysis process included using raw quotes from the participant interviews while coding and theme development to help confirmability, credibility, and authenticity.

Results

RQ: How do former pregnant or parenting teen and young mothers describe their experiences of utilizing mental health services?

Theme 1: Unintended Pregnancy and Emotions Linked with Finding Out About Pregnancy as Reasons for Seeking Mental Health Services

I asked the study participants to discuss their decision to seek mental health services. The first theme of unintended pregnancy was developed. Four out of eight participants expressed the need to seek mental health services after finding out about their pregnancies. Participant 1 stated, “Well, when I found out, I became really depressed because it was not planned or anything like that.” Participant 2 said, “I was extremely overwhelmed with everything I had going on. Therapy was the only safe space that I

had." Participant 5 stated, "I was in shock because I was in graduate school, and I was also on birth control. So, this was a huge shock for me; it definitely rocked my world. It wasn't expected at all."

Despite the age difference among study participants, the knowledge of their unplanned pregnancy produced difficult emotions for the participants. Some mothers experienced feelings of sadness and depression. For others, it was worry and anxiety. As a result, each mother sought services to help them navigate the emotional distress that came along with the knowledge of their pregnancies. Participant 3 stated,

> Well, I think it all started with having a baby during the pandemic or becoming pregnant during the pandemic. So, I think the support was very limited because your spouse wasn't able to come in the appointments with you. And then also, I was having anxiety with working in the NICU, and I'm seeing people having babies at 25 weeks and things of that nature. So, I definitely want to seek some therapy for my own peace of mind, for the health of my baby.

Participant 6 stated,

> I went into two seizures, and they had to take him out of me before my body continued to shut down. So, after that, I was dealing with a depression that I never dealt with before. I didn't know anything about the postpartum depression, but on top of that, I had left the hospital and he was still in the hospital because he was born weighing two pounds. So, I became depressed.

Finding out about their pregnancies produced different emotions for each mother. They all felt the need to seek treatment due to the emotional toll the knowledge of their

pregnancy presented. For some, it was depression or sadness about the pregnancy, and other mothers experienced anxiety. Fears about bringing home a new baby and being an effective parent were additional reasons that these first-time mothers sought mental health services.

Theme 2: Stress, Anxiety, Illnesses, and Coping with Stress Are Types of Support Sought Through Therapy

Each of the study participants expressed emotional changes while either being pregnant or parenting. Anxiety, depression, stress, illnesses, and health concerns for themselves or their babies were stressors for all the participants. Life changes, and adjustments to becoming new mothers were additional challenges listed by the participants. Therefore, one of the questions posed to the participants was, "What are some of the challenges you faced during your pregnancy?"

Participant 8 replied,

> I was in therapy mostly for anxiety. I'm a doctoral student, and I'm just also a very anxious person. I know with pregnancy, that increased. I already had a therapist before I was pregnant. I'm also high risk. So, trying to keep my health regulated, physical, mental, my social and emotional at school, are kind of things that I'm always balancing.

Anxiety was a common stressor listed among all the participants. Participant 1 experienced anxiety about her daughter's health before her birth.

> It was really upsetting to find out she had a little hole in her lungs during the ultrasound. She had a hernia. I was also trying to become more financially stable, so I was worried about that too. I just became depressed mostly.

Her daughter was born prematurely, and this added to her anxiety. Three out of the eight mothers interviewed had babies born prematurely, creating depression and anxiety.

Participant 6 stated,

> And on the 6th month, I had my son. He was premature. I had personal issues on top of having a baby. I was still in the healing process and having to go all the way from the southside to Buckhead just to visit my son. I was depressed and blamed myself for him being there.

Participant 7 said that her daughter was born prematurely and, "therapy pretty much prepared me for the process of taking her home with it just being so traumatic for me how it all happened so fast. I developed postpartum depression." The mothers who experienced premature births experienced additional emotional stressors not shared by the other participants. Those concerns included guilt and not feeling competent in taking care of their baby. These emotions created different stressors that were addressed during the therapeutic process.

In addition to the stress brought on by becoming a new mother, two participants found the therapeutic process stressful**.** Participant 2 reported, "Therapy was slightly overwhelming too. To start with, I'm like, I don't even know where to start. There was so much that I needed to talk about. It's really daunting being vulnerable. There is a fear of being judged." Participant 7 stated, "It's a job."

Theme 3: Family, Friends, and Therapist Are a Part of The Support Network

In previous studies, mental health stigma, a lack of community and family support has been shown to become a barrier when receiving mental health services (Ashby et al., 2019; Chang et al., 2016). Religious expectations were also reported as a determining factor of whether individuals from diverse cultures opted to participate in therapy (Neely-Fairbanks et al., 2018). Participants were asked if their family and friends supported their decision to seek treatment. Participant 1 said her mother was the only person who knew she was attending therapy.

> She encouraged me to seek it because she noticed that I had changed from being all happy and laughing and goofing. When I got the support to go, it made me feel like I wasn't crazy because nowadays I feel like people associate therapy with people that are really unstable and stuff.

After the premature birth of her daughter, Participant 6 said her mother was supportive of her going to therapy. Due to her depression, she had difficulty going to the hospital to see her baby. The nurse asked her if she wanted the child: "My mom told the nurse that she did not know what I was going through." Her mother was supportive of her decision to attend therapy. Participant 8, who works as a therapist, reported that her lead therapist at work, her mother, and her boyfriend supported her decision to attend therapy: "My boyfriend, he's always encouraging me to make sure I'm going every week. Just noticing things that I have changed regarding my anxiety helps." Participants expressed appreciation for those family members and friends who supported their therapeutic

journey and encouraged their attendance. Having a therapist that was supportive had a positive impact on their therapeutic relationship.

Participants 3 and 5 stated that some individuals in their immediate circle were not supportive of the therapeutic process. Participant 3 said,

> Some people were against it because they didn't think I needed it, but then I didn't care about what anybody thought really. I knew I had to do it for myself and not for others. Some people are stuck in their own ways and don't want to change, and I tried to tell them, but that was their point of view. I honestly felt like they should seek therapy too.

Participant 7 said she did not tell anyone that she was receiving services: "They did not know. I wasn't really vocal because I was just trying to figure everything out. I was just trying to process it all myself." Participant 5 said religious beliefs influenced her family's thoughts about attending therapy. She stated,

> Seeing a therapist is a big no-no in my family. I kept it hidden. Nobody knew. I was the only person in my family at the time that ever saw a therapist. I was told to just go pray and sit down somewhere. In the Black community, we are always made to feel bad like, oh my God, what's wrong with you? You don't need to see anyone else for help. God's got you. I was breaking through some barriers that nobody in my family could help me with. Therapy helped me obtain the truth. I was trying to fill a void. That I was broken and hiding from it.

The participant said she needed to heal for herself and her child. She did not want to pass down generational trauma. She tried to heal to be a better mother.

Cultural beliefs played a role in the type of support one participant received with her thoughts surrounding therapy. Participant 2 said,

> I think a lot of people in my generation especially, we grew up in a different household when it comes to parenting. So, a lot of stuff in Black households, it's kind of stuffed under the rug, where we don't talk about it. We don't deal with it. My friends had similar experiences growing up where we felt like we couldn't talk about different things. It's affecting us through different decisions that we are making in our lives right now.

Participant 2 said her family knew she was in therapy but did not know why she was receiving services: "My friends were very supportive of the process, and they were checking in to make sure I was consistently attending my appointments for therapy." Participant 7 said, "With the therapist, and that being my first child at the time, it was good to get a listening ear where someone was just calm and just let me know everything is going to be okay." Overall, the mothers in the study had a strong support system, which positively impacted their therapeutic experience. For those who may not have had the support of their family and friends, this did not serve as a deterrent to seeking mental health services. The mothers who did not have support acknowledged the changes in generational perspectives regarding mental health. They felt like therapy was necessary, whereas the generation before did not share their beliefs.

Theme 4: Barriers to Treatment Include Finding a Therapist, Insurance, Finance, Time, Work, Schedule, Health Concerns, Parenting, and Understanding Therapist Qualifications

The participants listed various barriers to treatment. These barriers included finding the right therapist, sickness during pregnancy, insurance concerns, finances, time constraints, work schedule, and balancing multiple tasks such as parenting, working, school, and other obligations. Finances slowed down the therapeutic process for Participant Number 2.

> Therapy was challenging because of how expensive it is. Then I was in a weird transition with my insurance from my parent's insurance to my own insurance. My insurance isn't all decked out like my parent's insurance, so I had to pay a little more per session. I went from going every week to every two weeks and then to once a month. I couldn't afford to go consistently like I used to.

Participant 2 said that illness played a role in therapy participation and her ability to interact at times during her sessions and reported, "I constantly had headaches and stuff. It was hard to kind of stay focused on the session because I just wanted to sleep." Participant 4 said, "I was sick during my first trimester, so it was difficult driving because I would get sick. I'd say that it's exhausting being tired, but just like with anything else, you have to do it for yourself." The participant said she still attended her sessions but was "just uncomfortable." Participants 6 and 7 ended their sessions through the hospital once their children came home. Participant 7 said that once she returned to work, it became too much for her to try to take care of her child and attend her sessions: The barriers faced by

the participants created challenges for them and directly impacted their therapeutic experience.

A recurring theme among participants was finding “the right” therapist. Participants were asked, “When you attempted to seek therapy, what was the process like for you?” Several challenges were listed. Not understanding licensing credentials and really understanding “how” to search for the right clinician created obstacles for two of the study participants. Participant 1 stated, “It was a little hard because I didn’t really know what I was looking for, as far as degrees and stuff to help me find like a good one.” Cultural competency and having someone whom she could identify with were essential to Participant 8 during her search for a clinician:

> I love my therapist. I am really frustrated, especially being a Black therapist myself, that there are not a lot of therapists of color. I’m searching wrong, but advertisement-wise? It was really hard to find a Black therapist. I think I would probably have a stronger rapport with my therapist if she was a black female because the only thing, we don’t discuss is race.

Participants six and seven were referred to a therapist by the hospital after the premature births of their babies. Sessions were typically scheduled on the same days at the hospital that they would visit with their children. Participants 4 and 5 were referred by their jobs for therapy. Respondent 4 was a clinician. Her manager referred her to therapy after her brother’s death during her pregnancy.

Three out of eight participants reported having more than one therapist. Changes were made due to insurance, finances, or not feeling like the initial therapist was a "good fit" for their therapeutic needs. For example, Participant 3 responded,

> I am really a vibe person, so it just took me calling several different people just to see who I could vibe with or relate to. You want to keep that same energy that you project out. So just being careful with who I was choosing.

She decided that her initial clinician was not a good fit. After her first session, she decided to work with a different therapist. She has a great rapport with her current therapist.

Financial barriers, finding a clinician, and insurance concerns were barriers identified in Chapter 2. Understanding how to navigate the process of finding a clinician could be helpful to individuals who seek mental health therapy in the future. Understanding the client and clinician dynamic continues to be an essential factor in the therapeutic journey. Hospitals are now identifying mothers who need services and are connecting them to clinicians. This process can help eradicate barriers that young mothers face if they require mental health services.

Theme 5: Additional Positive Outcomes Were Seen as Mothers Felt They Were Becoming Healthier, Happier, Better Parents, and Happier on an Individual Level

All eight participants expressed some level of satisfaction with their services. For some participants, the satisfaction was on a personal level, and for others, it was regarding their parenting skills. The mothers expressed they were becoming healthier, happier, and better parents. In addition, the participants reported an increase in overall

happiness in their personal lives. Finally, the participants were asked to share how the services influenced their parenting or personal lives.

Participant 1 said, “It influenced my parenting because I wanted my daughter to have a happy parent. I didn’t want her to see my problems. I wanted her to build off my energy. I didn’t want to make her sad and closed off. After therapy, I started to feel like my old self.” Participant 2 stated,

> Even now, I understand, and I see the impact of how much therapy played a part in my healing process. Just being able to talk about it now, and not have a meltdown, and be okay, and understand what is best for me, I definitely think it was extremely beneficial.

Participant 3 stated,

> I definitely wanted to seek therapy for my own peace of mind and for the health of my own baby. I am more patient. I’m just reliving my childhood through him, so we have a lot of fun together and just being there, not projecting negative energy on him.” Participant 4 said therapy provided her with “A lot of mental support. So, to have that on the front end feels like it’s paramount. This is something that impacts your life for the rest of your life. It’s especially important post-pregnancy, especially when you’re a new mom, and it’s your first kid; you need support.

Participant 5 stated,

> Therapy helped me obtain the truth, and the truth was I was broken. I was hiding my brokenness, so during my whole pregnancy, nobody knew I had this internal

> battle. Therapy helped me to really understand that I had layers and layers of healing and work that I couldn't run from. It helped me to be more patient. It helped me to see where I had childhood trauma and not to repeat that generational thing that we get passed down. I'm very mindful of what I say to my kids.

Participant 6 stated,

> It helped me to be more patient and to listen and think of my child as a different individual, not just my child. This child has a personality. It taught me to think outside of the box. Instead of having my perspective on what they think, I allow them to use their minds, to actually just tell me what they need. You just have to be a listening ear.

Participant 7 replied,

> It allowed me to look at my child differently., well compared to other kids, I can't expect my child to be walking when everyone else's child is walking. It allowed me to just review my child's growth and just to calm down really because I was panicking. With the therapist, and that being my first child at the time, it was good to get a listening ear where someone was just calm and just let me know everything is going to be okay.

Participant 8 stated,

> I had a lot of childhood-based trauma, so I went to therapy before I was pregnant. Because I knew by my being a therapist, it could impact my parenting, so that's why I originally sought treatment. We did a lot of trauma work, and now it's not messing up my pregnancy.

For the participants who found the therapeutic process challenging, they were still able to list ways in which they benefitted from their time in therapy. Participant 7 stated, “On a scale of 1 through 10, I would rate it like a 7. It was helpful. I just couldn’t tell you exactly how helpful it was.” Despite the challenges and stress associated with attending therapy for participant 7, she found some benefits, such as learning how to care for her child after the premature birth and managing stress. At times, having someone to talk to about what she was experiencing was helpful.

It was noted that the majority of the participants focused on the work of “healing” and becoming a better version of themselves during the therapeutic process. Learning personal coping skills was something that each study participant hoped to gain from their time in therapy. Seven mothers reported how learning more about themselves helped them become better parents. More than half of the participants stated that they benefitted from the parenting skills provided by their clinicians.

Theme 6: Additional Resources Provided by the Therapist and Having an Open Relationship with the Therapist Were Vital to The Overall Success of the Participant

Participants who seemed to gain the most from their therapeutic experiences expressed having a good relationship with their therapist. Finding the therapist that best suited their needs was essential. Four out of six participants had a previous therapist before finding their current therapist. Participant 3 completed one session with her first therapist and then terminated sessions with her. Once the participant identified the therapist with whom she felt an established rapport, she was asked to describe her

relationship with the therapist. Participant 3 stated, “That’s my girl! Yeah, I really love her because she doesn’t sugarcoat it. She can really break you down and tell me what’s the core of my issues. She really wants what’s best for me.” Descriptive words provided by participants used to describe the therapeutic relationship include trustworthy, open, non-judgmental, a friend, family, caring, and consistent.

The therapist’s genuine interest in the client’s well-being helped enhance the relationship as well. Participant 1 recalled,

> When she was talking to me, she made me feel as if she was a friend, and it was really easy for me to open up about my problems and how I was feeling. It just made me feel normal.

Participant 2 said,

> She called to check on me outside of sessions when she knew that I was really going through. We have really built a bond over the past year. She is invested in my well-being, and I needed someone to care. She is supportive of me. She calls and checks in on me to make sure I am okay.

Participant 5 stated, “Oh my God. She was phenomenal. It was a phenomenal experience for me. My therapist is amazing. She helps me to see things that I don’t see. She helps me to see things in my blind spot.” Participant 6 said, “I felt like she was kind of more like a family figure. She really helped me through a lot of things that I was trying to get out of. I couldn’t quite explain to a family member like my parents.” The therapeutic relationship had a significant impact on the continuation of services. Five out of the eight

participants are still in service. Four out of eight participants are currently working with their therapist, and one participant will be returning to therapy soon.

Additional Resources for Utilization Outside of Therapy Sessions

Each participant reported that the resources provided by the therapist were beneficial to the therapeutic experience. Other participants discussed tangible resources provided by the therapist. The additional resources helped them grow as individuals and provided aid outside their sessions. Resources included interventions to use, support groups, financial resource referrals, resources for single mothers such as parenting groups, and teaching parenting and calming skills. Participant 2 replied, “She made sure I had access to different support groups or finding different resources to help me with my mental health struggles, and being able to stay balanced, and keep my life together.” Participant 4 said,

> I have an almost two-year-old, so it’s a lot of tantrums, and it’s pretty stressful. When I meet with her, I am able to talk through it. We work through ways for me to calm myself down. She reminds me to take time for myself. So that I can be present.

Participant 6 stated,

> It (therapy) honestly brought me to a newfound practice of meditation and reading. I really like listening to music. Once I got into the study more and talked to her more, I learned more about myself. I learned more about becoming a parent.

Participant 8 replied, “I am always thinking the worse, and my therapist is helping me with that.” The participant is utilizing pregnancy affirmations to help her reduce the anxiety. She has a “more positive outlook about my pregnancy.”

Discrepant Case

A discrepant case was noted in which one of the participants documented the challenges therapy created for her. The challenge she faced was having to discuss her childbirth trauma in session. She said that was difficult and impacted her decision to discontinue services. She discussed the emotional toll of attending therapy.

> I did all the talking, and she just listened. It was nothing personal. I felt like I was just repeating what I had just lived. Therapy, for me, was just a job. Once I had to return back to work and figure out what kind of milk the baby needed and try to understand my own body, to go into a therapist and just break it all down, it became, that was stressful.

The participant ended her sessions once she returned to work.

Although there was a discrepant case, the other participants found the therapeutic experience valuable. Their relationship with the clinician was vital to their attendance, recovery, and decision to continue therapy. Trust was identified as a critical component of the therapeutic relationship in chapter two, along with cultural competency. Upon analysis of the data, these factors proved essential to the study’s participants. The additional resources and personal care provided by the clinician positively impacted the therapeutic relationship.

Summary

The study aimed to examine the perspectives and experiences teens, and young mothers had while participating in mental health services during pregnancy or while parenting. Since the current demographic is considered a marginalized population, having their experiences captured fills a necessary void in the existing body of literature. The therapeutic relationship with their clinicians impacted African American females' experiences in therapy. Trusting their clinician, not feeling judged, and having someone they could identify with allowed them to embrace the therapeutic journey.

Common diagnoses among study participants included stress, anxiety, depression, pregnancy or birth complications, and the pressures of becoming or being a mother while managing other aspects of their lives, such as work, school, and family. Positive outcomes of therapy included becoming a better/happier parent and learning coping skills. The additional resources provided by the therapist were also a key component in helping study participants feel more effective in their ability to parent their children.

Chapter 5 will give an overview of key findings and an interpretation of the data. Study limitations will be addressed along with recommendations for future research. Finally, the potential implications of the study findings will be provided, along with the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of the study was to explore the perception and experiences of pregnant and parenting teen mothers as it relates to the utilization of mental health services. Despite the documented need for mental health services due to the impact on young mothers psychologically, socially, and physically, utilization rates for this demographic remain low. Mental health services can produce a better psychological outcome for both the mother and baby. A one-on-one interview format was utilized to study the impact of counseling on pregnant and parenting mothers. Seventeen interview questions were designed to answer the research question: How do former pregnant or parenting teen and young mothers describe their experiences and perceptions of mental health services utilization? The goal of the study was to gain a better understanding of the therapeutic experience. Chapter 5 will present an interpretation of the findings, study limitations, recommendations, and social implications.

Interpretation of the Findings

Six themes were discovered during the data analysis process:

1. Unintended pregnancy and emotions linked with finding out about pregnancy as reasons for seeking mental health services.
2. Stress, anxiety, illnesses, and coping with stress are types of support sought through therapy**.**
3. Family, friends, and therapists are a part of the support network.

4. Barriers to treatment include finding a therapist, insurance, finance, time, work, schedule, health concerns, parenting, and understanding therapist qualifications.
5. Additional positive outcomes were seen as mothers felt they were becoming healthier, happier, better parents, and happier on an individual level.
6. Additional resources provided by the therapist and having an open relationship with the therapist were vital to the overall success of the participant.

Results confirmed that pregnancy and parenting could be stressful. All the study participants were first-time mothers or pregnant while undergoing therapeutic services. Each mother in the study reported some stress or anxiety related to their pregnancy or parenting, but the stressors were different. Financial stressors were also reported. A common theme for attending therapy was the desire to be a good mother. Stress and anxiety caused by the mother's worry about being a good mother and concerns about the children's emotional well-being were essential factors when seeking mental health services. The mothers felt like their trauma and emotional stress impacted their parenting ability. Resources provided by the clinician offered additional opportunities for the mothers to learn more about parenting and their children.

It was confirmed that the therapeutic process could be beneficial for mothers. All eight participants reported benefitting from therapy either during pregnancy or post-pregnancy. Mothers benefitted from the support provided by their therapist, talking through their concerns and fears during their pregnancy, decreasing thoughts of anxiety,

obtaining resources, and learning how to manage feelings of depression while pregnant or while parenting. Participants suffering from trauma worked on this with their clinician. Some of the trauma explored was childhood trauma, although other traumas were related to their pregnancies. The trauma work proved to be beneficial for the participants. The feeling of being supported by their clinician proved advantageous for all participants.

Half of the study participants confirmed that it was helpful to have the support of their family and friends during their therapeutic journey. They were encouraged to attend sessions. Their family and friends were a source of accountability for therapy attendance. Their support system would check in with them to ensure they were regularly attending sessions. They would ask how the therapeutic process was going and encouraged them to stay on task.

The importance of the therapeutic relationship was also confirmed. Each participant expressed the importance of the relationship between them and their clinician. Several participants sought counseling from a different therapist if they felt like they did not connect with their initial therapist. Those most satisfied with their therapeutic relationship used phrasing such as, “That’s my girl. She’s like family. I trust her, and she is non-judgmental and supportive.” While pregnancy was the catalyst to attending therapy for some participants, five out of eight participants decided to continue with their therapeutic journey post-pregnancy. One mother who discontinued services is attempting to start services again.

Theme 1: Unintended Pregnancy and Emotions Linked with Finding Out About Pregnancy as Reasons for Seeking Mental Health Services

Teen pregnancy and young parenting can be stressful (Ashby, 2019 & Graves, 2017). All the study participants were first-time mothers or pregnant while undergoing therapeutic services. Each mother in the study reported depression, stress, or anxiety related to their pregnancy or parenting. However, the stressors were different for each participant. For example, some participants worried about their children's health or health during pregnancy, whereas two participants faced challenges with the premature birth of their children. The emotional distress caused by their pregnancy-related situations prompted each mother to seek mental health services.

This theme relates to the SLT framework in terms of the assessment and interpretation of emotions as a first step to learning. According to Bandera's (1963) SLT framework, social learning explains how learned behaviors develop and the impact it has on decision-making and help-seeking behaviors (Benjamin et al., 2015; Kawaii-Bougee et al., 2017, Killebrew et al., 2014). Because this study intended to explore life experiences of young mothers and their decision to participate in mental health services while parenting, this initial step of learning about the pregnancy and initial emotions associated with learning that information may help researchers and practitioners to understand why these mothers determined that seeking help was necessary. That experience of learning of the pregnancy and the emotions linked with that seemed to be the first step toward determining that outside help was needed.

Theme 2: Stress, Anxiety, Illnesses, and Coping with Stress are Types of Support Sought Through Therapy

Mental health services can be used to aid in the treatment of mental health concerns during and after pregnancy (Breslau et al., 2016; Graves 2017; Harrison et al., 2017). It was confirmed that the therapeutic process was beneficial for mothers seeking support while parenting and navigating their emotional stressors. All eight participants reported benefitting from therapy either during pregnancy or post-pregnancy. Mothers benefitted from the support provided by their therapist, talking through their concerns and fears during their pregnancy, decreasing thoughts of anxiety, obtaining resources, and learning how to manage feelings of depression while pregnant or parenting. Participants suffering from trauma worked on this with their clinician. Some of the trauma explored was childhood trauma, whereas other traumas were related to their pregnancies. The trauma work proved to be beneficial for the participants as they reported decreases in stress, anxiety, and feelings of depression.

The SLT's fundamental concepts may help provide a better understanding of a young mother's choice to participate in therapy and gain insight into these young mothers' perspectives and experiences while utilizing therapeutic services. Again, part of the process of addressing their mental health concerns (part of that learning process) was seeking help from others. Whether that initially was a family member and then more formally a therapist or counselor, there was a clear step in interacting with others. Among adolescents' parental units, primary caretakers and peers are influential (Butler-Barnes et al., 2018). Social learning impacts the therapeutic experience as others learn from the

personal past experiences of individuals in their lives and become aware of what is culturally acceptable from their role models as it relates to the therapeutic process (Ashby et al., 2017; Graves, 2017).

Theme 3: Family, Friends, and Therapists are a Part of the Support Network

Stigma regarding mental health services has been documented as a barrier (Fripp et al., 2017; Planey et al., 2019). However, this was not a deterrent to attending therapy for the participants in the study. Four participants reported support from their therapist, family, and friends. The support was advantageous for all participants and their therapeutic experience. Half of the study participants confirmed that it was helpful to have the support of their family and friends during their therapeutic journey. They were encouraged to attend sessions. Their family and friends were a source of accountability for therapy attendance. Three participants received negative feedback about attending therapy, but it did not become a deterrent for help-seeking behaviors.

The support process and looking to peers and caretakers is demonstrated. Having a support network, this time along the lines of the more informal network, was critical to the success of the treatment, or formal help seeking network. This is another demonstration of how SLT frames the existing relationship between human behavior, cognition, and one's environment (Jones et al., 2019). Using family and friends to be accountable for attending counseling or therapy is a part of how these mothers is shown to be using SLT in their experiences with mental health services.

Theme 4: Barriers to Treatment Including Finding a Therapist, Insurance, Finance, Time, Work, Schedule Health Concerns, Parenting, and Understanding Therapist Qualifications

According to the literature review, barriers are faced when accessing mental health services (Campbell-Grossman et al., 2016; Chang et al., 2016; Fripp et al., 2017; Planey et al., 2019). Financial barriers were confirmed. The stigma of mental health services discouraging clients from seeking mental health services was not confirmed. Four participants sought mental health services despite the opinions of family and friends. Understanding the clinician's qualifications was an additional barrier faced by young mothers. The importance of having a culturally competent therapist was confirmed (Ashby et al., 2016).

Here, stigma was not an element that prevented mental health care seeking. SLT can be seen in the element of having a culturally competent therapist. I propose that this is also part of the social learning element in that involves relationships and similarities for modeling. Social learning occurs through watching, imitating, and modeling observed behavior (Bandura, 1963; Killebrew et al., 2014), therefore initiating and maintaining therapy with an individual who is culturally competent is important for that imitating behavior.

Theme 5: Additional Positive Outcomes Were Seen as Mothers Felt They Were Becoming Healthier, Happier, Better Parents, and Expressed Being Happier on an Individual Level

Mental health services are important in the management of both antenatal and postpartum depression (Graves 2017; Harrison et al., 2017). A common theme for attending therapy was the desire to be a good mother. Stress and anxiety caused by the mother's worry about being a good mother and concerns about the children's emotional well-being were essential factors when seeking mental health services. The mothers felt like their emotional distress impacted their parenting ability. Through the utilization of therapeutic services, three participants said they felt therapy helped them become better individuals, which in turn helped them to become better mothers. Respondent 1 reported, "I wanted my baby to have a happy mother. I didn't want her to see me sad all the time." Respondent 7 reported being a better listener and seeing her children as individuals with their own "emotional needs" after attending therapy. She said this helped her to become a better parent.

In general, it was evident that SLT played a role in the process of experiences and therapy for these mothers in that there were positive outcomes. Learning was occurring in these instances and participants' happiness and success with parenting was improving from their perspectives. Learning through social experiences is demonstrated by these outcomes.

Theme 6: Additional Resources Provided by the Therapist and Having an Open Relationship with the Therapist Were Vital to the Overall Success of the Participant

Young mothers can benefit from specialized interventions and resources (Breslau et al., 2017; Burrus, 2018). Additional resources provided by the clinician created opportunities for the mothers to learn coping skills and more about parenting and their children outside their sessions. Journal writing, music therapy, meditational instruction, and group referrals were provided to the mothers in the study. The mothers who attended the parenting groups found them helpful. They were able to learn more about parenting and themselves.

The therapeutic relationship is significant (Ashby et al., 2018; Ofonedu et al., 2017). Each participant expressed the importance of the relationship between them and their clinician. Several participants sought counseling from a different therapist if they did not connect with their initial therapist. Those most satisfied with their therapeutic relationship used phrasing such as, “That’s my girl. She’s like family. I trust her, and she is non-judgmental and supportive.” While pregnancy was the catalyst to attending therapy for some participants, five out of eight participants decided to continue with their therapeutic journey post-pregnancy.

The element of modeling behavior is seen in the SLT process. Once the information has been modeled and coded into one’s cognitive framework, the modeled behavior becomes a blueprint for future actions (Bandura, 1963; Benjamin & Carolissen, 2015). Those who model behaviors in the lives of mothers impact their beliefs, attitudes, and decisions (Benjamin & Carolissen, 2015)—this was demonstrated here. Among

adolescents' parental units, primary caretakers and peers are influential (Butler-Barnes et al., 2018). I would also argue that therapists end up in this group as well. Social learning impacts the therapeutic experience as others learn from the personal past experiences of individuals in their lives and become aware of what is culturally acceptable from their role models as it relates to the therapeutic process (Ashby et al., 2017; Graves, 2017). Thus, the important aspect of finding a therapist who is culturally competent and who can relate to the patient is important for the modeling behavior, learning, and the success of the process.

Disconfirmation of Previous Findings

Previous research showed that negative generational perspectives could be a barrier to help-seeking behaviors (Aspley & Padilla-Walker, 2020). The study results did not confirm this. Three study participants reported that their family and friends did not support their decision to obtain therapeutic services. However, this did not serve as a deterrent to seeking help. The respondents felt they could benefit from therapy and continued the process despite the lack of support. Four participants in the study were referred to services by either a family member or a friend.

Two participants opted not to inform their family and friends of their decision to seek help. "It was personal for me, and what everyone else thought did not matter." The importance of seeking mental health services was expressed by four of the participants. One respondent said due to her religious background, and she knew her family would not be supportive. Despite her family's religious beliefs, she stated, "I knew what I needed to do to get my healing." A second participant said her family was also very spiritual but

supported her decision to seek therapy. It was not confirmed that religious beliefs became a barrier to help-seeking behaviors.

Seven out of eight participants expressed wanting to be better parents, and attending therapy allowed them to do so. One respondent discussed communication issues within her family that she wanted to resolve. She saw how her family interacted and wished to attend therapy to break that cycle. Two other participants wanted to learn to listen to their children and see them as individuals. The idea of seeking mental health services, working through trauma, and finding more effective ways of parenting were not behaviors that were modeled for the study participants.

Limitations of the Study

The experiences of pregnant and young mothers seeking mental health treatment were explored during the research study. The phenomenon was explored through one-on-one interviews with the researcher. Due to Covid, the interviews were not conducted face-to-face. Instead, zoom and phone interviews were utilized. Some of the challenges faced by using these methods were technical difficulties, internet connections, buffering, and environmental interruptions. As a licensed professional counselor, reflexive journaling and member checking were used to ensure that personal biases were not an issue during the interviewing and coding process.

During the recruitment process, limitations were observed. The recruitment strategies were changed during the data collection process. The addition of social media outlets was requested, along with the use of a neighborhood. The age limit of study participants was also increased. The IRB approved the use of the Nextdoor app to aid in

the recruitment process. Changes were made to the age limit of study participants as well. The initial age requirement was 18 – 24. The final age demographic of study participants was 18 – 30. I was granted permission to reach out to local parenting agencies. The directors were only asked to post the information to their social media pages. They were not asked to recruit study participants.

Diversity within the study was another limitation. The study was open to women from various cultures, races, and ethnicities. However, the final group of participants were all African American females. It is difficult to say how women from diverse cultural backgrounds would be impacted by their experience with mental health services. Qualitative studies aim to find a representative group that mirrors the population (Levitt, 2021). Having women's opinions from various races, ethnicities, or cultures could have been advantageous. While the information found in the study can be applied to women within the African American community, the results may not translate the same due to diverse cultural beliefs and ideas surrounding parenting and mental health.

A lack of geographical representation was documented. All the study participants lived in Georgia. It would have been advantageous to the study to see how pregnant and parenting mothers who lived in different areas described their experiences with mental health services. Since this area lacked diversity, it is difficult to say how this information may apply to mothers from other geographical locations.

Recommendations

Good maternal mental health is an essential aspect of pregnancy for both the mother and baby (Nicolas-Lopez et al., 2022). Conversely, poor mental health has been

associated with adverse pregnancy outcomes (Voit et al., 2022). For some mothers, pregnancy and the weeks following childbirth are critical and emotional periods that can increase stress, anxiety, and depression (Voit et al., 2022; (Nicolas-Lopez et al., 2022). Previous studies focused on the emotional stress brought on by pregnancy and childbirth, but mothers' mental health was not the focal point (Voit et al., 2022).

Future studies could seek to understand better maternal mental health's impact on pregnancy and how first-time mothers adjust to parenting. For example, all study participants expressed the emotional challenges they faced during pregnancy or their parenting experiences. Future research could benefit from a better understanding of the impact of trauma on maternal mental health and parenting. For example, 5 out of 8 study participants expressed having experienced trauma at one point and felt it impacted their pregnancy and parenting ability.

Since diversity was a limitation of the current study, future research could examine how women from diverse cultures, ethnic backgrounds, or geographical locations view their experiences with mental health services. The barriers for the demographics may not be the same. Through hearing their stories and understanding their experiences, clinicians can learn what is needed to assist the population best. Documenting the stories of a diverse group of women is essential as mental health utilization is examined. Understanding maternal mental health needs can inform clinicians, and other healthcare professionals on how to best serve their clientele.

Since the Covid-19 pandemic, there has been a shift in the way mental health services are delivered. More clinicians are offering telehealth services. Use of online

maternal mental health forums is being used by pregnant mothers (McSorley et al., 2022). Future research could look at how some clients could potentially benefit from the online component of mental health services and continue the work of McSorley et al., 2022, who have begun to explore online services.

Implications

This study aimed to investigate what the therapy experience was like for women who sought treatment. These women overcame the boundaries that typically prevent others from seeking treatment. I wanted to identify the factors that led these women to seek therapy and to see which factors played a role in them seeking help despite the identified barriers. I wanted to determine whether treatment benefited the participants and learn how clinicians and other health professionals could enhance their therapeutic experiences.

Maternal mental health is an area I took an interest in due to my career and the research conducted while researching my dissertation topic. In the United States, 20% of women experience mental health concerns during pregnancy and/or up to 1 year following the birth of their child (Mind, 2020). However, only half of the women identified with maternal mental health concerns will seek treatment (Moore et al., 2019). Stigma regarding mental health services continues to be a barrier for women when deciding whether to seek mental health treatment (Mind, 2020 & Moore et al., 2019). During the interview process, mothers identified additional barriers. For example, being sick, having a hectic schedule, and trying to balance their life, therapy, and parenting

presented a challenge for some women. Therefore, it is necessary to identify barriers as clinicians work to understand the specialized needs of this demographic.

Conclusion

Historically, teen pregnancy and parenting have been shown to have negative social and emotional implications for young mothers (Kawaii-Bouge et al., 2017; Tanner & Tanner, 2020; Taylor et al., 2019). It was discovered that utilization of mental health services could positively impact the overall emotional health of mothers both pre-pregnancy and post-pregnancy. Several participants' feelings of depression and anxiety were lessened due to their therapy treatment. Although concerns related to pregnancy and parenting were the reasons the participants sought services, there was a positive impact on their lives post-pregnancy. Many participants continued therapy post-pregnancy to help with parenting skills and finding balance.

The study allowed me to explore the experiences and perceptions of mental health utilization experienced by teens and young mothers through the experiences of eight African American mothers. The selected demographic is a marginalized population (Harrison et al., 2017; Lucas, 2019). Therefore, the study added to the current body of literature by documenting experiences, providing a better understanding of the therapeutic process for these pregnant and parenting mothers, and identifying specific barriers related to the demographic.

The need to normalize therapy within the African American community can be worked towards. The study provided insight into how impactful the therapeutic relationship is. Finding culturally competent clinicians to which the clients can relate is

essential. Despite cultural and familial beliefs held by parents, family, and friends, participants were still willing to seek help without the support of others. Cultural norms, negative stigmas related to therapy, or behaviors modeled by family and friends connected to parenting and treatment did not serve as a deterrent for the participants.

Through the conducted research, I was able better to understand the importance of mental health during and post-pregnancy. Areas of improvement were identified. Finding a culturally competent therapist was essential to group participants. Several participants listed being able to relate to their therapist as being important. Psychoeducation is needed as it relates to finding a therapist, understanding the qualifications of clinicians, and finding ways to eliminate challenges with navigating insurance benefits associated with mental health services. Through sharing their stories, the participants allowed me to understand the specialized needs of the demographic.

Mental health is important. It was inspiring to see that each participant benefited from their therapeutic services. Hopefully, as more people attend therapy and share their experiences, the process of attending therapy will become normalized and more individuals will be encouraged to participate. Through future research, we can learn more about the needs of African American women and maternal mental health. When barriers are identified, it presents the opportunity to eradicate them so that more individuals can receive services.

References

Aguirre Velasco, A., Cruz, I., Billings, J., Jimenez, M. & Rowe, S. (2020). What are the barriers, facilitators and interventions targeting help-seeking behaviors for common mental health problems in adolescents? *A Systemic Review. Aguirre Velasco et al. BMC Psychiatry, 20,* 1–22. https://doi.org/10.21203/rs.2.15552/v2

Ahern, N. & Bramlett, T. (2016). An update on teen pregnancy. *Journal of Psychosocial Nursing, 54*(2), 25–28. https://doi.org/10.3928/02793695-20160119-03

Akella, D., & Jordan, M. (2015). Impact of social and cultural factors on teen pregnancy. *Journal of Health Disparities Research and Practice, 8*(1), 41–62. http://digitalscholarship.unlv.edu/jhdrp/

Ali, M., Teich, J., & Mutter, R. (2018). The impact of single mother's health insurance coverage on behavioral health services utilization by their adolescent children. *The Journal of Behavioral Health Services and Research, 45*(1), 45–56. https://doi.org/10.1007/s11414-017-9550-2

Alter, G., & Gonzalez, R. (2018). Responsible practices for data sharing. *American Psychologist, 73*(2), 146–156. https://doi.org/10.1037/amp0000258

Amankwaa, L. (2016). Creating protocols for trustworthiness in qualitative research. *Journal of Cultural Diversity, 23*(3), 121–127.

Anderson, R., Jones, S., Navarro, C., McKenny, M., Mehta, T., & Stevenson, H. (2018). Addressing the mental health needs of Black American youth and families: A case study for the EMBRace Intervention. *International Journal of Environmental Research and Public Health Case Report, 15*(5), 1–17.

https://doi.org/10.3390/ijerph15050898

Aparicio, E. (2016). “I want to be better than you:” Lived experiences of intergenerational child maltreatment prevention among teenage mothers in and beyond foster care. *Child and Family Social Work Journal, 22,* 607–616. https://doi.org/10.1111/cfs.12274

Aschenbrener, C., & Johnson, S. (2017). Educationally-based, culturally-sensitive, theory-driven, mentorship intervention with at-risk Native American youth in South Dakota: A narrative review. *Journal of Child Family Study, 26,* 14–27. https://doi.org/10.1007/s10826-016-0537-z

Ashby, B., Ehmer, A., & Scott S. (2019). Trauma-informed care in a patient-centered medical home for adolescent mothers and their children. *Psychological Services.* *16*(1), 67–74. https://doi.org/10.1037/ser0000315

Ashby, B., Ranadive, N., Alaniz, V., St. John-Larkin, C., & Scott, S. (2016). Implications of comprehensive mental health services embedded in an adolescent obstetric medical home. *Maternal & Child Health Journal, 20*(6), 1258–1265. https://doi.org/10.1007/s10995-016-1927-y

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: A developmental approach to research methodology. *Open Review of Educational Research, 4*(1), 33–45. https://doi.org/10.1080/23265507.2017.1300068

Baksh, B. (2018). To bracket or not to bracket: Reflections of a novice qualitative researcher. *Narratives of Processional Helping, 24*(3), 45–55.

Bandura, A. (1963). *Social learning and personality development*. Holt, Rinehart, and

Winston.

Barker, A., Huntzberry, K., Secura, G., Peipert, J., & McBride, T. (2018). Medicaid savings from the Contraceptive CHOICE Project: A cost-savings analysis. *American Journal of Obstetrics and Gynecology*, *219*(6), e1–11. https://doi.org/10.1016/j.ajog.2018.08.043

Benjamin, A., & Carolissen, R. (2015). "They just block it out": Community counselors' narratives of trauma in a low-income community. *Peace and Conflict: Journal of Peace Psychology*, *21*(3), 414–431. https://doi.org/10.1037/pac0000099

Birt, L., Scott, S., Cavers, D., Campbell, C. & Walter, F. (2016). Member checking. *Qualitative Health Research, 26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Breslau, J., Cefalu, M., Wong, E., Burnman, M., Hunter, G., Florez, K., & Collins, R. (2017). Racial/ethnic differences in perception of the need for mental health treatment in a US national sample. *Social Psychiatry & Psychiatric Epidemiology, 52*(929–937). https://doi.org/10.1007/s00127-017-1400-2

Brewer, L., & Williams, D. (2019). We've come this far by faith: The role of the Black church in public health. *American Journal of Public Health*, *109*(3), 385–386. https://doi.org/10.2105/ajph.2018.304939

Burrus, B. (2018). Decline in adolescent pregnancy in the United States: A success not shared by all. *American Journal of Public Health, 108*(S1), S5–S6. https://doi.org/10.2105/ajph.2017.304273

Butler-Barnes S., Martin P., Hope, E., & Copeland-Linder, N. (2018). Religiosity and

coping: Racial stigma and psychological well-being among African American girls. *Journal of Religion and Health, 5*, 1980–1995. https://doi.org/10.1007/s10943-018-0644-9

Cahyaningtyasa, D., Astuti, A., & Hani, U. (2020). Parents involvement and barriers of programme interventions to reduce adolescent pregnancy. *Journal of Health Technology Assessment in Midwifery, 3*(2), 73–86. https://doi.org/10.31101/jhtam.1312

Carlson, D. (2016). Challenges and transformations: childbearing and changes in teens' educational aspirations and expectations. *Journal of Youth Studies, 19*(5), 705–724. https://doi.org/10.1080/13676261.2015.1098771

Chang, C., Downey, C., Hirsch, J., & Lin, J. (2016). Positive psychology in racial and ethnic minority groups: *Theory, Research, and Practice. American Psychological Association.* 259–279.

Combs, K., Begun, S., Rinehart, D., Taussig, H. (2018). Pregnancy and childbearing among young adults who experienced foster care. *Child Maltreatment, 23*(2), 166–174. https://doi.org/10.1177/1077559517733816

Connelly, L. (2016). Trustworthiness in qualitative research. *Medsurg Nursing, 25*(6), 435–436. https://doi.org/10.1080/08924562.2017.1297750

Corcoran, J. (2016). Teenage pregnancy and mental health. *Journal of Societies, 6*(21), 1-9. https://doi.org/10.3390/soc6030021

Cox, J., Harris, S., Conroy, K., Engelhart, T., Vyayaharkar, A., Federisco, A., & Woods, E. (2019). Studies from children's hospitals provide new data on pediatrics (A

parenting and life skills intervention for teen mothers: a randomized controlled trial). *Mental Health Weekly Digest, 143*(30), 1–13. https://doi.org/10.1542/peds.2018-2303

Cuevas, A., O'Briena, K., & Sahab, S. (2017). What is the key to culturally competent care: Reducing bias or cultural tailoring? *Psychology & Health, 2017, 32*(4), 493–507. https://doi.org/10.1080/08870446.2017.1284221

Danawi, H., Bryant, Z., & Hasbini, T. (2016). Targeting unintended teen pregnancy in the U.S. *International Journal of Childbirth Education, 31*(1), 28–31.

Dee, D., Pazol, K., Cox, S., Smith, R., Bower, K., Kapaya, M., Fasula, A., & Harrison, A., (2017). Trends in repeat births and use of postpartum contraception. *Morbidity and Mortality Weekly Report, 66*(16), 422–426. https://doi.org/10.15585/mmwr.mm6616a3

DeJonckheere, M., &Vaughn, L. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health,7*(2), 1–7. https://doi.org/10.1136/fmch-2018-000057

Dobbins, C., Kenney, B., Meier, C. & Taormina, V. (2016). Down with teen pregnancy, up with mobility: Teen pregnancy prevention efforts in Gatson, County, North Carolina. *North Carolina Medicine Journal, 77*(6), 338–393. https://doi.org/10.18043/ncm.77.6.388

Dodgson, J. (2017). About research: Literature reviews. *Journal of Human Lactation, 33*(1), 115–118. https://doi.org/10.1177/0033354916688185

Dowden, A., Gray, K., White, N., Ethridge, G., Spencer, N., & Boston, Quintin. (2018).

A phenomenological analysis of the impact of teen pregnancy on education attainment: Implications for school counselors. *Journal of School Counseling, 16*(8), 1–25.

Dunne, T., Pharm, S., & Darcy, S. (2017). A review of effective youth engagement strategies for mental health and substance use interventions. *Journal of Adolescent Health, 60*(5), 487–512. https://doi.org/10.1016/j.jadohealth.2016.11.019

Fernandes-Alcantara, A. (2018). Financial and social costs of teen births. *Congressional Research Service: Report*, 8–10.

Fernandes, R., Meincke, S., Soares, M., Bueno, M., Corrêa, A., & Alves, C. (2017). Maternity in adolescence: Reasons for planning it. *Journal of Nursing, 11*(5), 1776–1782. https://doi.org/10.1111/ijn.12278

Fife Donney, J., Mitchell, S., & Lewin, A. (2020). Medicaid instability and mental health of teen parent families. *Journal of Family and Community Health, 43*(1), 10–16. https://doi.org/10.1097/fch.0000000000000240

Fleet, D., Burton, A., Reeves, A., & DasGupta, M. (2016). A case for taking the dual role of counselor-researcher in qualitative research. *Qualitative Research in Psychology, 13*(4), 328–346. https://doi.org/10.1080/14780887.2016.1205694

Fofana, F., Bazeley, P., & Regnault, A. (2020). Applying a mixed methods design to test saturation for qualitative data in health outcomes research. *PloS one, 15*(6), e0234898. https://doi.org/10.1371/journal.pone.0234898

Forero, R., Nahidi, S., De Costa, J., Mohsinz, M., Fitagerald, G., Gibson, N., McCarthy,

S.,

Aboagye- Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. BMC Health Serv Res 18, 120 (2018). https://doi.org/10.1186/s12913-018-2915-2

Freed, P., & Smith – Battle, L. (2016). Promoting teen mothers' mental health. *MCN Am Journal of Maternal Child Nursing, 41*(2), 84–9. https://doi.org/10.1097/nmc.0000000000000216

Fripp, J., & Carlson, R. (2017). Exploring the influence of attitude and stigma on participation of African American and Latino populations in mental health services. *Journal of Multicultural Counseling and Development, 45*(1), 85–94. https://doi.org/10.1002/jmcd.12066

Graves, L. (2017). Filters of influence: The help-seeking process of African American single mothers living in poverty seeking mental health services for their children. *Journal of Children and Youth Services, 38*(1), 69–90. https://doi.org/10.1080/0145935x.2016.1251836

Gubrium, A., Fiddian-Greena, A., Jerniganb, K., & Krauseb, E. (2016). Bodies as evidence: Mapping new terrain for teen pregnancy and parenting. *Global Public Health, 11*(5), 618–635. https://doi.org/10.1080/17441692.2016.1143522

Gul, R., & Russo, C. (2016). Meeting the needs of student parents. *School Business Affairs, 82*(5), 37–39. https://doi.org/10.3102/1880656

Harrison, M., Clarking, C., Rohde, K., Worth, K., & Fleming, N. (2017). Treat me but don't judge me: A qualitative examination of health care experiences of pregnant

and parenting youth. *Journal of Pediatric and Adolescent Gynecology, 30*(2), 209–214. https://doi.org/10.1016/j.jpag.2016.10.001

Haynes T., Cheney A., Sullivan, J., Bryant K., Curran G., Olson M., Cottoms, M., & Reaves C. (2017). Addressing mental health needs: Perspectives of African Americans living in the rural South. *American Psychiatric Association, 68*(6), 573–578. https://doi.org/10.1176/appi.ps.201600208

Hodgkinson, S., Beers, L., Southammakosane, C., & Lewin, A. (2013). Addressing the mental health needs of pregnant and parenting adolescents. *American Academy of Pediatrics, 133*(1), 1–11. https://doi.org/10.1542/peds.2013-0927

Holeness, N. (2015). A global perspective on adolescent pregnancy. *International Journal of Nursing Practice, 21*(5), 677–681. https://doi.org/10.1111/ijn.12278

Holeness, N. (2015). A global perspective on adolescent pregnancy. *International Journal of Nursing Practice, 21*(5), 677–681.

Horsburgh, J., & Ippolito, K. (2017). A skill to be worked at: using social learning theory to explore the process of learning from role models in clinical settings. *BMC Medical Education, 18*(156), 1–8. https://doi.org/10.1186/s12909-018-1251-x

Hudgins, R., Erickson, S., & Walker, D. (2014). Everyone deserves a second chance: A decade of supports for teenage mothers. *National Association of Social Workers, 39*(2), 101–108. https://doi.org/10.1093/hsw/hlu014

Jones, C., Whitfield, C., Seymour, J., & Hayter, M. (2019). “Other girls’: A qualitative exploration of teenage mothers’ view on teen pregnancy in contemporaries. *Journal of Sexuality & Culture, 23*, 760–773.

http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf.

Jones, S., McGarrah, M., & Kahn, J. (2019). Social and emotional learning: A principled science of human development in context. *Academic Journal*, 54(3), 129–143. https://doi.org/10.1080/00461520.2019.1625776

Kalman, M., (2019). "It requires interest, time, patience, and struggle": Novice researchers' perspectives on and experiences of the qualitative research journey. *Qualitative Research in Education, 8*(3), 341–377. https://doi.org/10.17583/qre.2019.4483

Karagiozois, N. (2018). The complexities of the researcher's role in qualitative research: The power of reflexivity. *The International Journal of Interdisciplinary Educational Studies, 13*(1), 19–31. https://doi.org/10.18848/2327-011x/cgp/v13i01/19-31

Katz, J., & McKinney, M. (2018). White female undergraduates' perceptions of Black pregnant adolescents: Does control over pregnancy matter? *American Psychological Association, 3*(1), 69–76. https://doi.org/10.1037/sah0000074

Kawaii-Bogue, B., Williams, N., & MacNear, K. (2017). Mental health access and treatment utilization in African American communities an integrative care framework. *Best Practices in Mental Health, 13*(2), 11–29.

Kennedy, D. (2016). Is it any clearer? Generic Qualitative Inquiry and the VSAIEEDC model of data analysis. *The Qualitative Report, 21*(8), 1369–1379; https://doi.org/10.46743/2160-3715/2016.2444.

Killebrew, A., Smith, M., Nevels, R., & Weiss, N. (2014). African-American adolescent

females in the Southeastern United States: Associations among risk factors for teen pregnancy. *Journal of Child & Adolescent Substance Abuse, 23*(1), 65–77. https://doi.org/10.1080/1067828x.2012.748591

Kim, G., Dautovich, N., Ford, K., Jimenez, D., Cook, B., Allman, R., Parmelee, P. (2017). Geographic variation in mental health care disparities among racially/ethnically diverse adults with psychiatric disorders. *Social Psychiatry & Psychiatric Epidemiology, 52*, 939–948. https://doi.org/10.1007/s00127-017-1401-1

Kim, H., Sefcik, J., & Bradway, C., (2017). Characteristics of qualitative descriptive studies: A systemic review. *The Journal of Research in Nursing Health, 40*(1), 23–42. https://doi.org/10.1002/nur.21768

Korstjens, I., & Moser, A., (2018). Series: Practical guidance to qualitative research. Part 4. Trustworthiness and publishing. *The European Journal of General Practice. 24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Kost, K., & Stanley H. (2014). U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race, and Ethnicity. *Guttmacher Institute*. (1),1–29.

Laurenzi, C., Gordon, S., Abrahams, N., du Toit, S., Bradshaw, M., Brand, A., Melendez-Torres, G. J., Tomlinson, M., Ross, D., Servili, C., Carvajal-Aguirre, L., Lai, J., Dua, T., Fleischmann, A., & Skeen, S. (2020). Psychosocial interventions targeting mental health in pregnant adolescents and adolescent parents: A systemic review. *Journal of Reproductive Healthy, 17*(1), 1–15.

https://doi.org/10.1186/s12978-020-00913-y

Levitt, H. M. (2021). Qualitative generalization, not to the population but to the phenomenon: Reconceptualizing variation in qualitative research. *Qualitative Psychology*, *8*(1), 95–110. https://doi.org/10.1037/qup0000184

Lindberg, L., Santelli, J., & Desai, S. (2017). Changing patterns of contraceptive use and the decline in rates of pregnancy and birth among U.S. Adolescents 2007 – 2014. *Journal of Adolescent Health, 63*(2), 253–256. https://doi.org/10.1016/j.jadohealth.2018.05.017

Logsdon, C., Myers, J., Rushton, J., Greggs, J., Josephson, A., Davis, D., Brothers, K., Baisch, K., Carabellos, A, Vogt, K., Joness, K., & Angermeier, J. (2018). Efficacy of an Internet-based depression intervention to improve rates of treatment in adolescent mothers. *Arches of Women's Mental Health*, *21*, 273–285. https://doi.org/10.1007/s00737-017-0804-z

Lu, W. (2019). Adolescent depression: National trends, risk factors, and healthcare disparities. *American Journal of Health Behavior, 43*(1), 181–194. https://doi.org/10.5993/ajhb.43.1.15

Lucas, G., Olander, E., Ayers, S., & Salmon, D. (2019). No straight lines – young women's perceptions of their mental health and wellbeing during and after pregnancy: a systemic review and meta – ethnography. *BCM Women's Health Journal*, *19*(152), 1–17. https://doi.org/10.1186/s12905-019-0848-5

Makanui, K., Jackson, Y., & Gusler, S. (2018). Spirituality and its relation to mental health outcomes: An examination of youth in foster care. Psychology of religion

and spirituality. *Psychology of Religion and Spirituality, 11*(3), 203–213. https://doi.org/10.1037/rel0000184

Maness, S., Buhi, E. Daley, E., Baldwin, J., & Kromrey, J. (2016). Social determinants of health and adolescent pregnancy: An analysis from the national longitudinal study of adolescent to adult health. *Journal of Adolescent Health, 58*(6), 636–643. https://doi.org/10.1016/j.jadohealth.2016.02.006

Marseille, E., Mirzazadeh, M., Biggs, A., Miller, A., Horvath, H., & Lightfoot, A. (2018). Effectiveness of school-based teen pregnancy prevention programs in the USA: A systematic review and meta-analysis. *Journal of Prevention Science, 19*, 468–489. https://doi.org/10.1007/s11121-017-0861-6

McMahon, S., & Winch, PJ. (2018). Systemic debriefing after qualitative encounters: An essential analysis step in applied qualitative research. *BMJ Global Health.* https://doi.org/10.1136/bmjgh-2018-000837

McSorley, L., Deighton-Smith, N., Budds, K., & Wang, X. (2022). "Hang in there mama!" The role of online parenting forums in maternal mental health. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace, 16*(4), Article 11. https://doi.org/10.5817/cp2022-4-11

Mind. (2020, April). *Postnatal depression and perinatal mental health.* https://www.mind.org.uk/informationsupport/types-of-mental-health-problems/postnatal-depression-and-perinatal-mental-health/about-maternalmental-health-problems/

Moore, D., Drey, N., & Ayers, S. (2019). A meta-synthesis of women's experiences of online forums for maternal illness and stigma. *Archives of Women's Mental*

Health, *23*(4), 507–515. https://doi.org/10.1007/s00737-019-01002-1

Morse, J. M. (2015). Data were saturated. *Qualitative Health Research Journal. 25*(5), 87–588. https://doi.org/10.1177/1049732315576699

Muzik, M., Kirk, R., Dip, S., Alfafara, E., Jonika, J., & Waddell, R. (2016). Teenage mother of Black and minority ethnic origin want access to a range of mental and physical health support: A participatory research approach. *An International Journal of Public Participation in Health Care and Healthy Policy*, *19*(2), 403–415. https://doi.org/10.1111/hex.12364

Neely-Fairbanks, S., Rojas-Guyler, L., Nabors, L., & Banjo, O. (2018). Mental illness knowledge, stigma, help-seeking behaviors, spirituality, and the African American church. *American Journal of Health Studies*, *33*(4), 162–175. https://doi.org/10.47779/ajhs.2018.69

Nicolas-Lopez, M., Gonzalez-Alvarez, P., Sala de la Concepcion1, A., Giralt-Lopez, M., Lorente, B., Velasco, I., Sol Ventura Wichner, P., & Ginovart. G. (2022). Maternal mental health and breastfeeding admist the Covid-19 pandemic: Cross-sectional study in Catolonia (Spain). *BMC Pregnancy and Childbirth*, *22*,733. https://doi.org/10.47779/ajhs.2018.69

Nusbaum, L., Douglas, B., Damus, K., Paasche-Orlow, M., & Estrealla-Luna, N. (2016). Communicating risks and benefits in informed consent for research: A qualitative study. *Global Qualitative Nursing Research*, *4*, 1–13. https://doi.org/10.1177/2333393617732017

Nutty, A. (2019). As teen pregnancy rates drop, disparities persist. *The Alaska Nurse*,

70(5), 12-13.

Ofonedu, M., Harolyn M., Belcher, H., Budhathoki, C., & Gross, D. (2017). Understanding barriers to initial treatment engagement among underserved families seeking mental health services. *Journal of Child Family Studies, 26,* 863–876. https://doi.org/10.1007/s10826-016-0603-6

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administrative Policy on Mental Health, 42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Paton, D., & Wright, L. (2017). The effect of spending cuts on teen pregnancy. *Journal of Health Economics, 54,* 135–146.

Percy, K., Kostere, K., & Kostere, S., (2015). Generic qualitative research in psychology. *The Qualitative Report, 20*(2), 76–85. https://doi.org/10.1016/j.jhealeco.2017.05.002

Pires, S., Grimes K., Allen K., Gilmer, T., & Mahadevan, R. (2013). Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures. *Center for Health Care Strategies, 1*, 1–100.

Planey, A., McNeil-Smith, S., Moore, S., & Walker, T. (2019). Barriers and facilitators to mental health help-seeking African American youth and their families: A systemic review study. *Journal of Children and Youth Services Review, 101*, 190–200. https://doi.org/10.1016/j.childyouth.2019.04.001

Radcliff, E., Hale, N., Browder, J., & Cartledge, C. (2018). Building community

partnerships: Using social network analysis to strengthen service networks supporting a South Carolina program for pregnant and parenting teens. *Journal of Community Health, 43,* 273–279. https://doi.org/10.1007/s10900-017-0417-5

Reardon, T., Harvey, K., Baranawska, M., O'Brien, D., Smith, L., & Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systemic review of qualitative and quantitative studies. *EUR Child Adolescent Psychiatry, 26,* 623–647. https://doi.org/10.1007/s00787-016-0930-6

Rijnsoever, F. (2017). (I can't get no) Saturation: A simulation and guidelines for sample sizes in qualitative research. *PLOS ONE, 12*(7), 1–17. https://doi.org/10.1371/journal.pone.0181689

Roberts, K., Dowell A., & Nie, JB (2019). Attempting rigour and replicability in thematic analysis of qualitative research data: A case study of codebook development. *BMC Medical Research Methodology, 19*(1), 66. https://doi.org/10.1186/s12874-019-0707-y

Romero, L., Pazol, K., Warner, L., Cox, S., Kroelinger, C., Besera, G., Brittain, A., Fuller, T., Koumans, E., & Barfield, W. (2016). Reduced disparities in birth rates among teens aged 15-19 years - United States, 2006-2007, and 2013-2014. *Center for Disease Control and Prevention Morbidity and Mortality Weekly Report, 65*(16), 409–414. https://doi.org/10.15585/mmwr.mm6516a1

Rouleau, T. (2017). Teen childbearing and depression: Do pregnancy attitudes matter? *Journal of Marriage and Family, 79,* 390–404.

https://doi.org/10.1111/jomf.12380

Russell, M., & Odgers, C. (2019). Adolescents' subjective social status predicts day-to-day mental health and future substance abuse. *Journal of Research o Adolescence, 30*(S2), 532–544. https://doi.org/10.1111/jora.12496

Sapthiang, S., Van Gordon, W., & Shonin, E. (2019). Mindfulness in schools: A health promotion approach to improving adolescent mental health. *International Journal of Mental Health, 17*, 112–119. https://doi.org/10.1007/s11469-018-0001-y

Schulkind, L., & Sandler D. (2019). The timing of teenage births: Estimating the effect on high school graduation and later life outcomes. *Pregnancy in Adolescents, 56*(1), 345–365. https://doi.org/10.1007/s13524-018-0748-6

Schurer Coldiron, J., Bruns J. E., & Quick, H. (2017). A comprehensive review of wraparound care coordination research, 1986–2014. *Journal of Child and Family Studies, 121*. https://doi.org/10.1007/s10826-016-0639-7

Shepherd, S., Willis-Esqueda, C., Paradies, Y., Sivasubramaniam, D., Sherwood, J., & Brockie, T. (2018). Racial and cultural minority experiences and perceptions of health care provision in a mid-western region. *International Journal for Equity in Health, 17*, 1–2. https://doi.org/10.1186/s12939-018-0744-x

Slovin, J., & Semenec, P. (2019). Thinking/writing within and outside the IRB box: Ethical disruptions of data in qualitative research. *Reconceptualizing Educational Research Methodology, 10*(1), 14–27. https://doi.org/10.7577/rerm.3241

Smith, C., Strohschein, L., & Crosnoe, R. (2018). Family histories and teen pregnancy in the United States and Canada. *Journal of Marriage and Family, 80*, 1244–125.

https://doi.org/10.1111/jomf.12512

Solivan, A., Wallace, M., Kaplan, K., & Harville, E. (2015). Use of a resiliency framework to examine pregnancy and birth outcomes among adolescents: A qualitative study. *Families, Systems, & Health*, *33*(4), 349. https://doi.org/10.1037/fsh0000141

Stahl, N., & King, J. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, *44*(1), 26–28.

Stokar, H., Davis, L., Sinha, B, LaMarca, L., Harris, A., Hellum, K., & McCrea, T. (2017). "Love your love life": Disadvantaged African-American adolescents cocreate psychoeducational romantic and sexual health resources. *Journal of Youth Studies*, *19*(5), 705–724. https://doi.org/10.1093/sw/swx012

Sutton, J. (2015). Qualitative research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, *68*(3), 226–231. https://doi.org/10.4212/cjhp.v68i3.1456

Tang, S., Davis-Kean, P., & Chen, M. (2014). Adolescent pregnancy's intergenerational effects: Does an adolescent mother's education have consequences for her children's achievement? *Journal of Research on Adolescence*, *26*(1), 180–193. https://doi.org/10.1111/jora.12182

Tanner J., & Tanner, E. (2020). Fairy tales don't come true: The impact of aspirational distance on teen pregnancy prevention messages. *The Journal of Public Health and Marketing*, *39*(1), 15–30. https://doi.org/10.1177/0743915618816062

Taylor, B., Croff, J., Story, C., & Hubach, R. (2019). Recovering from an epidemic of teen pregnancy: The role of rural faith leaders in building community resilience. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-019-00863-1

Teherani, A., Martimianakis, T., & Stenfors-Hayes, T. (2015). Choosing a qualitative research approach. *The Journal of Graduate Medical Education, 7*(4), 669–670. https://doi.org/10.4300/jgme-d-15-00414.1

Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing*, *7*(3), 155-163. https://doi.org/10.4300/jgme-d-15-00414.1

Thurairajah, K., & Przeglad. S. (2019). Uncloaking the researcher: Boundaries in qualitative research. *Qualitative Sociology Review, 15*(1), 132–147. https://doi.org/10.18778/1733-8077.15.1.06

Tuval-Mashiach, R. (2021). Is replication relevant for qualitative research? *Qualitative Psychology*, *8*(3), 365–377. https://doi.org/10.1037/qup0000217

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology, 18*(1), 148. https://doi.org/10.1186/s12874-018-0594-7

Voit, Falk A. C.; Kajantie, Eero; Lemola, Sakari; Räikkönen, Katri; Wolke, Dieter; Schnitzlein, Daniel D. (2022). Maternal mental health and adverse outcomes. *PLoS ONE. Vol. 17(8),* 1–18; https://doi.org/10.1371/journal.pone.0272210

Weis, D., & Willems, H. (2017). Aggregation, validation, and generalization of

qualitative date-methodological and practical research strategies illustrated by the research process of an empirically based typology. *Journal of Integrative Psychological & Behavioral Science, 51*(2), 223–24. https://doi.org/10.1007/s12124-016-9372-4

Whitworth, T. (2017). Teen childbearing and depression: Do pregnancy attitudes matter? *Journal of Marriage and Family, 79*(2), 390–404. https://doi.org/10.1111/jomf.12380

Wirihana, L., Welch, A., Williamson, M., Christensen, M., Bakon, S., & Craft, J. (2018). Using Colazzi's method of data analysis to explore the experiences of nurse academics teaching on satellite campuses. *Journal of Nurse Researcher* 25(4), 30–34. DOI:10.7748/nr.2018.e1516

Winters, L. I., & Winters, P. C. (2012). Black teenage pregnancy. *A Dynamic Social Problem, 2*(1). https://doi.org/10.1177/2158244012436563

Woods-Giscombe, C., Robinson, M., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G. (2016). Superwoman schema, stigma, spirituality, and culturally sensitive providers: Factors influencing African-American women's use of mental health services. *Journal of Best Practices in Health Professions Diversity, 9*(1), 1124–1144. https://doi.org/10.1177/1049732310361892

Yee, C., Cunningham, S., & Ickovics, J. (2019). Application of the Social Vulnerability Index for identifying teen pregnancy intervention need in the United States. *Journal of Maternal and Child Health, 23,* 1516–1524. https://doi.org/10.1007/s10995-019-02792-7

Zanchi, M., Pereira da Costa Kerber, P., Biondi, H., Rita da Silva, M., & Goncalves, C. (2016). Teenage maternity: Life's new meaning. *Journal of Human Growth and Development, 26*(2), 199–204. https://doi.org/10.7322/jhgd.119268

Appendix A: Interview Protocol

Interview Protocol

Demographics

What is your gender?

What is your current age?

How many children do you have?

What are the ages of your children?

Did you seek out and receive mental health services while you were pregnant or parenting between the ages of 18 - 30?

Interview Questions

1. Tell me about your decision to seek mental health services.
2. What do you recall about your family and friends' response regarding your decision to seek treatment?
3. Were you encouraged or discouraged from seeking treatment by family and friends?
4. Did their support or lack of support impact your decision to obtain services?
5. When you decided to seek help, what was that process like for you?
6. What were the challenges you faced being pregnant/parenting while receiving mental health services?
7. When you think about your experiences of being pregnant/parenting and seeking mental
8. health services, what stands out most?

9. How satisfied were you with the services?
10. Can you share how the services received influenced your parenting or your perception of mental health services?
11. If applicable, tell me what led to your decision to end treatment.
12. Is there anything else you would like to share regarding your experience?
13. When you think about your experiences of being pregnant/parenting and seeking mental health services, what stands out most?
14. How satisfied were you with the services?
15. Can you share how the services received influenced your parenting or your perception of mental health services?
16. If applicable, tell me what led to your decision to end treatment.
17. Is there anything else you would like to share regarding your experience?

Appendix B: Recruitment Flyer

Pregnancy and Mental Health

If you are 18 – 30 years old and received mental health treatment while pregnant or parenting, you may be eligible to participate in a research study.

Study for pregnant or parenting teen moms.

We are looking for teen moms ages 18-30 who received mental health services while pregnant or parenting. We would love to hear about your experience!

Participants will be asked to:

- Participate in a one-time 60 minute online interview.

To register for the study please contact:

[redacted]

Location

- In response to the pandemic, and to ensure everyone's safety, all interviews will be conducted online via Zoom.

Are you eligible?

- Ages 18-30
- Pregnant or parenting teen mom
- Utilized mental health services while pregnant or parenting

If you're unsure if you meet the requirements, call or email:

- Chana Campbell MA, MPhil
- Researcher

[redacted]