Social Identities and Psycho-Social Needs in Adolescents’ Health Literate Practices

by

Mimi Cimon
B.A. University of Victoria, 2001

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

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University of Victoria

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Abstract

Adolescent perspectives on health and the social and literate values of their health related behaviours require exploration and examination in health literacy, as knowledge gaps related to the constituents of health literate practices, and the functions and acquisition of health literacy exist in the literature. Research addressing this was approached based on socio-cultural and socio-ecological principles using a collective instrumental case design. Participants were new adolescent mother aged 15-18 recruited from 4 different community/education programs around Victoria, BC. Data was collected over a four month period, and consisted of individual and focus group interviews, journals, and researchers’ observations and field notes. Findings show that participants’ health behaviours changed significantly in tandem with their identities, the groups they associated with, and the social contexts they moved within. Findings indicate that identity, informal social environments, and unconscious cognitive process and psychosocial needs play a role in adolescents health literacy and literate practices.
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Dedication

This work is dedicated to my daughter Cimon and my mother Joan.
Chapter 1

Introduction

When I began considering research topics in the field of health literacy, I was certain that commercial mass media’s influence on adolescent health literacy would be a topic which adolescents would relish assisting me investigate. However, after listening to and observing the way the adolescent participants in this study responded to some of my media related queries it became clear that they were not critically aware of, interested in, or concerned with my preconceived topic, and/or how media might be influencing their health and/or literacy. What participants seemed very engaged and interested in was sharing information about themselves and the lifestyles they led before, during and after their pregnancies. What seemed important to them and what they were eager to discuss was the way their roles and identities as mothers transformed key aspects of their lives. Most notably, these aspects of life included their health attitudes and behaviours, social affiliations and activities, relationships with friends, families and boyfriends, and finally their hopes for the future. Initially, upon realizing that my media topic wasn’t going to “work” and that I would have to change it and the focus of my research, I felt I had done something wrong as a researcher. At this point a far more experienced researcher than I reminded me of some of the key tenets and benefits of the qualitative approach that I had chosen. These include the flexibility to change directions with an open mind and an eagerness to learn from the unpredictable, unforeseeable and uncontrollable circumstances and happenings that arise during the process of conducting an investigation (Creswell, 1998). I was reminded that in the qualitative paradigm, not knowing, and being open to the unexpected, is fundamental and viewed as an opportunity to gain otherwise unattainable insight into topics under exploration. It is this recognition about the researcher’s lack of control over the topics investigated that is the
hallmark of qualitative inquiry and that which allows interests, questions and themes to be pursued as they emerge in the research. Lincoln and Guba (1985) explain that an emergent design,

is not simply an effort on [a researcher’s] part to get around the “hard thinking” that is suppose to precede an inquiry; the desire to permit events to unfold is not merely a way of rationalizing what is at bottom “sloppy inquiry.” The design specifications of the conventional paradigm form a procrustean bed of such a nature as to make it impossible for the naturalist to lie in it - not only uncomfortably, but at all.

(as cited in Patton, 1990, pp. 61-62)

As the most vivid and meaningful data in this study came out of participants’ retrospective accounts of their experiences as adolescents prior to pregnancy, during pregnancy and as first-time mothers, it was necessary to shift the focus of this research to explore and represent their experiences. Fortunately, the approach and methods I had chosen made this change in focus feasible and natural.

The State of Adolescent Health in North America

In response to widespread concern over the state of adolescent health, adolescent health literacy and adolescents’ health related attitudes and behaviours in North America, research into the multiple factors that determine these interrelated aspects of adolescent health and life has flourished (Begoray, Poureslami, & Rootman, 2007; Hemming, & Langille, 2006; Manganello, 2007; Nutbeam, 2008, 2005, 2000; Percy-Smith, 2007; Rootman, & Ronson, 2005). Warrant for this growing concern and evidence that suggests fundamental problems with current methods of health education and promotion, and current conceptualizations of health literacy’s role in determining adolescents’ health-related behaviours are discernable and substantiated in a report
commissioned by the National Coordinating Committee on School Health and Safety. This report, generated in May 2004, states that;

the major causes of death, disability, and illness among young people (i.e., motor vehicle crashes, other unintentional injuries, violence, suicide, sexually transmitted diseases and unintended pregnancies) and among adults (ie., heart attack, stroke, cancer, lung disease, and diabetes) result from a few patterns of behavior that become established during school age years - alcohol and drug abuse, behaviors that result in unintentional injuries, sexual behaviors, tobacco use, unhealthy diets, and physical inactivity. [Emphasis added]

(as cited in Kolbe, 2005, p. 226)

Indicated here, and by numerous studies on various aspects of adolescent health, is that many of the health-related behaviours that adolescents take part in are thought to constitute the primary causes of illness, and death and disability are among them (Chang, Sherritt, & Knight, 2005; Flay, 2002; Wilson, Syme, Boyce, Battistich, & Selvin, 2005). Further, “mortality and morbidity rates for adolescents and young adults in Western countries have been increasing during the past few decades…” (Hurrelman, & Loselin, as cited in Raphael, Rukholm, Brown, Bailey, & Donato 1996, et al, p. 366).

Western Approaches to Health and Health Literacy Education

Traditionally, Western approaches to health literacy education and health promotion have been narrowly focused on the provision of health information, the prevention of individual diseases and “problem” behaviours, and the promotion of healthy lifestyles that include healthy eating habits and fitness regimes (Burkitt, 2005; Maes, & Lievens, 2003; Lynagh et al., as cited in Mukoma, & Flisher, 2004; Nutbeam, 2000). Two underlying assumptions of this approach are
that the state of one’s health is primarily self-determined and a matter of conscious effort and healthy decision making, and that health and health related behaviours are either healthy or unhealthy, without consideration given to the contexts within which they occur, and their values and/or benefits as they are perceived by the adolescents who enact them. Indicative of this approach to health education is the health component of British Columbia’s Planning 10 Curriculum (2007) which states that grade 10 students “are beginning to assume greater independence from adult-decision-makers who have guided them throughout their early years” (Planning 10, p. 29), making them ready to:

learn the decision making skills required to take increasing responsibility for developing and maintaining a healthy lifestyle…[and] learn to assess the short-term and long-term consequences of their health decisions for themselves and for their families, peers, and society at large. (p. 17).

Health and health literacy, according to this document, are matters of lifestyle choice, self-regulation, self-responsibility and careful, conscious consideration of the multiple short and long term health implications of behaviour. To contextualize and apply this approach and demonstrate its problems, consider the way youth are taught that what they eat is their choice and a matter of self-regulation, when in fact much of what determines their dietary and/or nutritional intake is dependent on what is affordable and/or promoted, and made available to them in their homes, schools, communities and broader society (Evans, Wilson, Buck, Torbett, & Williams, 2006; Maes, & Lievens, 2003; Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006). Social and environmental factors such as these are precisely what many adolescents have little or no awareness of, and therefore little or no control over, or choice in. Further, the expectation that 14 to 16 year old adolescents should have the will, wisdom, self-control, critical consciousness
and/or critical literacy skills necessary to accomplish the learning outcomes outlined in Planning 10 seems unreasonable, as self-awareness and critical literacy instruction within health contexts are not core components of the curriculum. Approaches to health that focus on conscious, individual choice making such as this, do not attend to the social, economic and environmental factors that determine health and behaviour (Frith, M. & Frith, K., 1993; Maes, & Lievens, 2003; Nutbeam, 2008), nor do they teach adolescents about the roles of unconscious cognitive processes and psycho-social needs in motivating their behaviour.

These assumptions about health literacy involving self-discipline and self-responsibility explain to some extent why the emphasis in health education and promotion has been placed on the provision of health information and disease prevention; as presumably if adolescents are well informed about the risks and possible consequences of their behaviour, they should choose not to participate in them. Unfortunately, this is not the way human adolescents, or adults, function, develop, learn and grow. Approaches to health and health literacy learning like this have proven to be unsuccessful in fostering lasting positive changes to adolescents’ health attitudes and behaviours (Frith, K., & Frith, M, 1993; Glantz, & Mandel, 2005; Nutbeam, 2000; Wyrick, D., Haworth Wyrick, C., Bibeau, & Fearnnow-Kenney, 2001), and “problem behaviours” persist in North America despite the proliferation of prevention campaigns and health education and promotion programs that inundate youth with volumes of fear evoking information about the serious risks and lifelong health implications of certain behaviours. (Glantz, & Mandel, 2005; Godin, Anderson, Lambert, Desharnais, 2005; Janssen, Katzmarzyk, Boyce, King, & Pickett, 2004; Stahl, Rutten, Nutbeam, Bauman, Kannas, et al., 2001; Wyrick, Haworth Wyrick, Bibeau, & Fearnnow-Kenney, 2001).
Media’s Role in Constructing Health and Disseminating Health Information

While health education and promotion attempt to deter adolescents from taking part in risky behaviours and adopting unhealthy attitudes and lifestyles, the commercial mass media, a dominant socio-cultural transmitter and information source, creates and perpetuates adolescent behaviour norms and social identities that encourage youth to emulate and participate in them (Brown, Halpern, L’Engle, 2005; Kaplan, & Cole, 2003; Kardes, 2005; Kubey, 1994; Lavine Zamir, 2007; McQuarrie, & Phillip, 2005; Tiggemann, 2005; Wright, Friestad, & Boush, 2005).

For example, fast food is sold to youth by associating its consumption with vitality, fitness, happiness, beauty, popularity and fame (Garfinkel, & Garner, 1982; Kanner, 1994; Kaufman, 1980; Nemeroff, Stein, Diehl & Smilack, 1994; Signorielli, 1993, as cited in Borzekowski, Robinson, & Killen, 2000; Kline, 2006), when in fact regular consumption of fast food is negatively correlated with diabetes and obesity among children and youth. That adolescents are continually exposed to and unconsciously influenced by deceptive and misleading media content and imagery that negatively impacts their health and sense of well being is irrefutable (Kaplan & Cole, 2003). Representative of mainstream Western culture and its capitalist, consumer ideology (Brown & Witherspoon. 2000; Burkitt, 2005; Frith, K., & Frith, M., 1993; Gee, 2004), health has been constructed by commercial media as a commodity consisting of, and attained by choosing the “right” lifestyle and following a “fitness regime” (Burkitt, 2005, p. 377). Further, Hoikkala and Hakkarainen (2005) state that one of the results of media depicting health in terms of consumption and choice is that “education programs aimed at improving the health literacy of young people now have to be directed at ‘the individual choice generation’ for whom exerting freedom of choice and developing life management skills is a key component of success” (as cited in Burkitt, 2005, p. 377). The emphasis placed on individual responsibility for, and freedom
to choose health and health related behaviour ignores the central roles that social, political, economic and environmental factors play in determining health related behaviours and their values – both healthy and unhealthy (Flay, & Phil, 2002; Nutbeam, 2000; Stokols, 2000).

More recently, this Western notion of health has been reconsidered and revised in the literature, as researchers and educators have observed and reported on the multiple interacting social and environmental factors determining health and behaviour patterns (Raphael, Rukholm, Brown, Bailey, & Donata, 1996). “This shift has come from the recognition that individual behavior is shaped and reinforced by mutual and dynamic interactions within one’s physical and social surroundings” (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006, p 30), resulting in a more holistic, comprehensive and ecological perceptive on health (Stokols, 1996, as cited in Novilla, et al.; Raphael, Rukholm, Brown, Bailey, & Donata, 1996). Reflective of this change to the way health is perceived, the World Health Organization (WHO) defines it as “a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity” (as cited in Frith, M. & Frith, K.,1993, p. 420), and The Ottawa Charter’s “Prerequisites for Health” states that “peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity” are “fundamental conditions” for its realization (WHO, 1986).

This socially, culturally and ecologically conscious stance on health has caused problems for Westerners due to their social-political history and orientation, as “the implication that ‘health’ has a social existence that somehow transcends the individual does not easily mesh with the western belief in individualism” (Frith, K, & Frith, M, 1993, p. 421; also see McKinlay, & McKinlay, 1997; McKinlay, & Marciaeu, 1999; McLeroy, & Crump, 1994, as cited in Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006). Evidence of this incompatibility and of
Western ideology’s focus on individual rights, freedoms and responsibilities are clearly evident in current definitions of health literacy and current methods of health education, as they place the onus of creating and maintaining health squarely on the shoulders of individuals, and in this case on the shoulders of individual adolescents. These programs designate this responsibility to youth without providing them with information about their own human psycho-social needs, the unconscious cognitive processes that motivate much of their behaviour, and the critical literacy skills required to recognize, understand, and subsequently change the inequitable social and economic circumstances that surround them and impact their health (Simpson, & Freeman, 2004).

**Relationships between Health and Literacy**

In spite of acknowledgements made in the literatures on adolescent health and health education and promotion which point to the necessity of addressing the social and ecological determinants of adolescent health, governments, policy makers and the public have not yet come to terms with the necessity of dealing with society’s social problems, including poverty and inadequate social and educational programs. The interrelated social consequences and realities of a society that fails to ensure that all its citizens have their basic human needs met through equitable access to resources; food, housing, childcare, employment, and education, is indicated by Rootman and Ronson (2005), as they report that "low literacy has direct and indirect impacts on health" and that people with "lower levels of literacy tend to live and work in less healthy environments, [and] have more difficulties obtaining employment and income security" (p. S62). Literacy is so closely tied to health and issues of identity and power that “literacy skills predict health status even more accurately than education level, income, ethnic background, or any other socio-demographic variable” (Grossman, & Kaestner, 1997; Weiss, 2001; Organization for
Economic Co-operation and Development, 2000, as cited in Rootman, & Ronson, p. S68; Lindau et al., 2002; Parker, et al., 2003; Schillinger, et al., 2002; Williams, et al., 1998, as cited in Speros, 2005). This has lead to the common understanding that literacy is directly related to income and “overall health status and mental health status” (Baker, Parker, Williams, Clark, & Nurss, 1997; Baker, Gazmararian, Sudano, Patterson, Parker, & Williams, 2002; Roberts, & Fawcett, 1998, as cited in Rootman, & Ronson, p. S67). Known determinants of adolescent health which are also determinants of adolescent literacy, identity, and health-related behaviours, include socio-economic status (2006 Report Card on Child and Family Poverty in Canada; Evans, Wilson, Buck, Torbett, & Williams, 2006; Goodman, Huang, Schafer-Kalkhoff, & Adler, 2007; Peterson, Lowe, Peterson, & Janz, 2006; Potter, Speechley, Koval, Gutmanis, Campbell, & Manuel, 2005), culture, language, race and/or ethnicity and education (Chen, 2005; Delpit, 1992; Gee, 2000; Gee, 1989; Ladson-Billings, 1992; Sparkes, 1997; Vygotsky, as cited in Berk, & Winsler, 1995), gender, (Guzzeti, Gritsavage, Fyfe, & Hardenbrook, 2002), self-perception and/or self-belief (Valentine, Cooper, Bettencourt, & DuBois, 2002; Walker, Deng, & Dieser, 2005), "early childhood development, aging, living and working conditions, [and] personal capacity/genetics" (Rootman, & Ronson, 2005, p.s63). The latest figures on literacy levels in Canada derived from The International Adult Literacy and Lifestyle Survey (2005) show that 42% of Canadians aged 16 to 65 fall into the lowest two literacy categories; with 15% scoring in the lowest level representing “people who would have difficulty meeting everyday reading requirements” (Rootman & El-Bihbety, 2006, p. S7). According to Statistics Canada, “this means that 3 million Canadians aged 16 to 65 have problems dealing with printed materials”, making low literacy a serious problem in Canada (Rootman & El-Bihbety, pp. S7-S8). While the social, political and economic ramifications of low literacy continue to be of central concern to
researchers, there is little evidence that sufficient action has been taken to address these concerns, as studies have shown that "more years spent at school are not linked to higher literacy levels" (Rootman, & Ronson, 2005, p. S64; Nutbeam, 2008).

Theoretical Perspective

The theoretical perspectives drawn upon in this study are fundamentally socio-cultural and socio-ecological as these theories recognize “that individual behavior is shaped and reinforced by mutual and dynamic interactions within one’s physical and social surroundings” (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006, p 30; Raphael, Rukholm, Brown, Bailey, & Donata, 1996; Stokals, 2000). These socially oriented theories emphasize the multiple interacting social, economic and environmental factors determining health, literacy, identity and behaviour patterns (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006, p 30; Nutbeam, 2000; Raphael, Rukholm, Brown, Bailey, and Donata, 1996; Stokals, 2000), and “the joint influence of behaviour and environment on wellness rather than focusing exclusively on either category of health-determining factors” (Stokals, 2000, p. 24). Socio-cultural and socio-ecological theories have been widely accepted and applied across disciplines and literatures dealing with adolescent health, literacy, health literacy and health-related behaviour patterns.

Statement of Problem

Current definitions of adolescent health literacy do not reflect the views, concerns and values of many adolescents, nor do they clearly define the constituents of health literate practice. This is due, in part, to a lack of knowledge integration across literacy fields. As a result of this, fundamental aspects of literacy that have been widely acknowledged in other adolescent literacy fields have not been recognized and incorporated into understandings of health literacy. Such literacy fundamentals include recognition of informal settings and unconscious cognitive
processes in literacy learning and functioning, and the roles of psycho-social needs, social identities and social contexts in determining literacy development and the literate value of health attitudes and behaviours. Health literacy definitions and health education and promotion methods seem narrow in scope and tend to represent mainstream Western values that serve the interests and demands of a capitalist, consumer society and its economy, as health has been constructed as a commodity for public consumption, an individual responsibility and a matter of choice.

Statement of Purpose

One of the main purposes of this study was to obtain adolescent views on their own health, health literacy and health related behaviours, as well as to understand if and how they value them. Further, this study investigated relationships between adolescent health literacy and other adolescent literacies by attempting to ascertain the basic human needs and functions they serve and fulfill. Specifically, adolescents’ out of school literate practices and health literate practices were examined, and their constituents compared according to the corresponding literatures. To explore these relationships and the constituents of literate practices across forms, an approach that draws upon and integrates principles from socio-cultural and socio-ecological theories was used. By discussing participants’ health related attitudes and behaviours as literate practices, this study illuminates the role of unconsciousness processes and needs in becoming health literate and determining adolescents’ health literate practices. Finally, this study attempts to create a more integrated, comprehensive understanding about what it means to be literate.

Research Questions

1. How do adolescent mothers view and/or value health and their own health related behaviours before pregnancy and after becoming mothers?
2. What are the constituents of health literate practices according the literature on adolescent health literacy, and what criteria are used to determine whether health related behaviours are considered health literate practice?

3. What roles do unconscious psycho-social needs and cognitive processes play in adolescent literacy learning and literate practices according literatures related to other literacies?

4. How are adolescents’ health-related behaviours currently valued according to the literatures on adolescent health literacy and health related behaviour?
Chapter 2
Literature Review

In an effort to gain a more integrated perspective on adolescent literacies, and apprehend their essential natures, characteristics and functions across modes, content areas and contexts, this literature review will first provide background information about language ideology and/or social and political movements impacting literacy definitions, literate practices and literacy education in North America since the late 1906’s; second, the critical role of groups in forming adolescents’ social identities, Discourses and literate practices will be discussed; third, specialized forms of literacy including multiple literacies, media literacy, critical literacy and health literacy will be defined and fourth, literacy’s primary functions and forms of acquisition will be identified and discussed in terms of the human needs they fulfill and human conditions they serve.

Before situating this review historically, it seems necessary to explain why the history drawn upon here is based on the struggles of African American students in American public schools. Nowhere in the literacy literatures are the human, social and political facets of adolescent identity and the evolution of literacy theory, literate practices and literacy education more thoroughly researched and vividly illustrated than in the case of African Americans. For this reason, and due to the fact that there is no parallel body of literature in Canadian contexts documenting the process by which informal, out of school ways of speaking, being and acting become recognized as literate practices, this study refers to the robust research on the literate practices of African American students. This is not to suggest that literacy studies on Canadian adolescents, marginalized and otherwise, do not exist, as they do and are referred to extensively throughout in this study and this review.
Language ideology refers to a set of collectively held beliefs about different languages and the identities of people who use them. More precisely, it refers to a set of assumptions and perceptions about people who speak in certain languages and act in certain ways (Wassink & Curzan, 2004). These preconceived ideas about language and groups of people were of central concern in the United States during the late 1960s and early 70s when the social-political movements of the time sparked a great deal of interest in and controversy over language and literacy education. Much more than the ability to read and write, literacy was recognized as integral to the construction and expression of identity, and for its power to liberate people from oppression and/or maintain the status quo by failing to provide adequate and equitable instruction in dominant forms of discourse (Delpit 1988; 1992; Freire, 1970; Gee, 1989; Heath, 1983; Orr, 2002). In American public schools, these issues of language, identity, education, and power were focused on African American students due to their consistently low performance and graduation rates (Wamba, 2006).

Historically, disparities between middle and upper-middle class White students and African American students, as well as other low-resourced racial and ethnic minorities, were attributed to dialect differences in their homes and communities, and to the fact that the English dialect taught in public schools and valued by mainstream society was, and is, Standard American English (SAE). Important reasons why the use of SAE presented serious problems for African American students include that it was the dominant form of discourse used by White speakers; it symbolized America's history of Black oppression, and functioned as an instrument of discrimination against African Americans and other minorities (Alim, 2004; Delpit, 1988; Fordham, 1999). Two primary consequences of these differences in identity, history, and social
status, as they were expressed and signified through language, is that African American students felt unrecognized and unrepresented in terms of their collective, racial identity, and thus had difficulty envisioning themselves as successful students in mainstream academic contexts, and/or felt the need to resist being successful in such environments due to their predominantly negative and White associations with having to use SAE to be successful within them. Ironically, a factor which further complicated the problem of dealing with students’ discourse differences effectively and equitably was the literate status given to "African American Vernacular English (AAVE) [which now] ranks among the most widely documented varieties in the sociolinguistic literature" (Poplack, 2000, p. 1). This recognition of AAVE is of central importance to this study, its findings and this literature review because it documents the legitimization of primary forms of discourse and literacy learned informally outside of school without conscious awareness or effort, and within the realms of students’ homes, cultures and communities (Heath, 1983).

One of the most vocal critiques of literacy education in American public schools and one of the most notable scholars to describe the way it has functioned to privilege white students and disadvantage students of colour, including African American and Native American students, is Lisa Delpit. In her paper entitled *The Silenced Dialogue: Power and Pedagogy in Educating Other People’s Children* (1988) Delpit explains how well intentioned “middle-class liberal educators” and scholars perpetuate existing power structures that support inequities in schools and society by their approach to *educating other people’s children* (p. 285). Referring to this phenomenon as the “the culture of power”, Delpit describes its characteristics and functions as follows.

1. Issues of power are enacted in classrooms.
2. There are codes or rules for participating in power; that is, there is a “culture of power”.
3. The rules of the culture are a reflection of the rules of the culture of those who have power.

4. If you are not already a participant in the culture of power, being told explicitly the rules of that culture makes acquiring power easier.

5. Those with power are frequently least aware of – or least willing to acknowledge its existence. Those with less power are often the most aware of its existence. (p. 282)

The rules for participating in power, according to Delpit, “relate to linguistic forms, communicative strategies, and presentation of self; that is, ways of talking, ways of writing, ways of dressing, and ways of interacting” (1988, pp. 282-283). Elaborating on how and by whom issues of power are enacted in classrooms, Delpit states that “the power of the teacher over the students, the power of the publishers of textbooks and of the developers of the curriculum to determine the view of the world presented; …[and] the power of an individual or group to determine another’s intelligence or ‘normalcy’” (p. 283) are all implicated. The rules of the culture of power are reflective of the culture of those who have power, as “success in institutions – schools, workplaces, and so on – is predicated upon acquisition of the culture of those who are in power” (p. 283). In other words:

children from middle-class homes tend to do better in school than those from non-middle-class homes because the culture of the school is based on the culture of the upper and middle classes – those in power. The upper and middle classes send their children to school with all the accoutrements of the culture of power; children from other kinds of families operate within perfectly wonderful and viable cultures but not cultures that carry the codes or rules of power(p. 283).
In keeping with Delpit’s assertions, Alim (2005) argues that linguistically profiled and marginalized students need to be armed "with the silent weapons needed for quiet, discursive wars" (xiii), adding that the role of language in society and schooling must be viewed critically, as the tradition of viewing it through a noncritical lens "can actually be harming linguistically profiled and marginalized students" (p. xxiii). Alim goes on to state that critical language awareness views educational institutions as designed to teach the citizens about the current sociolinguistic order of things without challenging that order, which is based largely on the ideology of the dominating group and their desire to maintain social control. Citing Foucault, Alim reminds us that, "history teaches us, discourse is not simply that which translates struggles or systems of domination, but it is the thing for which and by which there is struggle; discourse is the power which is to be seized" (xiii). From this position and based on this understanding about the roles of discourse, literacy education and schooling and the necessity of questioning their origins, this study proceeds in its investigation of the constituents and determinant of adolescents’ health literate practices.

Western Constructions of Adolescence and Identity

Before discussing the role of identity in adolescent literacy, health, health literate practices and/or health-related behaviour, it is important to define adolescence and identity as they are commonly understood in North American culture. Fiske explains these concepts from a Western perspective as follows:

In Western societies, adolescence is primarily a cultural construct. It symbolizes a period of breaking away from the collectivity of home and family and the emergence of the ideal unit of Western democratic societies – the “individual” self. Adolescence involves the rejection of the dominant (adult) culture and the
actualization of the individual as an historical and social construct formed both by his or her material social history and by the discourses through which he or she has experienced that history.


Indicated here is the paradox of adolescence and identity in Western culture, as these constructs are based on individuality and self-determination, yet the process of constructing an individual identity and sense of self is largely dependent on, and recognizable by social status, social groups and social affiliations for its definition. Epitomizing Western ideology’s individualistic worldview is the extent to which North American social psychology and the public institutions (public schools) it informs and is imbedded in, are characterized by self-centered language. For example, the subject indexes of widely used social psychology texts contain lists of terms and theories such as; “self-schema, self-complexity, self-verification, self-focusing, self-referencing, self-monitoring, and self-affirmation” (Brewer, 1991, p. 475). As these terms are preoccupied with “internal structure and differentiation of the self-concept rather than connections to the external world”, they ignore human evolutionary history and the fact that human beings are socially dependent animals that are “highly adapted to group living and not well equipped to survive outside a group context” (Brewer, p. 475). Absent from Western conceptualizations of identity is the critically important role that group membership plays in the cognitive and emotional development and health of adolescents.

Adolescent Social Identities, Big “D” Discourses and Literate Practices

According to James Paul Gee (2000) and other social literacy theorists (e.g., Barton & Hamilton, 2000; Street, 1995; 2001; 2003), adolescents’ literacies and literate practices are “inextricably connected to ‘identity work’” (p. 412). Central to this social-cultural perspective on
literacy is the understanding that rather than the “self contained ability to read and write English or some other language” (Gee, 2000, p. 412) and/or master “psycholinguistic processing skills”, literacies are socially situated acts of self-representation and communication about who we are, what we do, what groups we associate and identify with, and what we know (Gee, 2001, p. 714). While social identities are known to determine the social behaviours of adolescents and express their literate knowledge of various social and cultural groups and contexts to the extent that they are recognized as literate practices in literacy fields unrelated to health, their role in determining adolescents’ health related behaviours is not widely recognized. On the basis of Gee’s social literacy theory and his discussion of big “D” Discourses, which is outlined below, this review will attempt to bridge this gap in knowledge on the constituents of adolescents’ health literate practices.

“Socially situated identities” are defined as multiple identities that adolescents “take up as they move in and out of different social contexts and situations.” (Gee, as cited in Marsh & Stolle, 2006, pp. 48-49). While personal identity, or “core identity” is “whatever continuous and relatively ‘fixed’ sense of self underlies contextually shifting multiple identities” (p. 49), and/or refers to “the individuated self [and] those characteristics that differentiate one individual from others within a given social context” (Brewer, 1991, p. 476), social identities are “categorizations of the self into more inclusive social units that depersonalize the self-concept, where I becomes we” (Brewer, 1991, p. 476; Gee, 2006). Socially situated identities that adolescents adopt, enact and/or recognize in different social environments express their social literacies (Dagenais & Toohey, 2006; Moje, 2000; Schofeild & Rogers, 2004), as they demonstrate knowledge of the ways in which various groups of people within various social contexts behave, speak, think, and value. Further, it seems reasonable, and is consistent with what is known about adolescent
literacies, language learning, leisure behaviour, adjustment, and health that the acquisition, expression and enactments of social identities, social knowledge, social relatedness, social competence, and social status through literate practices function through unconscious cognitive processes that fulfill their basic human psycho-social needs.

Explaining his theory of literacy and making distinctions between its different levels, realms and scopes, Gee (1989) states that little “d” discourses represent mere “stretches of language that make sense” in grammatical terms, while big “D” “Discourses”, more than language mechanics and grammar, represent combinations of “saying (writing)-doing-being-valuing [and] believing” (p. 6). Big “D” Discourses are “ways of being in the world…which integrate words, acts, values, beliefs, attitudes, and social identities as well as gestures, glances, body positions, and clothes” (1989, p.6). Illustrating the extent to which identity and literacy are interrelated, Gee further describes Discourses as “‘identity kits’ which come complete with the appropriate costume and instructions on how to act, talk, and often write, so as to take on a particular role that others will recognize” (p. 7). This description of Discourse emphasizes “connections among language, embodied experience, and situated action and interaction”, thereby tying “language [and literacy] to embodied action in the material and social world” (Gee, 2001, p. 714; Marsh & Stolle, 2006).

Key components of big “D” Discourses include social languages, literate practices, genres and cultural models. Social languages are “ways with words (both oral and written) within Discourses that relate form and meaning so as to express specific socially situated identities and activities” (Gee, 2001, p. 721). Similarly, literate practices are socially situated behaviours and activities, and “socially situated beliefs, values, and purposes that shape how and why people use literacy” (Barton; Street, as cited in Moje, 2000, p. 655). When social languages
and literate practices are combined and associated with specific Discourses, they are referred to as genres. Explaining the role of genres in Discourse, Gee (2001) states that they are:

combinations of ways with words (oral and written) and actions that have become more or less routine within a Discourse in order to enact and recognize specific socially situated identities and activities in relatively stable and uniform ways (and, in doing so, we humans reproduce our Discourses and institutions through history) (p. 721).

This process of social and cultural reproduction is paramount during adolescence, as youth adopt and shed trends in music, dance, substance use, fashion, beauty, and language as they construct social identities reflective of their culture. A final component of Gee’s theory of Discourses which extends the social and cultural boundaries of genres and the knowledge contained in them is what he refers to as cultural models. Cultural models are:

Often tacit and taken for granted schemata, storylines, theories, images, or representations (partially represented inside people’s heads and partially represented within their materials and practices) that tell a group of people within a Discourse what is typical or normal from the point of view of that Discourse. (p. 721)

As different Discourses operate according to different cultural models, and thus place different values on social languages, behaviours and/or literate practices, they can cause conflict for those who move from one Discourse to another or for those who recognize those differences in value. Explaining the extent to which multiple Discourse appropriation can create conflict for users, Toohey, referencing the work of Bakhtin (1981; 1986), asserts that:

the appropriation of the words of others is a complex and conflictual process: because the historical, present and future positioning of the speakers and those of their interlocutors are expressed in the 'very words' of utterances, words are not neutral but express
particular cognitive predispositions, value systems and identity positions. Utterances, for Bakhtin, represent a voice, a perspective. Second language learning, then, becomes a struggle to come to voice. Learners must appropriate unfamiliar words and identity positions from others who may resist their appropriation - denying the legitimacy of 'those words' in 'those mouths'. Language learners face the complex and conflictual task of expressing their own meanings (suffused throughout with others' meanings) and finding responses for others' words (as cited in Toohey, 2000, p. 126).

Contributing to conflicts between Discourses and their associated communities is the fact that some Discourses are recognized as dominant and powerful while others are noted for their distinct lack of dominance and social capital (Delpit, 1988; 1992). This may explain why the “literate practices of marginalized adolescents are often referred to in terms of deviance or resistance” (Moje, 2000, p.651). For example, “gang-connected youth, in particular, are routinely represented as engaging in acts of villainy or resistance, but are rarely represented as meaning makers, people who are expressing their beliefs, values, and interests” (Moje, p. 651). As Moje aptly points out, “[i]f literacy theorists want to claim that literacy is a tool for transforming thought and experience…[they] need to extend that theoretical claim to all literacy practices by asking what unsanctioned literacy practices do for adolescents” (Moje, 2000, p.651). The extension and application of literacy theory to behaviours that are disapproved of by the mainstream, and thus misrepresented as purely unhealthy, bad, deviant and/or the consequence of a lack of literate knowledge, is precisely what this study attempts to accomplish with regard to the health literate practices of adolescents.
Defining Literacies

In an effort to locate and describe relationships between different forms of literacy and create a more integrated and unified understanding about what literacies and literate practices are, what they do and how they function for adolescents, this section will define specific literacies, including functional literacy, “new” multiple literacies, critical media literacy and health literacy, and identify areas among them that intersect, overlap and inform each other. These particular literacy forms were chosen for review due their implications and impacts on health and health literate practice. The intent here is to apply literacy knowledge and concepts derived from Gee’s Discourse theory, and the field of adolescent out-of-school literacies, to adolescents’ health literate practices.

Functional Literacy: While there are variations on the definition of functional literacy, most reflect and expand on UNESCO’s simple definition which states that “a person is literate who can with understanding both read and write a short simple statement on his everyday life” (as cited in Rootman & Ronson, 2005; Nutbeam, 2008). Taking this definition a step further, an expert panel of scholars on health literacy in Canada define literacy as “the ability to understand and use reading, writing, speaking and other forms of communication as ways to participate in society and achieve one’s goals and potentials” (Rootman & El-Bihbety, 2008). Further and more specific still, Nutbeam (2008) states that literate people are those who are able to “participate more fully in society, economically and socially, and are able to understand and exert a higher degree of control over every day events” (p. 2072). As the variations on this definition indicate, ideas about literacy have evolved and become more complex in terms of what they allow and/or expect people to do as result of their literate ability and skill. Another aspect of these definitions that requires critique is their focus on the exercise of “control”, the
“achievement” of goals, and participation in social and economic systems. These areas of emphasis (individual control, achievement and participation in economic and social arenas) equate literacy with democratic citizenship and capitalism (Burkitt, 2005; Gee, 2006).

**New Multiple Literacies**

Coinciding with and contributing to the recognition of “literacy as an instrument of economic and social power” (Willms, 1999, p. 11), an indicator of social identity, affiliation and status (Gee, 2006; March, & Stolle, 2006) and an important determinant of health (Nutbeam, 2008; Rootman, & Ronson, 2005) was the shift that occurred in dominant modes of communication during the mid-20th century (Luke, 2003; Gee, 2006). This shift, characterized by prolific expansion in the use and uses of mass communication technologies (i.e. television, movies, computers, and the internet), and a homogenous, commodified Western world view (Burkitt, 2005; Gee, 2006; Shilling, 2005) has contributed to the emergence of multiple, “new literacies”. Multiple literacies, which “involve learning a repertoire of practices for communication and getting things done in particular social and cultural contexts” (Nixon, 2003, p. 407; Hagoord, 2003; Kress, 2003; Luke, 2003; Mackey, 2003; Schofeild, 2004; Shilling, 2005; Street, 2003; Tatum, 2006; Young, Dillon, & Moje, 2004), currently receives the most attention from researchers of adolescents’ literate practices. This is due, in part, to the monumental changes that communication technologies have created in socio-cultural transmission, forms of representation, information delivery and exchange, adolescent health problems, leisure behaviours, literate practices, identity and culture. These multiple, interrelated adolescent realms and media’s impact on them are clearly represented in current literatures on adolescent literacies, as they tend to focus on specific modes of media technology (i.e. video games, texting, and/or the internet), and specialized subject and/or content areas (i.e. health literacy, cultural literacy,
visual literacy, critical media literacy) that are influenced and/or transformed by media. While it is prudent to research literacy topics and modes that are widely used by, and relevant to contemporary adolescents, it is also critical to investigate if and how these new forms of literacy function to serve, disrupt and/or fulfill adolescents’ psycho-social needs, and how adolescents are influenced by their content and use on conscious and unconscious levels.

**Critical Media Literacy**

If you are unable to decode the significance of ordinary things, and as long as you take the signs of your culture at face value, you will continue to be mastered by them. But once you see behind the surface of a sign into its hidden cultural significance, you can free yourself from that sign and perhaps find a new way of looking at the world. You will control the signs rather than having them control you (Solomon, as cited in Glasgow, 1994, p. 494).

Critical media literacy definitions vary across disciplines and depend on the theoretical framework one employs in its use. For example, in cultural studies critical media literacy is used to identify and discuss “how issues of ideology, bodies, power, and gender produce various cultural artifacts” (McRobbie, as cited in Alvermann, & Hagood, 2000, p. 194), while a post-modern perspective uses it to examine the way individuals absorb cultural texts differently depending on various aspects of their identity (Alvermann & Hagood, 2000). Similarly, the focus of critical media literacy from a feminist perspective is the way texts from popular culture function to produce and/or reproduce gender norms to reinforce existing power relations between them (Finders, 1997; Lewis, 1998; Luke, 1994; Moje, Willes, & Fassio, in press, as cited in Alvermann, & Hagood, 2000). Whichever theoretical framework people choose to investigate the meanings and factors that are most immediately relevant to them is of much less importance.
than knowing that these meanings exist and can be accessed and explored through critical inquiry, or the application of critical media literacy skills. Due to the volume and variety of media texts that youth encounter on a daily basis and in every conceivable context, critical media literacy instruction and skills development are needed; as these skills allow youth to navigate their way through volumes of information and comprehend the broader implications of the texts they engage with (Brown, 2006).

An example of the benefits of offering youth instruction in media literacy is illustrated in a yearlong study conducted in a grade 11 English media/communication course. In this study, students’ “ability to access, analyze, evaluate and communicate messages in a wide variety of forms” was measured (Hobbs & Frost, 2003, p. 334). Two demographically matched groups of grade 11 students were compared, one having had no media literacy instruction and the other having taken a course in media literacy which incorporated extensive critical media analysis of print, audio, and visual texts. The nonequivalent group design examined students' reading comprehension, writing skills, critical reading, critical listening, and critical viewing skills for nonfiction informational messages. Results from this study suggest that media literacy instruction improves students' ability to identify main ideas in written, audio, and visual media, and statistically significant differences were observed for writing quantity and quality. Specific text analysis skills also improved, including the ability to identify purpose, target audience, point of view, construction techniques used in media messages, and the ability to identify omitted information from the news media broadcast in written, audio, or visual formats” (Hobbs & Frost, p. 331). Due to the fact that many, if not most, forms of information, communication and cultural transmission today, including health information, are expressed through visual forms of mass media: television, film, magazines and the Internet, (Gonzales, Glik, Davoudi & Ang, 2004, p.
189; Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005; Natharius, 2004), it is crucial that media literacy be made a fundamental part of literacy and health literacy instruction (Brown, 2006; Brown, 2002; Gonzales, et al., 2004). While media literacy has been taught in some educational contexts, it has much less frequently been studied and used in health contexts.

It is interesting to note that when youth demonstrate their knowledge of culture and identity by emulating attitudes, behaviours and values depicted and contained in media, it is often attributed to a lack of media literacy skills, and not to an astute sense of cultural literacy. Alternatively, when adolescents demonstrate their knowledge of and identification with their racial and ethnic backgrounds, communities, and cultural identities, their behaviours are attributed to literate knowledge and literate practice, and/or primary forms of discourse. This observation suggests the extent to which designations of value are subject to social and political issues and the perceptions of those in power. It also points to the need to maintain a critical view of these designations and contemplate the role of consciousness in literacy.

**Critical Media Literacy Instruction in Health Contexts**

The purpose of adopting a critical stance in health promotion, particularly where media is concerned, is to empower adolescents by helping them gain an understanding of how inequitable social, political and economic forces function to determine the quality of their health and the conditions of their lives, so that they may begin to change them (Simpson, & Freeman, 2004). An example of a critical approach being applied in a health context is offered in a study conducted by Oliver (2001) with eight 8th grade middle school girls (two groups of four). Participants in this study were invited to engage in critical inquiry about images of the female body from popular culture, particularly those in girls’ and women’s magazines. Initially all participants were asked to explore images in teen magazines and to keep journals documenting times when they noticed their own bodies. In addition to the journals, girls were given two
disposable cameras. With the first camera they were asked to take photographs of things that made them feel good and/or bad about their bodies, and with the second they photographed things that they thought sent messages to girls about their bodies. Oliver points out that she asked the girls to participate in the camera exercise so that they could explore issues and images surrounding their bodies that were not constructed by those who hold social and cultural power (Delpit, as cited in Oliver, 2001). Later the girls broke into two groups of four. The first group of girls studied girls’ perceptions of what attracts attention to female bodies, and the second group studied perceptions of the “Beauty Walk”. Finally, based on findings derived from these study groups, the girls and the researcher discussed how girls’ perceptions could be helpful and/or harmful to the well-being of girls generally and tried to imagine ways of thinking about the feminine self that would be healthier and more supportive of it. Findings from this study illustrate the challenges researchers and educators face when trying to encourage adolescents to think of themselves in ways that are not contained and represented in media, and in this case teen magazines. Participants in this study were unable to conceive ways of being that challenged media generated portrayals of femininity and beauty and/or extended beyond their limits and constraints.

Similarly, in terms of youth adopting identities and roles portrayed by the media, another study tested the effectiveness of school-based media literacy lessons in reducing adolescent boys’ and girls’ internalization of media portrayed body ideals (Wilksch, Tiggemann, & Wade, 2006). Results from this study showed that boys are also affected by media ideals of masculinity and should therefore be included in eating disorder prevention programs. Further, media literacy instruction was found to be a promising tool for preventing youth from internalizing media ideals and developing eating disorders. Another example of media literacy instruction being used in a
health context is illustrated in a media literacy-home intervention study in which elementary school students learned about the role of media in shaping their values in terms of nutrition. With this new media knowledge, these students subsequently designed their own nutrition campaigns for their parents. The goal of the pilot was to increase the children’s consumption of fruits and vegetables and change the home nutrition environment, measured by fruit and vegetable availability, accessibility and parental support. Findings from this pilot study indicate that the media literacy intervention was successful in changing the home environment of these children (Evans, Dave, Tanner, Dube, Condrasky, et al., 2006). Studies like these suggest that health literacy and media literacy inform each other, and are inextricably connected, as youth receive and act upon information and messages about what is healthy, beautiful, socially acceptable, and normal through the programs they watch without conscious effort or awareness. These studies also indicate the extent to which messages transmitted through media are at odds with what is taught about health in formal settings.

Currently North American adolescents are not ideologically or critically equipped to understand and process the information they take in via the media. This is a fundamental reason why media literacy instruction should be a mandatory feature of health literacy education. Without adequate critical media literacy instruction, youth cannot be expected to perceive the underlying messages of commercial media. Further, it is unreasonable to expect youth to value their health and behave in ways that the dominant culture (media culture) does not support. While critical media literacy instruction across content areas is absolutely necessary and seems to have been successful in raising adolescents’ awareness about social and political forces that impact their health and lives, adolescents still have to reconcile and contend with differences
between what the media, and dominant culture promotes, and what their parents, schools and health classes attempt to teach them about health.

Health Literacy: The concept and study of health literacy arose from long standing knowledge about the integral relationship between health and literacy (Nutbeam, 2008; Rootman & El-Bibbety, 2006). One of the key areas within which health literacy’s definition has been developed, refined, redefined and applied is public health. In this realm, which includes health education and promotion, health literacy has been described as skills and capacities that enable people to “to exert greater control over their health and the factors that shape health” (Nutbeam, 2008, p. 2072), and as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (Manganello, 2007, p. 8). In a recent report published by the Canadian Public Health Association (CPHA) health literacy was defined as “the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course” (Rootman & El-Bibbety, 2008, p. 3). Similarly, the World Health Organization (WHO) defines health literacy as “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health” (as cited in Rootman, & Ronson, 2005, p. S66-S67). Further WHO, among other health and literacy researchers and organizations, acknowledge “health literacy as critical to empowerment” (Nutbeam, 2000).

As these variations on the definition demonstrate, health literacy is evolving as research in this field emerges. However, there are certain aspects of these definitions that seem consistent, and that express a particular point of view on health. These features include the role of conscious cognitive processes in motivating, regulating and determining behaviour and/or exercising
control over one’s self and one’s life, individual responsibility for creating and maintaining
health, and fixed values placed on what is good, healthy and appropriate in terms of decision
making and behaviour. These aspects of health literacy definitions are problematic due to the
way they appear to contradict the social-cultural and socio-ecological principles upon which they
are based. Citing Crawford and Crossley, Benford and Gough (2006) aptly point out that health
and health literacy definitions involve and include constructions of “moral character” implying
that “to be healthy is to be a good person” (p. 428). Further, Benford & Gough assert that “to
reject or transgress advice on healthy living, for example to smoke or drink alcohol to excess, is
to risk a stigmatized identity” (p. 428). These observations and comments about moral values
and judgments placed on health, people and their health related behaviours are reflected in
Talcott Parson’s work and writings which point to “the deep cultural values underpinning
Western society and the rights and obligations institutionalized within the ‘sick role’” (as cited in
Shilling, 2005, p. 25). While Shilling states that Talcott’s ‘sick role’ is obsolete as a model for
behaviour in current contexts, he maintains that Talcott’s ideas retain their relevance because
they suggest that “values rooted in Christian traditions and concerned with maximizing
instrumental efficiency, would continue in the future to ‘steer’ the construction, deconstruction
and reconstruction of specific social roles related to health and illness” (p. 25). These roles and
their corresponding values are discernible in relationships between adolescent identities and
health related behaviours. Other values conveyed through health and health literacy definitions
are those related to consumer, capitalist culture and its economy, as health, according to Burkitt
(2005) has been constructed as a consumer commodity that is synonymous with fitness and
lifestyle choices.
Another problem with current definitions of health and health literacy related to the values they connote is that they do not account for “profound cultural variations in how people recognize and experience health and health promotion” (Flick, Fischer, Neuber, Walter, & Schwartz, 2003; MacLachlan, 2006, as cited in Stewart, Riecken, Scott, Tanks, & Riecken, 2008, p. 182). For example, research suggests that the health and wellbeing of Indigenous groups is improved through political empowerment, strengthening cultural identity, and creating greater cohesion within their communities (Kirmayer et al., as cited in Stewart, Riecken, Scott, Tanks, & Riecken, p. 182). Further, traditional conceptualizations of health from an Indigenous perspective refer “to a balance and harmony between and within all of the four aspects of a person’s nature, which are mental, physical, spiritual, and emotional” (Blue & Darou, as cited in Stewart, Riecken, Scott, Tanks, & Riecken, p. 181) These conditions for the creation of health may not apply to, or be recognizable by people outside this community, and are not contained in mainstream definitions of health literacy. These differences in perspectives on health and the constituents of literate practices make definitions challenging to compose. Further illustrating such differences, and the extent to which people in positions of power, and/or those who construct health literacy definitions can be unaware of and/or resistant to acknowledging points of view that seem to contradict their aims, values, and epistemology is the extent to which people outside academic and government realms feel silenced and excluded from discussions about issues concerning their health. For example, while attending a BC Public Health Association Conference in Vancouver, BC one year where various community and special interests groups, as well as researchers in the field, gathered to discuss how health literacy research and policy might proceed and progress, an Aboriginal representative stood up to express her views and those of her community. Addressing everyone in attendance, she stated that members of her
community were disinterested in being subjects to any further research on how and why Aboriginal and/or First Nations people were among those with the poorest health and the lowest literacy levels. Appearing frustrated with the proceedings, she said that there was no lack of research documenting the poor health and living conditions of her people, and that no further studies in this regard were needed. She stated that what was lacking was action on the part of those in power to address basic human needs by providing resources to her people. At another health literacy conference, The International Union for Health Promotion and Education (IHUPE), also in Vancouver, the following note was posted:

Anyone “Pissed off” by the “Inequities” at the Conference, let’s meet to discuss action and mobilization. Meet at the Ontario Health Promotion Booth in Hall B (Exhibition Area) at 5:30 PM today. Some examples are inaccessible conference events, lack of diversity in speakers, “privileged attendees”, that have free access to all events, allotted time/space to network, socialize, etc, lack of participation of communities we work in, workshops dealing with race, diversity, and culture have no speakers, race not promoted as a social determinant of health, etc….etc…Email me at… if you can’t make it to support an action before the conference is over.

(Note posted at IHUPE Conference, June, 2007 – see Appendix J).

As these examples clearly show, there are diverse and important points of view on health and health literacy that are not being heard and applied, and current definitions and methods of health promotion reflect this. Among these voices, those of adolescents are least heard, understood and utilized, yet their potential to benefit public health is great (Manganello, 2007).
Functions of Literacy and Theories of Acquisition

In order to gain an integrated understanding of literacy that is applicable to, and inclusive of all, or most literacies, it is necessary to identify its essential characteristics and functions, as well as identify the underlying human needs fulfilled through its uses. To apprehend these literacy fundamentals Halliday (1969) believed that a set of criteria, specific and relevant to language users, in this case children, needed to be established based on the demands that users place on language in their everyday lives:

(The child knows what language is because he knows what language does.) The determining elements in the young child’s experiences are the successful demands on language that he himself has made, the particular needs that have been satisfied by language - for him. He has used language in many ways – for the satisfaction of material and intellectual needs, for the mediation of personal relationships, the expression of feelings and so on. Language in all these uses has come within his own direct experience, and because of this he is subconsciously aware that language has many functions that affect him personally. Language is, for the child, a rich and adaptable instrument for the realization of his intentions; there is hardly any limit to what he can do with it.

(p. 27)

Using his young son as his subject, Halliday observed and documented eight “early functions” of language. These “early functions” are instrumental, regulatory, interactional, personal, heuristic, imaginative, representational, and ritual. Later in his research, Halliday added an additional four functions to his functional language system, identifying them as “later functions”. These later functions include interpretive, logical, participatory and organizing.
Early Functions

1. Instrumental is identified as the simplest, first to evolve and marks the point at which children realize language can be used to “get things done” (p. 28).

2. Regulatory is an instrument of control used to regulate the behaviour of others (p. 29).

3. Interactional language “is used to define and consolidate the group, to include and to exclude, showing who is “one of us” and who is not; to impose status, and to contest status imposed; and humour, ridicule, deception, persuasion” (pp. 30-31).

4. Personal refers to children’s awareness that language as an extension and tool that can be used to express individuality (p. 31).

5. Heuristic language is a means of learning about and exploring things through questioning and explaining (p. 31).

6. Imaginative language relates to children creating environments however they wish to.

7. Representational is the language model used to communicate content (p. 33). According to Halliday, this model that is the only model that is “the subject of conscious attention” and the only one that is “externalized” (p. 33).

8. Ritual language, similar to, yet different from interactional language due it being “very partial and one-sided”. Ritual language represents the one’s internalized image of language and functions to “define and delimit a social group”. Halliday describes this mode as one which “downgrades language to the level of table manners” (p. 33).
Later Functions

1. Interpretive functions are used to “interpret whole of experience”.

2. Logical, also interpretive, “expresses logical relations”.

3. Participatory “expresses wishes, feelings, attitudes, [and] judgments”.

4. Organizing discourse is used for organization. (Piper, 1998, p. 199)

As Halliday’s functions of literacy suggest, literacy acquisition takes place through interaction with others, experience and its use in satisfying various human physical, mental, emotional, and social needs, as well as exercising and developing human capacities.

Other social learning theorists whose work complements Halliday’s are Vygotsky, Bandura, and Lave and Wenger. Indicative of the complementary relationship between Halliday’s work and Vykotsky’s Social Development Theory is the assertion that language and thought are constructed and developed through social interactions and experiences, making language learning a social, interactive endeavor. Demonstrating the extent of this assertion, Vygotsky argued “that social interaction precedes development” and that “consciousness and cognition are the end product of socialization and social behavior” (Learning Theories Knowledge Base). According to Vygotsky’s theory ([1934] 1987; Leont’ev 1959);

cognition is a profoundly social phenomenon. Social experience shapes the ways of thinking and interpreting the world available to individuals. And language plays a crucial role in a socially formed mind because it is our primary avenue of communication and mental contact with others, serves as the major means by which social experience is represented psychologically, and is an indispensible tool for thought.

Reminiscent of Carl Jung’s concepts of the “collective unconscious” and “archetypes”, which were collectively held values, beliefs and ideals of human characteristics, identity types, behaviour patterns, events and/or story lines thought to be universally recognizable and emulated, Vygotsky believed that “the ‘mind extends beyond the skin’ (Wertsch, 1991a, 90) and is inseparably joined with other minds” (as cited in Berk, & Winsler, p. 12). Extending Vygosky’s theory are Bandura’s Social Learning Theory (1977) and Lave and Wenger’s Situated Learning Theory (1990). While both Bandura and Lave and Wenger emphasize the social nature of learning, the focuses of their theories are different. For example, Bandura’s “Social learning theory explains human behavior in terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences” (Learning Theories Knowledgebase), while Lave and Wenger’s theory is more concerned with authentic, socially situated contexts in which learning takes place. Suggestive of this focus on informal, authentic settings, Lave and Wenger argued that “learning is embedded within activity, context and culture” and that “it is also usually unintentional rather than deliberate” (Learning Theories Knowledgebase).

As Halliday states and addresses in his Functions of Literacy, there is a need to create and establish a clear set of criteria from which the constituents of adolescents’ literate practices can be determined. These criteria, as social learning theories suggest, must include literacies and literate practices learned without intention or conscious awareness and within authentic, social settings that are relevant to their users, in this case adolescents. Recently the need to create such criteria and apply them to the socially situated “bad” behaviours and/or literate practices of “gangsta” adolescents has been called for by Moje (2000), and by researchers in the field of health literacy in relation to culture-based health literate practices (Hemming & Langille, 2006; Hoikkala & Hakkarainen, 2005; Stewart, Riecken, Scott, Tanks, & Riecken, 2008; Smylie,
Williams, & Cooper, 2006; Benford & Gough, 2006). The form and nature of this call within the field of adolescent health literacy and literate practices is suggested below:

Norman Zinberg (1984) has explored the relationship between education, objective information, and social learning. He maintains that drug use is social learning acquired unconsciously in everyday life. Young people learn that drug use is a part of certain youth cultures…and learn various rituals and sanctions in everyday life, through which they may gain an understanding of the nature of drugs and related health risks that deviates from prevailing attitudes and information.

(as cited in Salasuo, 2005, p. 141).

As the comments above and the social learning theories discussed here illustrate, there are significant differences between traditional, formal learning environments within which abstract, decontextualized information and knowledge are delivered to students, and nontraditional, informal, socially situated learning environments within which information and knowledge is imparted, experienced and used tacitly, and/or without deliberate and/or conscious intent. Socio-cultural learning theory “reminds us that school literacies are different and unique…and that curricula focusing in a prescribed range of literacy practices are restrictive” (Scholfield & Rogers, 2004, p. 239). When these theories, which are widely referenced in adolescent literacies, are applied to health literacy, it becomes feasible to argue that health related behaviours that adults disapprove of may be viewed as health literate practices.

**Psycho-Social Needs as Important Motivators of Literacy Acquisition**

Research in the field of psychology supports social learning theories and Halliday’s ideas about the way literacy is acquired, and how it develops and functions, as it identifies basic human psycho-social needs that unconsciously motivate behaviour and are thought to be
universal (Deci & Ryan, 2000; Sheldon, & Niemiec, 2006). These needs, as Self-Determination Theory (SDT) defines them, are competence, autonomy and relatedness (Deci & Ryan, 2000). According to SDT, the fulfillment of these needs depends, in part, on supportive social contexts that “facilitate natural growth processes including intrinsically motivated behavior and integration of extrinsic motivations, whereas those that forestall autonomy, competence, or relatedness are associated with poorer motivation, performance, and well being” (Deci & Ryan, 2000, p. 227; Pyszczynski, Greenberg, & Solomon, 1997; Sheldon & Niemiec, 2006). Other processes and needs which are paramount during adolescence include the development of a positive self-regard, or sense of self-esteem (Bowker, 2006; Torres, & Fernandez, 1995), and a sense of belonging (Baumeister, & Leary, 1995) and mattering to one’s community and larger society (Marshall, 2001; Rayle, 2005). In Western cultures, these interdependent psycho-social needs and processes are known to be key determinants of adolescent health, health-related behaviour and psychological well being (Brown & Ryan, 2003; Deci & Ryan, 2000; Goodman, Huang, Schafer-Kalkhoff, & Adler, 2007; Baumeister, Campbell, Krueger, & Vohs; Oishi, Diener, Lucan, & Suh, as cited in Clay, Vignoles, and Dittmar, 2005; Mruk, as cited in Bagley, Bertrand, Bolotho, & Mallick, 2001). Further, research has shown that “young adolescents with poorer self-esteem are likely affiliated with deviant peer groups which give uncertain support in negotiating role transitions towards successful academic achievement, freedom from delinquency and drug use, healthy sexuality, and entry into employment” (Kaplan, & Patterson et al., as cited in Bagley, Bertrand, Bolotho, & Mallick, 2001, p. 393). As a critical time of transition, identity construction and self-esteem building marked by the need to extend one’s self beyond the familiar social realms and pillars of home, family and school, the extent to which the potentials
of these processes are realized is highly dependent on socially supportive environments and relationships with others (McGee, Williams, Howden-Chapman, Martin, & Kawachi, 2006).

Conclusion

Studies describing and exploring adolescent views on health literacy and health literacy’s relationship to other adolescent literacies and literate practices are needed (Manganello, 2007; Rootman & Ronson, 2005). To fully understand the origins and purposes of current health literacy definitions and ascertain the reasons why health behaviours are valued and constructed the way they are, it is necessary to consider the value system and/or the ideologies underlying them, and identify whose interests their inclusion serves. It is also important to consider what is omitted from definitions and discussions of health literacy. This includes the role of conscious and unconscious processes in literacy and the extent to which literacy may exist and function without conscious intent and/or awareness of a particular goal or purpose.
Chapter 3
Methodology

Research Overview

This chapter will first, identify and describe the theoretical perspective from which this study was conducted; second, explain the constituents of, and principles involved in a collective instrumental case study; third, identify the participants in this study as a group and explain how, why and from where they were recruited; fourth, identify the role of the researcher; fifth, outline data collection methods and questions asked of participants; sixth, issues concerning the trustworthiness of the data, its transferability, and its delimitations/limitations.

Theoretical Perspective

The theoretical perspectives drawn upon in this study are fundamentally socio-cultural, socio-ecological and social constructivist as these theories recognize “that individual behavior is shaped and reinforced by mutual and dynamic interactions within one’s physical and social surroundings” (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006, p 30). These socially based theories emphasize “the joint influence of behaviour and environment on wellness rather than focusing exclusively on either category of health-determining factors” (Stokols, 2000, p. 24). For this reason such a perspective seemed appropriate for use in this study, as social environments played a significant role in determining participants’ health related behaviours. Socio-cultural, socio-ecological and social constructivist theories have been widely accepted and applied across disciplines and literatures dealing with the multiple interacting social, economic and environmental factors determining adolescent health (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006), literacy (Manganello, 2007; Nutbeam, 2000; Rootman, &
Ronson, 2008), identity (Gee, 2006; Marsh, & Stolle, 2006) and behaviour patterns (Flay, 2002; Raphael, Rukholm, Brown, Bailey, & Donata, 1996).

Case Study Design

A case study is an empirical inquiry that investigates a contemporary phenomenon “when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used” (Yin, 1989, p. 23). A case study design was chosen because it allows researchers to conduct an in-depth exploration of “complex social phenomena” (Yin, p. 14) in an organic and/or a holistic way that attempts to capture, interpret and represent phenomena as they emerge and exist in the real world. The case is “bounded” or contextualized by time, place, activity, and/or other factors that define, or set boundaries around it (Creswell, 2005). Typically, a case is investigated and built over a sustained period of time and upon extensive data collection from multiple sources that are rich in descriptive detail (Creswell). This prolonged engagement with both participants and data allows researchers to develop a dynamic and dialogic relationship with them, as opportunities exist to verify, alter and/or expand on themes and issues as they arise in the data during the process of conducting research. This case study took place over a four month period (March 2007 – June 2007) and consisted of eight focus group meetings lasting approximately 2 hours each, or 2, 2 hour meetings per month. In addition to this, individual interviews lasting approximately 1 hour each were conducted at one of the recruitment sites.

The Collective Instrumental Case Study

A collective instrumental case study “serves the purpose of illuminating a particular issue” through the investigation of several cases (Creswell, p. 439). What makes this particular case study collective is that it uses multiple cases. What makes it instrumental is that the cases
were used for the purpose of constructing an understanding about a topic or an issue that extends beyond the cases themselves. While each case in a multi-case design is carefully examined in-depth, scrutinized in detail and recorded to facilitate a greater understanding about the issue under investigation across cases, the individual cases are of secondary interest to the research (Stake, 2005). The emphasis in a collective instrumental case study is on outcomes across cases. As this study used multiple cases to explore and document issues surrounding adolescent health literacy and health-related behaviour, the evidence produced from it is considered to be more compelling and robust than it would otherwise be had only one or two cases been used (Yin, 1989).

Cases may be “similar or dissimilar, with variety and redundancy each important” to understanding the topic, and the collection of cases as a whole (Stake, 2005, p. 446). According to Yin (1989), a critical consideration in conducting a coherent multi-case study is the “replication logic” underlying it (p. 53). Yin analogizes correct use and understanding of this qualitative approach to a quantitative researcher having the ability to carry on six to ten experiments on related issues simultaneously and effectively. Replication logic used in conjunction with a multi-case design makes this multi-tasking possible because its aim remains constant regardless of whether cases demonstrate variation, uniformity, or both variation and uniformity. The aim is to achieve either (1) “literal replication” which yields and/or predicts similar results across cases or “theoretical replication” which produces contrary results for reasons that may be predicted and/or speculated upon (p. 53). For example, if a researcher used six to ten cases effectively within a multi-case design he/she could yield results that produce both literal and theoretical forms of replication. In a situation like this, literal replication (similar results among cases) would provide compelling support for certain aspects of the study
based on the aggregate created across cases. Within the same multi-case study, evidence revealing inconsistencies and problems with current theories and/or issues surrounding a topic could also be provided through theoretical replication (dissimilar results among cases), thereby supporting the need to revisit and revise problematic assumptions. Thus, collective instrumental case studies can be used to gain a range of insights into an external issue so that generalizations about it can be reconsidered and redrawn (Stake, 2005).

Participants and Sampling

The participants in this study were 7 young women who are or were adolescents (ages 15-18) when they became pregnant and/or mothers. All participants are or were in the process of attempting to complete high school by attending community programs that provide childcare for them while they attend classes and/or attempt to finish their high school education. All participants had previously dropped out of school.

Adolescent mothers were chosen for this study using an intense and a purposeful sampling strategy which seeks out “information rich cases” on the premise that they will “manifest the phenomenon of interest intensely” (Patton, 1990, p. 182). This group of adolescents was selected for this investigation based on the assumption that their situations as both adolescents and single-mothers or mothers-to-be would heighten their awareness of the consequences and implications of their health-related behaviours. I predicted that these participants’ observations and concerns about health and their own health behaviours would be greater and/or more astute than they would otherwise be if they were not new parents.

I further assumed that having to contend with the dichotomous demands and roles of both adolescence and motherhood would heighten participants’ experiences of identity transition. This unique, dual perspective allowed interesting and valuable comparisons to be
made among participants and between participants and larger representative groups of adolescents. It is important to point out that while the participants in this investigation are adolescent mothers, the issues explored are not exclusive to them or focused on adolescent pregnancy and motherhood. In this study, discussion about these matters is limited to their pivotal impact on participants’ sense of identity, as expressed through their health and literate practices. Thus, findings from this research are intended to offer some insight into the struggles of North American adolescents generally.

Other important reasons for selecting this particular group of adolescents include their vulnerable status, as these young women are raising their children without having completed their high school education and most do not have the physical, emotional, and/or financial support of their children’s fathers, and/or in some cases their families. An additional reason that this vulnerable adolescent population was chosen for this study is that British Columbia’s ACT NOW initiative designated this group and their pre and post-natal health issues as priorities for research funding in the province. My research was conducted, and my data collected from within a larger, ACTNOW funded research project entitled HOPE (Healthy Opportunities for Parents Expecting). The HOPE project received ethical approval and began the process of recruitment in February 2007, with Dr. Joan Wharf Higgins as its principal investigator. With the permission and supervision of both Dr. Joan Wharf Higgins and Dr. Deborah Begoray (my MA supervisor with the Department of Curriculum and Instruction), I worked on the HOPE project as a research coordinator and assistant since its inception. Dr. Wharf Higgins allowed me to include and incorporate my research questions into the Hope project with the understanding that I would use data collected from it for my Master’s thesis. My research questions were included in the Human Research Ethics Board application.
Recruitment and Sites

Participants for this study were recruited from four community based sites in the city of Victoria, British Columbia and the surrounding area. These community centres/sites include the Saanich Adult Education Centre (SAEC), the Native Friendship Centre (NFC), the Girls’ Alternative Program (GAP), and Higgins House Daycare Centre, which is operated by the Cridge Centre and functions on location at, and in conjunction with Victoria High School. All sites offer childcare and/or educational programs to adolescent mothers and expectant mothers.

With the assistance and cooperation of each centre’s program director or teacher, recruitment for both the initial focus group meetings and the focus groups that followed these preliminary meetings took place at each of the four sites over a period of 3 weeks. At sites where potential participants were not present collectively and/or at predictable times of the day introductory information about the study was left in the hands of a centre’s director in the form of a letter. These letters of introduction outlined the intents and purposes of the study, the role potential participants would play in it, contact information and information about honorarium payments for participation. At sites where a collective introductory meeting with potential participants was not practical, and dates and times for initial focus groups were arranged with those wanting to participate through the directors of the centres.

At sites where young mothers were present collectively on a routine basis, introductions to the study were given in person by me and other members of the research team. In these situations researchers traveled to sites, met with prospective participants and delivered information to them about the study both verbally and in the form of a letter. After introductions were made and information was distributed, young mothers were asked if they
would like to volunteer to take part in the focus groups that would be held separately, one at each of the four sites. At the time participants were informed that their participation in the initial focus group meetings did not in any way obligate them to continue their participation in the project. After identifying those wishing to volunteer, dates and times were arranged to conduct the focus groups. Dates and times of all initial focus groups were chosen based on what was convenient for the groups of participants at each site. Healthy snacks and beverages were provided at meetings and arrangements were made with the convenience and comfort of participants in mind, and in an effort to maximize attendance at meetings. For example, meetings took place when childcare could be provided for all participants and during times that did not interfere with their studies. At times when children could not be left, participants were told that they were welcome to bring their children. This occurred infrequently, but when it did, children and participants were warmly received and accommodated by all in attendance. Transportation and/or parking were arranged and/or paid for by the project with the assistance of teachers and/or program directors at various centres. These preliminary meetings allowed potential participants to gain a sense of what would follow if they chose to volunteer and allowed researchers to determine whether adequate numbers of young mothers were interested in participating in the study.

Prior to commencement of the initial focus groups participants were asked for their free and informed consent (See Appendix C). At this time the contents of these forms was read aloud and explained to participants. After reading the information on the consent forms aloud to participants, they were asked if they had any questions about anything they just heard or any other aspect of the research that concerned them or that they were unclear about. After questions were raised and answered, potential participants were asked if they would like to
volunteer to take part, and reminded that they were under no obligation to do so. Those who stated that they wanted to participate were then given consent forms to sign. Participants received copies of these forms and told to feel free to contact members of the research team if they had any further questions or concerns.

Immediately following each of the initial focus groups, the first held on February 26, 2007 at the Girls’ Alternative Program (GAP), the second held at the Native Friendship Centre on February 27, 2007, the third held at Saanich Adult Education Centre (SAEC) on March 5, 2007, and fourth at Higgins House in the month of February (due to participants not being present at this site at the same times, the program director spoke with potential participants about the HOPE project on our behalf) recruitment for the four month case study took place. At this time further information was provided to participants, including details about what their involvement would mean in terms of their time, the activities they would undertake, and how they would be compensated for their commitment to the project. Potential participants were informed that meetings would be held at the University of Victoria where researchers had access to computers and the internet, as well as conference rooms. Participants were told that the precise dates and times of focus group meetings would be determined later once the number of participants was known, and that they would be based on what was most convenient for them, their child care providers and their schedules at school.

Honoraria

As each community centre/site and its director played an important role in allowing researchers to gain access to participants and facilitating the recruitment and research processes by hosting initial focus groups and providing childcare to participants, the project purchased and donated a computer, printer and workstation to each centre for its young mothers to use.
While participation in the study was entirely voluntary, participants were paid $25.00 honorariums for taking part in the initial focus group meetings which were approximately 2 hours in length. For participating in the 4 month long case study participants were paid further honorariums of $400.00 each. This amounts to approximately $10.00 per hour and includes childcare and travel costs, for their participation in the research. Due to the fact that involvement in this project required a 32 hour time commitment, and that participants have childcare and travel expenses to cover in order to attend the meetings at the University, this amount of money seemed appropriate and reasonable to compensate these young mothers for their time and energy and invaluable insights. Upon receiving all honorariums, participants signed forms indicating this transaction. (See Appendix D)

Data Collection Methods and Sources

In keeping with case study design, data were collected from multiple sources (Creswell, 2005). Data sources include (1) interviews conducted individually and in focus groups. These were audio recorded and transcribed; (2) documents in the form of participant composed journals in conjunction with collages made from images derived from print media and photographs taken by participants; and (3) observations and field notes taken during focus groups, internet search activities, member checks and peer debriefings.

A key purpose of collecting data in various forms was to ensure that all participants had opportunities to express themselves fully and in ways that they felt competent and comfortable with. Another important reason for using multiple data sources is corroborating and/or triangulating evidence to ensure its accuracy and validity (Creswell, 2005, p. 252).
Individual Interviews and Focus Group Interviews

The purpose of conducting interviews in qualitative research is to “find out what is in and on someone else’s mind” and ascertain information from participants that cannot be observed (Patton, 1990, p. 278). Specifically, interviews are conducted in order to gain access to people’s feelings, thoughts, experiences and intentions based on the assumption that the perceptions of others are “meaningful, knowable, and able to be made explicit” (Patton, p. 278). An interview is a conversation consisting of questions and answers, with a researcher asking participants 1 or more questions and recording the answers. Data collected through an interview is not neutral, but is a text created and negotiated by the interviewer and interviewee (Denzin, & Lincoln, 2005, p. 642).

In this study both semi-structured focus group and one-on-one interviews were conducted with participants using pseudonyms to maintain anonymity. One-on-one interviews are more time consuming than focus groups and ideal for interviewing people who are well spoken, expressive and at ease with sharing their views (Creswell, 2005). A focus group is a form of interview used to collect shared understandings from several individuals as well as ascertain the views of specific people (Creswell, 2005, p. 215). Focus groups are “collective conversations” with 4 to 6 people (Kamberelis, & Dimitriadis, 2005, p. 887). In this study the numbers of participants present at focus groups varied from 4 to 8. Focus groups are particularly effective in acquiring information when participants have a rapport with each other and interact cooperatively. Conducting focus groups are effective in encouraging otherwise reluctant individuals to share their views (p. 215). This assumption about the way participants behave in group interviews may be true in some situations, but it may be that introverted, apprehensive and/or shy participants, especially teenagers, are just as likely to be
uncomfortable with expressing their opinions among others. The group dynamic created in focus group interviews is an efficient way of generating high quality data, as ideas are viewed from multiple perspectives at once and this facilitates thorough exploration and development of topics under investigation (Creswell).

Semi-structured interviews are interviews in which researchers ask both close ended and open ended questions (Creswell, 2005). Closed ended questions are those with answer options that are preset or limited by the researcher either explicitly or implicitly (p. 589). Open ended questions are the least constrained by researchers’ preconceived ideas about topics under investigation, as questions are posed in such a way as to allow participants to respond on their own terms and “take whatever direction and use whatever words they want in order to represent what they have to say” (Patton, 1990, p. 297). The majority of questions asked in interviews were open ended and sought participants’ perspectives on motherhood, parenting, relationships, health and lifestyles. In total 9 questions were asked in focus groups, and 8 were asked in individual interviews.

When interview methods were first conceived, only focus groups were planned and subsequently conducted. However, as this study progressed and participants’ attendance at focus group meetings dropped significantly and became unpredictable, it became necessary to hold individual interviews with them wherever and whenever they were available. Of the eight focus group meetings planned, only the first four had sufficient numbers of participants present to conduct them. After this, when only two participants were showing up for our pre-arranged focus group meetings, the research team decided to try to arrange individual interviews with participants. The range of factors effecting participants’ attendance included; last minute changes to childcare and transportation arrangements, children being sick, court dates,
appointments with doctors, waning interest in the study, and in one case a breast implant surgery. After repeated attempts at scheduling and rescheduling appointments to conduct individual interviews with participants and several “no shows”, only three out of a potential seven interviews were conducted. The focus group questions included the following:

1. Tell us about a typical day for you and your child(ren): what happens when you get up until you go to bed? (e.g., probe for when and what is eaten, play time/leisure activities, who cares for the children when the mother is in school/work, sleep patterns, media use)

2. Compared to others your age that you know, how would you rate your health – excellent, good, fair or poor? Can you tell us why you gave yourself that rating – that is, what about your life led to a rating of ‘good’?

3. Compared to others your child’s age that you know, how would you rate their health – excellent, good, fair or poor? Can you tell us why you gave your child that rating – that is, what about his/her life led to a rating of ‘good’?

4. What does your child’s health mean to you?

5. Do you think about your health or the health of your child(ren) a lot? What kinds of issues concern you or are you interested in finding information for? When would you look for information about health – only when you or your child is sick or to help prevent illnesses or promote health?

6. How do you find answers to your health related questions? What sources of information did you use (e.g., friends, doctor, magazines, the internet) and how do you know if the information you are finding is accurate and trustworthy?

7. What was your first thought or biggest concern when you first found out you were pregnant and how did you go about figuring out what to do about your concern.
8. If and how have your concerns changed since you’ve had your child, or since you found out you are pregnant?

9. What things do you think about now that you didn’t think about before you had your child, and/or before you became pregnant?

The eight questions asked during individual interviews included the following:

1. Tell me the story of your life so far. Where and with whom did/do you live? (location, socio-economic status, neighborhood, community)

2. What were your home life and upbringing like? (Extra-curricular, substance use, number of parents at home)

3. How were your relationships with family and friends?

4. How did you do at school, what kind of student were you?

5. What circumstances and events led you to become pregnant?

6. Tell the story of the rest of your life. If you could do anything you wanted to do, anything at all, what would it be?

7. Do you think this life is one you could make happen for yourself in actuality, why or why not?

8. What would you have to do to get to where you want to go and what would be your biggest obstacle to overcome in getting there?

Interview Protocol

The approach to interviewing participants in this study was primarily “standardized” (Patton, 1990, p. 280). However this study also incorporated aspects of an “interview guide” approach into the interview structure, as combining these approaches makes it possible to ask a number of precisely worded questions in a predetermined manner, while “permitting the
interviewer more flexibility in probing and more decision making flexibility in determining when it is appropriate to explore certain subjects in greater depth or even undertake whole new areas of inquiry that were not originally included in the interview instrument” (287).

Standardized interviews are those in which participants are asked the same series of questions in the same order, and the precise wording of interview questions is predetermined (Patton, 1990, p. 280). Using pseudonyms, participants were asked to identify themselves before responding to each question and told that after their responses to direct questions they should feel free to continue discussions naturally, or however they wished to. Such unplanned conversant discussions usually occurred without interfering with standardized interview protocol. Similarly unplanned interview scenarios occurred if participants seemed unresponsive to a particular question. In these situations the researcher restated the question spontaneously using different words and/or by offering illustrative examples that were not scripted. Three benefits of posing questions in a standardized, uniform way is that participants’ responses are easily comparable, data is more easily organized and analyzed, and data sets for each participant are complete A drawback to this approach is that the wording of questions may restrict participants’ responses (Patton, 1990). This standardized, yet informal interview strategy facilitated organization and saturation of data by ensuring that all participants had opportunities to respond to all questions fully while also creating space to pursue discussion of topics that were generated by participants in the moment.

Journals

Participants were asked to write one journal entry, based on a given prompt, following every group meeting. Participants’ responses to these prompts were summarized, checked and
verified with participants in subsequent focus group meetings. Journal prompts were given to participants over a period of four months. There were six prompts in total as follows:

**March 12, 2007**

1. What is the biggest, most surprising, or most important thing you have learned or changed about yourself, your health or your life since you’ve become pregnant or become a mother? What things matter now that may not have mattered to you before?

**March 26, 2007**

2. Find an image or a picture in a magazine or on a website that reflects your idea of a healthy family lifestyle. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of a healthy lifestyle. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.

**April 2, 2007**

3. Find an image or a picture in a magazine or on a website that reflects your idea of a healthy mother and child relationship. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of this relationship. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.

**April 16th, 2007** - Following four journal entries presented with disposable cameras

4. Find images in magazines and/or on the internet that you think send unhealthy and/or confusing messages to children and/or youth. Cut them out and write a journal entry explaining what you think the image is saying and why you think the message is
unhealthy or harmful. (This was originally a journal prompt but I decided to pose this question in a focus group instead. I provided magazines.)

5. Photograph people and things in your life that represent healthy living to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you. Make sure to state which parts of healthy living your pictures show.

6. Photograph people and things in your life that represent healthy relationships to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you.

This constitutes two entries of one and half double spaced pages per month. Completed journals had an added benefit to participants, as many were given school credit for having participated in writing activity, even though their journals were not subject to scrutiny by teachers. The purpose of journal prompts were aimed at ascertaining participant views of healthy lifestyles, relationships, and roles as mothers.

Unfortunately, for the purposes of data generation, journal writing, for most participants, was an arduous task that they associated with classroom work. While participants did their best to fulfill my request that they write about their personal views in journals, journaling was not a literate practice that they were at ease with and proficient in using as a means of authentic, in-depth self-expression. It was access to precisely such authenticity of voice that I wanted to document and learn from. While participants lacked interest and proficiency in writing about their experiences, they excelled at talking about them. In spite of participants’ preference to respond to questions and prompts verbally, some valuable data were retrieved from journal entries and the image collages that accompanied some of them.
Observations and Fieldnotes

Observation is the process of gathering and recording open-ended, first hand information about participants in a study at the research site (Creswell, 2005). As a data source, observation has advantages and disadvantages. Advantages are that researchers can observe and document behaviour, events and other forms of information as they happen. Observing participants can be particularly useful in studying the behaviour of people who may not express themselves verbally and/or in response to questions as well as they do by their actions and behaviours (Creswell).

Disadvantages of observation are that researchers are limited to the sites and situations they have access to and that it may be difficult to establish a rapport with participants that makes people feel sufficiently comfortable being and expressing themselves. In this study, this potential disadvantage was alleviated by the frequency of meetings with participants and the duration of time over which meetings took place. Another factor that may have alleviated any feelings of awkwardness was that researchers as well as participants disclosed personal information about themselves upon meeting with participants and that participants and researchers shared similar experiences. These included the fact that I am a mother and a former high school dropout and that my colleague (another research assistant) was visibly pregnant at the time of these meetings. One of the participants in this study was also pregnant during meetings. Similarities among researchers and participants as well as the informality, frequency and duration of meetings all contributed to the extent to which everyone felt safe, comfortable, relaxed and willing to reveal and discuss personal information.
Data Analysis

The overarching approach to data analysis in this study is inductive, iterative and recursive. Such an approach allows “patterns, themes, and categories of analysis…to emerge out of the data rather than being impose on them prior to data collection and analysis” (Patton, 1990, p. 390). Deductive strategies were also employed to verify initial propositions against the data as well as check relationships among sub-categories identified in the latter part of coding (Strauss, & Corbin, 1990). Data were analyzed through the process of organizing, identifying, examining, describing, categorizing, connecting, clustering and ultimately “recombining the evidence” to address the research questions posed in the study (Yin, 1989, p. 105).

Elements of narrative analysis were employed to analyze the data in this study. Specifically, aspects of “restorying” were used to sequence, organize, interpret and/or represent the story data in a way that conveyed participants’ individual experiences (Creswell, 2005, p. 486) and highlighted their key features. By restoring each case, individual “case analysis”, was completed and case descriptions for each participant interviewed were composed (Patton, 1990, p. 376). Similarly, “cross-case analysis” was conducted which involved grouping answers to common questions together from different participants (Patton, p. 376). Subsequently a case description was composed and an explanation built about it based on individual cases.

To accomplish these tasks competently and draw conclusions that are fair, valid and convincing, general analytic strategies and procedures are needed to aid researchers in choosing appropriate analytic techniques, deciphering which pieces of evidence to highlight and which to omit, and eliminating, and/or identifying “alternative interpretations” of the evidence (Yin, 1989, p. 106). Two highly effective strategies used to organize and analyze the data and/or cases as a whole in this study were first to rely on the study’s initial theoretical propositions to
guide the process of analysis and second to develop descriptive categories based on the data to organize the analysis (Yin). These two basic methods were used in this study, in conjunction with “explanation building” (Yin, p. 113).

With explanation building a final explanation about a case is arrived at through a series of iterations. According to Yin this process begins by:

making an initial theoretical statement or an initial proposition about policy or social behaviour; comparing the findings of an initial case against such a statement or proposition; revising the statement or proposition; comparing other details of the case against the revision; again revising the statement or proposition; comparing the revision to the facts of a second, third, or more cases; and repeating this process as many times as needed (p. 115).

In this study, an iterative, explanation building process was used to construct a reasonable and credible explanation about health literate statuses and practices of participants. This was accomplished, in part, by applying explanation building practices to current conceptualizations of adolescent health literacy, as they exist in the literature, which do not adequately address and/or explain the literacy’s role in participants’ health-related behaviours.

Procedures

Six steps were taken in this process of data analysis. These steps were not carried out sequentially, especially in the latter stages, as this process of analysis is iterative and nonlinear. Issues and insights arise that require revisitation and revision of themes and ideas. As Creswell (2003) outlines, these steps include: (1) scanning and/or taking an inventory of all data sources and preparing them for analysis. This involves listening to and transcribing interviews and focus groups, summarizing field notes and grouping data depending on its source and/or type;
(2) reading through and reviewing the data to gain a general sense of its content and meaning, and taking notes on preliminary impressions of and/or concerns about it; (3) analyzing text data in detail and identifying initial themes, and/or types of information to create broad categories of data through “open coding”, starting with “line-by-line” analysis and later through “entire document” analysis (Strauss, & Corbin, 1990, pp. 61-74). Open coding involves breaking down and/or conceptualizing the data by labeling its parts. This process is followed by comparing and clustering or grouping like ideas and themes together; (4) after linking clusters and themes, these can be broken down and described in greater, more intricate detail and descriptors of phenomena, including the people, settings, situations, events and/or narratives indicative of them, can be composed. This coding procedure, known as “axial coding” involves the sub-categorization and reconstruction of data and the contextualization of phenomena. Connections between categories are drawn and the conditions, actions, and/or interactions leading to the phenomena are described and its consequences identified (Strauss & Corbin, 1990, pp. 96-97); (5) choosing pieces of narrative data that accurately and effectively capture and represent participants, descriptions and themes identified through analysis and in the findings; and (6) interpreting the meaning and implications of the data in relation to the researcher’s interpretation of its cultural, historical and/or political significance, the existing literature on the topic and/or areas requiring further research, and finally, determining how data might influence policy (Creswell, 2003).

Credibility

In order to ensure the credibility and accuracy of the data and findings in this case study, procedural measures were taken. These include four types of triangulation including (1) methods triangulation, (2) triangulation of sources, (3) analyst triangulation, and (4)
theory/perspective triangulation (Patton, 1990, p. 464). Generally speaking, triangulation is “considered a process of using multiple perceptions to clarify meaning [and] verify the repeatability of an observation or interpretation” (Stake, 2005, p. 454) and “is the process of corroborating evidence from different individuals, types of data, or methods of data collection in descriptions and themes in qualitative research” (Creswell, 2005, p. 252). As qualitative researchers acknowledge the multiplicitous nature of reality and its dependence on observers, they also acknowledge that observations and/or interpretations are never “perfectly repeatable” (Flick, as cited in Stake, 2005, p. 454). Therefore researchers use triangulation to assist them in clarifying meaning by observing and reporting on the different ways in which a case is perceived (Flick, as cited in Stake). In a qualitative case study credibility is gained “by thoroughly triangulating the descriptions and interpretations, not just in a single step but continuously throughout the period of study” (Stake, 2005, pp. 443-444). By triangulating evidence in this way, descriptions, observations and interpretations of the case are authenticated.

As Patton (1990) explains, methods triangulation involves comparing and/or “checking the consistency of findings generated by different data collection methods”. In this study data collected from interviews, journals, and field observations were compared and checked against each other for consistency. Similarly, triangulation of sources involves “checking out the consistency of different data sources within the same method”. Interviews conducted in different settings (within focus groups and on an individual basis) were checked against each other. As well, different participants’ responses to questions and their comments in individual interviews and journal entries were compared. Analyst triangulation requires others, both investigators and participants to review and/or verify the data and findings. To accomplish this
on-going peer-debriefings and member checks took place throughout the data collection process. Finally *theory/perspective triangulation* uses multiple perspectives and/or theories to interpret the data (p. 464).

“Peer debriefings” were held immediately following meetings with participants. At debriefings researchers reviewed, compared and discussed the data collected at meetings and their impressions about the meetings themselves (Lincoln & Guba, as cited in Creswell, 1889, p. 202). Further, such proceedings were documented by researchers through detailed note taking, reiteration and tracking of processes, ideas and events. Additional meetings among researchers were also held between meetings with participants to further review, compare, verify and synthesize data so that emergent themes could be identified and compiled for review by participants at the beginning of each subsequent meeting.

At the beginning of each subsequent group meeting member checks with participants were held with reference to the data collected at each prior meeting. “Member checking” is a process in which researchers take their findings back to one or more participants and ask them to check the accuracy of the findings (Creswell, 2005, p. 252). At this time researchers seek feedback about and verification of the data by reviewing it with participants and asking them to confirm, disconfirm, add, alter, elaborate on, and/or omit any information and/or theme identified by researchers.

Two final aspects of this research and its design that lend it validity and vitality are that researchers had multiple opportunities to engage with participants over a prolonged period of time and that multiple, context rich data sources were used. As Fetterman (1989) contends, prolonged engagement and persistent observation enhance the trustworthiness, depth and dimension of the data collected in a study (as cited in Creswell, 1998, p. 201). The continual
interactions among researchers, participants and the data afforded by this design allowed insightful and vivid illustrations of issues and topics under investigation to be accessed, expressed, clarified, and expand upon.

Transferability

Transferability is defined as "the extent to which its findings can be applied in other contexts or with other respondents" (Erlandson, et al., 1993, p. 31). Two ways to ensure transferability are, “through thick description of sufficient detail and precision that it brings the reader vicariously into the environment under investigation, and through purposive sampling governed by emerging insights and information achieved during the course of the investigation” (Erlandson, 1999, p. 3). While this study does not survey large numbers of adolescents, it does allow for in-depth detailed descriptive information to be gathered about adolescent health attitudes and behaviours based on multiple cases derived from purposeful sampling. The data collected in this study are compared with data collected from other longitudinal studies on adolescent health-related behaviour that used much larger samples of adolescents. Specific comparisons are made in Chapter 4’s discussion of findings.

The Role of the Researcher

Qualitative researchers stress the socially structured nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek to answer questions that stress how social experience is created and given meaning. (Denzin, & Lincoln, 2005, p. 10).

My role as a qualitative researcher is unavoidably and unabashedly subjective. I am an interpreter/reporter. As such, it is critical that first, I identify the ideological stance, or
framework I have adopted to investigate my topic, second recognize and report on my own values, assumptions and biases, and third identify those that exist in the dominant culture as they are expressed through the literature. Fundamental to these declarations are explanations about the researcher’s perspectives on the nature of reality, or ontological perspective, the relationship between the researcher and that being investigated and the origin and/or nature of knowledge, or epistemological perspective. As these perspectives inform every aspect of the research they must be identified and reported as clearly and transparently as possible. This self-reflective and explicitly stated stance is referred to as “positioning” (Creswell, 1998, p. 9).

Such a positioning recognizes reality and meaning as multiplicitous constructions created by the researcher, the individuals being researched, and the reader/audience together. Researchers functioning from within this paradigm must reflect upon and “report these realties, rely on voices and interpretations of informants through extensive quotes, [and] present themes that reflect words used by informants” (Creswell, 1998, p. 76).

Limitations and Delimitations

A limitation of this study lies in my personal history as a teenager who felt deeply inadequate as a student and unrecognized as a person of intellect and literate potential in the context of school. Consequently, I disengaged from and performed poorly in school and left home to work and live on my own at the age of 15. During this time I honed my literacy skills among people within discourse communities outside of school and those associated with non-academic adult realms. Specifically, I became highly literate in the complex practicalities of everyday working and living. I became adept at accurately assessing and appropriately responding to a wide range of people, situations and environments and adjusting my discourse style to fit into an array of social contexts, both mainstream and marginal. As many of the
literacy skills I demonstrated were not sanctioned by my school and deemed socially unacceptable in someone my age they were not often recognized, appreciated and valued as literate behaviours. In some instances my proficiencies in these areas were considered deficient, undesirable and even threatening by some of the teachers, parents and peers surrounding me.

Another aspect of my life that shapes my view of participants and the issues explored in this study include the pivotal changes in self-perception and quality of life I experienced when I returned to school in my early 20s to discover that the literacies I had developed when I left school were of great benefit and advantage to me in college. Equipped with these skills I realized that with accurate information, proper training, practice, perseverance and support (both financial and academic), I was as capable as anyone of learning to use academic discourse and perform in academic environments. Eventually, with continual struggle and bouts of self-doubt, I completed a bachelor’s degree in English and history as well as a teacher certification program.

During my years in public school I learned and became convinced that my poor performance meant that I lacked natural intellect, literacy and academic ability and that these attributes were dependent on each other, stable and intrinsic to one’s identity. Unfortunately, the schools I attended helped create and reinforce these beliefs in me as they catered to, favoured and valued particular groups of students and particular literacies to the exclusion and degradation of others. When I began to suspect that some of the problems I had in high school may have had something to do with factors that didn’t involve my short-comings, I was able to go back to school, begin challenging my old perceptions of myself as a student, and recognize what my biggest obstacles to learning and achieving in high school had been. These were my
beliefs about the nature of identity, intelligence, literacy and ability and my beliefs about who
and what I thought I was in the contexts of school, culture and society.

My education, including my experiences in high school, post-secondary institutions and
the “real world”, and my current position as a high school teacher and single mother of a
teenage daughter who has participated in many frightening health related behaviours, suffered
with mental health issues, and associated with so-called deviant groups of youth, all profoundly
influence my perspective on participants and their literate practices. All of these experiences
and roles have fueled my interest in this research with this particular group of adolescents. I
believe that my background enhances my ability to identify with and understand participants’
experiences as students, “drop outs”, mothers and young women who left home before
graduation.

I also recognize that certain aspects of my background which closely resemble
participants’ may also limit my ability to gain a sense of objectivity about them and their
situations. For example, when participants seemed disinterested in exploring issues that I felt
should concern them, or if they exhibited ideas about themselves that I felt reflected self-doubt,
I noticed myself feeling both impatient towards them and judgmental about what I saw as their
lack of understanding about the implications of their circumstances. At times I felt protective
and motherly towards participants, forgetting my past and the way some people perceived me
and assessed my lack of participation in school. At other times I felt myself devaluing the
concerns and interests of participants and blaming them for being in the compromised positions
they found themselves in when they didn’t meet my expectations. At these latter times and
upon reflection of my automatic inner reactions, I realized that without my will or awareness I
had adopted views and biases that were indicative of mainstream culture and based on concepts that I would have consciously rejected and argued against at an earlier period of my life.

Delimitations of this study include that it relies, primarily on interviews (both individual and focus groups) for its data. While interviews are known to generate in-depth information about participants’ experiences, they are “negotiated texts” that are dependent on the perceptions of the interviewee and the interviewer (Denzin, & Lincoln, 2005, p. 642). Further, these data sources rely on participants’ ability to articulate their opinions and to express information. Whether or not they are articulate and comfortable with the discourse and research setting will have a huge impact on the interview data. Another potential disadvantage of conducting interviews is that the researcher’s presence may inhibit, alter and/or otherwise affect participants’ responses (Creswell, 2005). To alleviate these concerns, measures were taken to maximize the comfort of participants and give them multiple opportunities to communicate using various forms of expression and in various scenarios. These included individual and group interviews, journaling via email or writing, and finally collage and photography. Overall, an informal atmosphere was created to encourage open conversation during meetings.

Conclusion

Adolescent health related behaviours, such as smoking or running track and field, are value laden, and decisions about research methods and methodology were chosen with the particular participants in mind. What is not clear, and what requires examination in the field of adolescent health literacy is the process and criteria by which health behaviours are designated as healthy and health literate and/or unhealthy and related to a lack of health literate knowledge and/or ability. Identifying and understanding these designations and their corresponding values, which function to legitimate some behaviours and groups of adolescents while devaluing
others, is of central interest to this study and important to understanding adolescent health, literacy and behaviour. In the chapter that follows, findings will be reported and discussed with the intent of locating insight into these issues.
Chapter 4

Findings and Discussion

To fulfill the purposes of this research (see Chapter 1), findings will be reported and discussed in the five sections that follow. The first section will provide an overview of differences between cases and participants’ backgrounds. The second section will present an aggregate story entitled *Hope’s Story*, based on findings across cases. This story will be previewed by an explanation about how and why it was conceived and constructed. The third section will report findings across cases prior to pregnancy. The fourth section will report findings across cases derived from participants’ pregnancy stories and lives as adolescent mothers. The fifth section in this chapter will discuss and contextualize key findings relative to aspects of the adolescent health and health literacy literatures that they confirm and raise questions about.

Differences between Cases and Participants’ Backgrounds

Before outlining differences between participants’ backgrounds including particulars about their relationships with family members, situations at home, and socio-economic statuses growing up, it is important to point out that inconsistencies in participants’ attendance at focus group meetings and individual interviews during the latter part of this study made it impossible to access background information on all seven. While these meeting and interview times were set well in advance, and arranged to accommodate participants’ schedules, and child care and transportation needs, most participants (five out of seven) did not attend the final four focus group meetings during the final two months of the study, and only three were available for individual interviews. Thus, the information provided in this section on differences in backgrounds is based on only three of seven participants.
Megan

With regard to the extent which Megan felt accepted and supported within the context of her family, she stated the following:

Growing up I didn’t get along with my parents and my whole family thought it was my fault that everything was wrong, but really it was basically everybody’s. I didn’t know any better. All I seen was mom and dad and how they treated me so I got beat a lot, hit a lot, and didn’t know the difference until I got into grade 7.

Megan reported that both her parents were always home, although, in a seeming contradiction, she also reported that her parents were absent for two months out of year due to being away on business. She also reported that there was no drug or alcohol abuse in her home, but that her father beat her up regularly and her mother did nothing about it. Megan described her family’s socio-economic status as “very high class, like extremely high class, lots of money, lots of money”.

Jessica

Unlike Megan, Jessica reported getting along with her parents very well, until adolescence set in, as she stated “My upbringing was great…My relationship with mom and dad great”. Jessica described herself as “quite a little mommy’s girl” who ran home at lunch for macaroni and cheese. She recalled “always being good friends with [her] mom until [she] hit a rough age”.

Jessica reported growing up in an upper-middle class neighborhood with both of her parents and her older brother, with whom she reported having quite a lot of conflict. Her parents both worked in semi-professional fields. As Jessica stated it, “we were comfortable, very
comfortable. Umm and I guess maybe to some people with very less money would probably consider us rich.”

Lisa

Lisa reported growing up most of her life in a “good neighborhood” with her brother and both parents in a house that their family owned. Later in her life, when Lisa was 17 years old, her mother and father “split up” after many years of marriage. At this time she went to live with her mother. Lisa’s brother, who she described as the “troubled one” and “quite a headache”, got into trouble and was arrested frequently. This, according to Lisa, caused big problems within the family. Lisa reported that her relationship with her parents would have been fine had it not been for her brother and the stress that his alcohol and substance abuse, and criminal activities caused. In reference to this she said that, “It was quite different with me; my mom and my dad. It was fine. My brother added into the equation wasn’t so good”.

To summarize, the socio-economic statuses of participants’ families ranged from lower to upper middle class, with two participants reporting that they believed their families might be considered ‘rich’ and one participant (not included in the excerpts above) reporting that she and her family, at one time, lived out of a car. Other circumstances and conditions which varied among participants included the number and presence of parents and siblings in the home. At least four were brought up in two parent households with one or two siblings. The quality of relationships with parents and siblings ranged from one participant who reported being physically abused by her father, while others reported ‘getting along’ either reasonably well, or very well with their parents until they became adolescents. Two participants reported having very contentious relationships with their older brothers due to substance abuse and criminal activity. A final difference which seems pertinent to mention is that two of the seven participants
in this study are of Aboriginal descent; however this cultural distinction was not brought forward or pronounced in the comments of these participants.

While the examples above are intended to highlight differences in participants’ experiences growing up, these differences were not evident in their self-reported behaviour patterns and attitudes during adolescence. Further, participants’ retrospective accounts of the factors that led them to think, act, feel and socialize with the people they did as adolescents, as well as the value of those factors, closely resembled each other. Indicative of the extent to which findings were consistent across cases in these realms are Hope’s Story, an aggregate constructed entirely from excerpts taken from participants’ stories about their health related attitudes and behaviours prior to pregnancy, during pregnancy, and after childbirth as adolescent mothers.

Hope’s Story and its Construction

The decision to construct an aggregate story for use on the HOPE website, entitled HOPE’s Story, came about as a means of addressing both participants’ recommendations for the site and our/their concerns about maintaining their anonymity. Specifically, participants recommended that real personal stories of young mothers like themselves be featured on the site, as they felt the inclusion of such narratives would lend it authenticity and provide visitors with much needed sense of moral support and connection to others like themselves. Other factors and/or concerns about the inclusion of personal stories on the website were that too many stories and too much text might prevent potential users from engaging with it and therefore prevent them from accessing the health information contained on it. After consideration of these recommendations and concerns, participants agreed that the use of an aggregate story would address the above mentioned concerns as well as portray their collective experiences fairly and accurately.
Participants’ recommendations about the value and effect of Hope’s Story on the website were later confirmed in the second year of the study when it was reviewed by numerous other teen mothers from various locations in and around Greater Victoria. Most of the teen mothers who reviewed the site and the Hope’s Story reported that they identified strongly with its content, and shared many of the experiences, feelings and concerns represented in it. Hope’s Story now appears as an audio-visual clip on the HOPE website. Its content is slightly different than the story below, as the story teller, an adolescent mother and former participant in a latter part of the HOPE study, phrased some aspects of the story differently.

HOPE’s Story consists of direct quotations and paraphrases derived from participant interviews and journal submissions. Constructing this story and presenting it as an accurate portrayal of the events, behaviours and circumstances that led this study’s seven participants to become mothers during their adolescence was possible due to the striking similarities of their experiences. Also similar were participants’ views on the way those experiences and behaviours contributed to their current statuses and situations as single adolescent mothers.
Hope’s Story

Before I found out I was pregnant I wasn’t living a good life. All I was doing was partying and hanging out with friends. I drank almost every other day and started doing harder and harder drugs like ecstasy, meth and cocaine. I was smoking weed everyday and later started selling it, until I got caught. Smoking and drinking became my extra-curricular activity.

When I found out I was pregnant I was 16 years-old and living at my boyfriend’s friend’s house. I was supposed to be going to school but never really went. I finally dropped out half way through grade 10 and got a job at a coffee shop. I wasn’t talking to my parents and was really scared. I didn’t know exactly what I was going to do and everyone around me wanted me to get an abortion. Even my boyfriend was pushing me to get one. At first I agreed but then I just couldn’t do it. I was balling my eyes out and freaking out. I just couldn’t go through with it. I’ve always believed in pro-choice for sure, but for me keeping the baby felt right. Then my boyfriend said no matter what I decided he would stay with me and love me, but when I told him I was definitely going to keep the baby, he got really pissed off and said the baby wasn’t even his. He said he wouldn’t help me at all, which is actually a good thing because one month later he ended up in jail for dealing drugs and breaking into cars.

Before I was pregnant and had my daughter, I used to see kids crying and screaming at the mall and stuff and be like, why isn’t their mother taking care them or why are they crying? I didn’t understand. When you’re not a mother, you just don’t get what it’s like, or like why a child throws a fit in a store. But now that I have my daughter I understand that, you know, it’s just hard to control and hard to handle.
When I decided to keep my baby, I knew I had to be concerned about the future and that I would straighten my life out and go back to school. The day my daughter was born, everyone’s opinions changed. It was hard. Since then my whole outlook on life has changed pretty much. Now I just think about what’s best for my daughter and me and getting a career. Now I live healthier. It’s exciting in a way because I always wanted to go to college or university but probably would never have done it if I hadn’t become pregnant because you just keep saying, “oh, I’ll do it next year”. But now you just know you need to do it now. It gave me a bit of a push in the right direction. My name is HOPE. I am 17 years-old and I have a seven-month old girl named Alyssa.

Findings across Cases Prior to Pregnancy

The strikingly similar findings reported across cases in this section, and the following section, about participants’ health-related attitudes, behaviour patterns and experiences leading up to, during and after their pregnancies was possible to obtain due to the consistency with which most participants (four to six out of seven) attended the first four focus groups and submitted journal entries during the first two months of this study. While attendance at these first four focus groups was consistent enough to collect the data and report the findings below, the repeated absences of some participants meant there were fewer opportunities to collect data from them, and thus further confirm, or disconfirm, the themes reported in this section. However, it seems likely that absentee participants would have experienced and/or taken part in more of the behaviours than they had opportunities to report due to their reporting most of the others. The literature on adolescent health related behaviours supports this speculation as behaviours are known to cluster and arise from the same underlying causes and/or conditions, conditions that many participants shared (Flay, & Phil, 2002; Wilson, Syme, Boyce, Battistich & Selvin, 2005).
Unfortunately, these frequently absent and inconsistently present participants could either not be reached to schedule and/or reschedule appointments to conduct individual interviews, or failed to show up when a meeting to be interviewed had been arranged. In spite of repeated attempts to contact these participants, arrange meetings with them, and/or go to meet them after a meeting had been arranged, only three interviews were conducted during the latter part of this study. That some participants did not manage to take part in this study as much as they agreed to, and seemed to want to, may be testimony to the extent to which their lives as single parents were demanding and unpredictable. It may also very well be that their interest in the HOPE project was waning, and their top priorities, their children, relationships and studies, demanded their attention.

While the themes below are listed one through eight, they did not emerge in this linear manner, and were reported in various sequences and clusters, with some items occurring simultaneously. To reflect these variations, findings will be presented under headings indicating the patterns within clusters. While the sequencing varied, as well as the degree to which participants became involved with each item listed, all seven participants reported experiencing and/or taking part in five out of the eight themes listed. These themes include:

2. Conflict at home.
3. Disengagement from school, under-achievement, and dropping out.
4. Substance use.
5. Dropping extra-curricular activities (ECA).
6. Early sexual involvement.
7. Leaving home to live with others.
Involvement in crime.

Characteristic of all reports is the way participants related and discussed individual themes relative to the occurrences of others. As the headings and participant reports below demonstrate, behaviours and events were related to each other, as one thing lead to another. What seemed consistent across cases was that participants turned away from childhood roles and activities as they adopted new ones. Often this transition was initiated by both adolescence and the introduction of a new, older, adult-like friend, and group of friends. This is consistent with concepts contained in Gee’s Discourse Theory, as participants’ behaviours changed relative to their social identities, social groups and affiliations, and social contexts. Further, when the eight themes listed above and discussed below are contextualized as Big “D” Discourse, it becomes possible to perceive the health literate value and status of these otherwise “bad” and seemingly anti-social behaviour. For example, while drinking, smoking, using drugs, being sexual active, leaving home, dropping out of school and hanging out with older people are not behaviours that most adults approve of, these behaviours definitely set the adolescents who take part in them apart from those who attend school regularly, hang out with kids their own age, live at home, and choose not to take drugs or drink. As Discourse Theory suggests, these ‘problem’ behaviours, rather than indicating a lack of knowledge and skill, actually represent specialized knowledge of particular social realms and communities of adolescents. Taking part in these activities and behaving in these ways constitute literate practices, as they express social competencies and identities that are recognizable by people within, and from outside, their communities.
Lisa

Prior to adolescence, Lisa reported being involved in extra-curricular activities including swimming, dance, music, and baseball. However, when she entered middle school her friends, interests and activities changed dramatically. During an interview with Lisa she stated that;

My extra-curricular activity was drugs and sex. I was in school and doing pretty good up until grade 8 and then I met a bad crowd and got suspended for three days. Moved on to grade nine at a different school and then went to a different school for grade 10. Didn’t do so good, lots of drugs, getting sick...In grade 11 I went half way through the year and couldn’t do it anymore cause I was too far in to drugs, so I dropped out…I met this girl in grade 8 and we were really bad together. On our own we were fine but as soon as we got together we shop lifted and stuff, got caught. . .

Indicative of this same pattern Lisa described, is what Jessica describes below.

Jessica

Jessica became involved with a new, older group of friends and their social activities, primarily “partying”, and/or doing drugs, as she dropped out of school and dropped ECAs that she formerly loved. Upon entering middle school Jessica expressed that her “old friends were in their comfort zone and wanted to stay there” while she “wanted to meet new people”. Jessica also reported that she “left school half way through grade nine and didn’t go back for about a year” due to being “drawn back into the party scene again”. After having returned to school temporarily, Jessica recalled having “met up with different people, more mature people, older people that were into the drug scene”. Describing how she became involved with these older
people (in their mid to late twenties) and the nature of her association and activities with them, Jessica stated the following:

    I met them through this one person that I met when I was hanging out downtown when I was younger, who I wasn’t really friends with, but then when I was older I bumped into him and we started hanging out…Then he introduced me to his whole group of friends…I started hanging out with those people.

Prior to leaving school and her immersion into the party scene, Jessica’s primary ECA had been horseback riding to the extent that she owned her own horse and worked in a stable. Remarkingly, on this and expressing regret about ceasing to continue with her riding, Jessica stated that, “I unfortunately decided to sell my horse and I lost interest in it because of the party life”.

    Emphasizing how disengagement from one realm and/or cluster of behaviours is replaced by another, as well as differences between the communities, identities and roles within which they are common is further suggested in Megan’s explanation about how she became disassociated from her school life.

Disengagement from School, Under-Achievement, Substance Use, & Crime

    Megan

I was a straight A student. I was second best in my class; me and my cousin, and then I got into grade 7 and started getting into drugs and alcohol, all that kind of stuff and stealing and umm….after a while my grades went down a lot.

As Megan began using drugs with increasing frequency, and of increasing strength, she reported that her interest and performance in school plummeted leading her to eventually drop out. The rate at which her drug use escalated and lead her to become immersed in communities and activities related to drugs is suggested by her reports of taking both prescription and
nonprescription drugs including “ecstasy, fat burners (diet pills), Ritalin and Dilotas”. She also smoked “lots and lots of weed” which she eventually began selling to others. In terms of alcohol use, Megan admitted, “Yep, yah I use to drink like every second day. I would drink and drink and party some more”. This escalation in frequency of use was accompanied by an increase in risk taking behaviour, as Megan’s substance use lead to her drug trafficking.

Under the heading that follows, another cluster is described with an emphasis on changing schools, meeting new friends and early sexual involvement as the factors that initiated the substance use, criminal activity and leaving home that followed.

*Early Sexual Involvement, Substance Use, Criminal Activity, & Leaving Home*

*Lisa*

In grade 9, I went to a different school and that’s when I got into, I met another girl and then I met her brother and her brother was into breaking into cars, breaking into houses, drinking, doing drugs. We ended up dating for a long time. I lost my virginity to him and umm, Yah and then, so I ended up breaking into cars and stuff, I got caught and finger printed and stuff. Not good. And uhh, then yah, so that was a big wild life and he was the one that first bought me my E (Ecstasy) since I wanted to try it. Then I said I wanted to try coke, so he bought me that….He was the initial person who got me into things.

Here Lisa states explicitly that it was her boyfriend, who was approximately three years Lisa’s senior, who introduced her to drugs and got her involved in committing crimes. In a very similar account, Jessica describes her experiences below.

*Jessica*

Jessica reported that her boyfriend (incarcerated at the time of this interview and the father of her child) was nine years older than she was, stating “he just turned 27 so…when he’s
30, he’ll still be with a young little thing. I’m 18 now so in 3 years I’ll only be 21, just legal in the states. He’ll be 30!” With regard to a previous boyfriend (also older) Jessica stated that he had introduced her to, and provided her with ‘harder’ drugs. Identical to what Lisa expressed about who had introduced her to drugs, Jessica stated that, “Yes, it (her drug use) would be completely from him”. Regarding her relationship with this particular boyfriend, she stated:

I probably made a pretty bad decision to start dating this one guy who was just,

“Ugh!”…I moved out on my own with this guy in this apartment that my parents ended up paying for three months…I was 16 turning 17 and umm so that was really stupid and I probably, I went completely overboard with like, what I was doing. Like I started using Meth, and that was really, I don’t know what I was doing.

Under the final heading that follows, another cluster is described which emphasizes how conflict in the home accompanied by early sexual involvement, dropping out of school and leaving home together created conditions that lead participants to act and live as they did during adolescence.

**Conflict at Home, Early Sexual Involvement, Dropping Out & Leaving Home**

After intense and on-going conflict in her home involving regular beatings by her father and a lack of action to stop this by her mother, Megan describes her experiences below.

*Megan*

After a while, yah, after they [her parents] tried to get me to go to counseling and everything, go to counseling with them, I let everything out and I said, “there you go, that’s what every sessions going to be like”, and they wouldn’t do it anymore and then I moved out…I moved out of the house when I was 13. Never went back. When I was fifteen I dropped out of school because I had, of course, got in with the wrong guy and
problems occurred with his ex-girlfriend and so I just didn’t want to deal with it and I left school…

Lisa

Conflict in Lisa’s home revolved around her older brother and did not involve her directly. Lisa also dropped out of school, became sexually involved with an older male, used illegal substances and took part in criminal activities as an adolescent. Below she describes the intensity of her home environment and emotionally charged conflicts that she witnessed and lived with.

There were nights when he would come home, like covered in blood and can just remember my mom yelling at him and my mom crying and storming up to her room and then my dad yelling at him…my brother he’s, he’s addicted to crystal-meth now. He’s selling it. His life is pretty messed up. Before it was good, he was into mountain bike racing and he went to the provincials and he was like second place or something. Like he was doing really good and then I don’t know what happened. Just always getting in trouble, always getting arrested by the police, always coming home drunk, getting kicked out a lot.

While Lisa reported that the conflicts in her home were not caused by or centered on her, and that her relationships with her parents was fine, it seems possible that all of the negative attention focused on her brother and his issues may have taken parental attention away from her and her activities. Across cases most participants reported taking part in the behaviours listed above during times of considerable instability and conflict at home, and estrangement from their parents and families.
Summary of Pre-Pregnancy Findings

Common among most participants’ experiences prior to pregnancy, and the circumstances surrounding the onset of the health related behaviours they reported, are that they coincided with their middle school years, the onset of adolescence, and occurred during times of significant conflict at home and breakdowns in their family relationships. These factors together disrupted participants’ home, school and extra-curricular activities and routines. Also common among participants is that they sought and formed new relationships, often with older groups of people outside of home and school. Upon forming and establishing these new relationships and bonds, these adolescents adopted new attitudes, activities and behaviours reflective of those held and practiced by the groups of people they associated themselves with. Participants agreed that their boyfriends and the groups they associated with played an instrumental role in introducing them to, and encouraging them to take part in the behaviours they reported. Considering the circumstances participants were in and the way they felt during the time they acted as they did, it seems possible that the decision to remain pregnant and have children may have been motivated (unconsciously) to some extent by a need to stabilize and gain control over their lives.

Contrasting, yet consistent with, pre-pregnancy findings are the findings reported in the next section derived from participants’ pregnancy stories and lives as teenage mothers. Contrasts between these findings lie in participants’ sense of identity, health-related attitudes and behaviours, social affiliations and family relationships, and interest in schooling and the acquisition of higher levels of education. Alternatively, consistencies between pre and post-pregnancy findings exist in the sense that changes in attitudes and behaviours continue to cluster in accordance with shifts in identity, roles, and social groups, and function to fulfill psycho-social needs.
Pregnancy Stories - Findings across Cases

Upon receiving the news that participants were pregnant, all reported that their boyfriends, friends, and families advised them, and in many cases vehemently, to terminate their pregnancies or risk estrangement and/or abandonment (by boyfriends in two cases). The disapproval and challenges participants faced when they decided not to have abortions, and instead become mothers as adolescents suggests that the prospect of motherhood held value for them, and was in some way powerfully appealing. More so than their identities and lives as adolescent girls, participants seemed to view motherhood as an opportunity to gain status, recognition, support, autonomy, and purpose.

Findings across cases during participants’ pregnancy stories include:

2. Acquiring higher levels of education to improve quality of life.
3. Conflicting demands and dual roles of motherhood and adolescence.
4. Changes in health attitudes, behaviours, concerns and lifestyles.
5. Changes in perspectives on relationships with partners, friends and parents.

The extent to which motherhood seems to have transformed participants’ perspectives and lives cannot be over-stated, as all reported making significant changes to numerous aspects of their lives when they became pregnant and decided to become parents. While there were differences among participants in terms of which aspects of their lives they placed the greatest emphasis on, all were concerned with improving their physical, mental and emotional health, as well as improving their living conditions and access to resources through education and employment.
Changes in Sense of Identity, Purpose and Life Direction

For Elle, and all the participants in this study, becoming a mother was a life and an identity changing that was powerfully motivating. While Elle expressed that the transition from teenager to mother was difficult, she also expressed pride in herself and the extent to which she felt prepared to act responsibly, and in the best interest of her daughter and self.

*Elle*

When I found out I was pregnant and decided to keep it, her. I started going back to school to straighten my life out…the day that like, she was born, everyone, their opinions changed…It was hard. I was 17 when I got pregnant and 18 when I had her…My whole outlook on life changed pretty much. Now I just think about what’s best for my daughter and getting a career.

*Cree-Wind*

Although the circumstances that Cree-Wind was in, and the challenges she faced as a pregnant woman were more severe and seem completely different from Elle’s, or any other participant, like the others motherhood held a meaning so profound that it motivated her to change her life entirely. When Cree-Wind became pregnant, she reported that she was living on the streets and “Not living a good life”. Explaining her feelings and situation, she stated:

I knew I wanted her. I was living a really bad life though so I had to go into detox to prove I wanted her. If there were any questions about my prior life, I could be like, that was my back up plan. She wasn’t born, like, addicted to anything. Because everyone knew me as living on the streets and doing this and that, that was my back up plan. I really wanted her. She was tested at birth and she was fine at birth. I knew she would be a healthy girl.
Since having her daughter, Cree-Wind stated:

I have opened up my heart and thoughts. I have begun to care, wanting to show love and compassion. I used to be uptight and not care about anyone or anything… The most important word to me now is family. I will do anything to see that it is secure, safe, healthy and loving.

Cree-Wind’s focus in terms of altering her life’s direction was clearly on the quality and state of her relationships with her family and children, as well as the maintenance of her sobriety, health and personal recovery.

*Jessica*

Much like Elle, Jessica too was highly motivated by motherhood. Embracing her new status and role as a mother to her child, Jessica gave up her former “partying” lifestyle and began living in ways that were supportive of her long term goal of being a responsible, independent woman and mother. Gaining control over her life, health and circumstances by completing her education and acquiring gainful employment were her top priorities. Suggestive of these new goals and purposes, Jessica said the following:

I really find myself being more responsible, and really owing up to this little person. I do not want to let her down as well as myself... I was sort of scared at first, obviously…I was really, like, didn’t really know what I was doing. I was just sort of wandering around…you know I was just like plodding along, working too, but I had some responsibilities, but I wasn’t really like, concerned about the future and then as soon as I became pregnant and decided to keep the baby I knew that I had to be concerned about the future now, and so I had to go back to school and I just started living a little bit more healthier, which is good.
As the reports above clearly illustrate, having children provided participants with a strong sense of identity, purpose, empowerment and direction. These things combined motivated and inspired participants to change their relationships, attitudes and behaviours in ways that they felt improved their current and future lives.

**Acquiring Higher Levels of Education to Improve Quality of Life**

The most common way that participants chose to improve themselves and their future prospects was to acquire higher levels of education. As one participant, Elle, said, “my future, now it’s a big priority to me. To get a good career so I can support my daughter and give her the life my parents gave me.” Indicative of participants’ new sense of purpose and view towards the future, Megan and Jessica outline their plans as follows:

*Megan*

After I would get my trade, my certificate, I would go to work and baby would be in daycare while John would finish his schooling. We would save up to own a house and have a car and basically be able to give our daughter whatever she would like and umm, that’s basically, I want to own my own business, for electrical….basically after all that stuff has happened just work and grow old, that’s it! I have my life extremely planned out. One of the biggest [obstacles] would be learning to finance our money… and hoping that John doesn’t get jealous because I would be making more money than what he is at the time.

*Jessica*

I also decided that I had to go back to school and plan positively for the future, such as; high school graduation and completion with college……it’s sort of exciting in a way because I always wanted to go to, like, college in the future, or university, and I honestly
probably would never have done it wasn’t for being pregnant because you just keep saying “oh, I’ll do it next year, I’ll do it next year”. But now you just know you need to do it now, so it gave me a bit of a push, in the right direction.

As the findings above indicate, participants viewed education as a fundamental means of redefining themselves, and gaining access to resources and power they otherwise would not have. Unlike their more immediate concerns prior to having children, and the tendency to behave in whatever way seemed most immediately gratifying, motherhood seemed to afford participants a tangible sense of the passage of time, and/or the implications and potential impacts of their present actions, collectively, on their futures.

*Conflicting Demands and Dual Roles of Motherhood and Adolescence*

Realizations surrounding the conflicting desires, demands and roles of being both a parent and a teenager simultaneously were common among participants. While they chose to become mothers and looked forward to having and attending to their responsibilities of parents, participants also felt confused, isolated, and conflicted as they transitioned away from familiar, former ways of being, socializing and behaving; such as hanging out and ‘partying’ with friends. As most participants’ friends were not parents, and did not have the same adult / parental responsibilities and priorities that they did, participants began to spend more time with their families. Within this context, that of the family, there were greater opportunities to interact and behave in ways that were conducive to building and establishing their new identities and lives as mothers. Within family contexts they felt recognized and supported in their new roles. This process of identity transitioning and having to contend with its dualities in terms of communities, purposes and social practices is something participants found both frustrating and rewarding. In
the following passage Mandy explains what she has learned about herself and her abilities as a result of having to deal with these issues.

*Mandy*

I was fifteen when I had my daughter and fifteen when I got pregnant, just fifteen. I was still a kid… Since having my daughter, making the right decisions haven’t been the easiest of things. I wasn’t given the chance to grow up properly and become an adult. Peer pressure will always be around, unless I completely isolate myself from all my friends. It is a good thing because I could not risk losing my daughter or hurting her. The decisions I’ve made helped me to realize I’m more reckless without her. I’ve learned that I’m able to adjust myself to deal with the everyday task of being a parent. It is difficult, and most of the time frustrating but that’s part of being a parent. Another part that wouldn’t of mattered before were relationships. It’s hard to be with someone and risk the chance of my daughter losing a father figure. It will always be a difficult situation.

Mandy’s comments about having to grow up and make decisions about her life indicate growth, maturation and increased self-awareness. It is worth pointing out that she learned, and/or is the processes of learning, these important life lessons informally, and without conscious effort through experiencing and dealing with the consequences of her “bad” behaviours and struggles as an adolescent and a teen mother.

*Changes in Health Attitudes, Behaviours, Concerns and Lifestyles*

Among health related attitude and behaviour changes made by participants upon becoming pregnant and deciding to have children, one of the most common involved the use and abuse of substances, and the need to stop. Other health topics participants expressed concern about were their children’s nutrition and their own eating habits with an emphasis on weight gain.
and/or weight loss. In the following passage Emily discusses her former marijuana use and her efforts to eat a healthy diet.

*Emily*

Before I became pregnant I used to smoke pot everyday! As soon as I found out that I was pregnant I quit smoking it. I thought it would be hard to quit but it really wasn’t at all. I thought that after I had had my baby I would smoke pot again, and I have 3 times but now I don’t like it. That is probably the thing that had changed the most for me. I probably won’t smoke pot ever again. I guess I would say my health matters to me now to an extent. Again relating to smoking pot, I don’t do it anymore. I never drank very often at all. I try to eat healthy but it’s really hard. I have a very big sweet tooth.

In the passage that follows, Jessica explains how her pregnancy provided her with a reason to quit using substances and how effortless this was due to her condition.

*Jessica*

When I decided to continue with my pregnancy, I took it very seriously. I knew that I had to be responsible, and change a lot of my lifestyle. A lot of me also thought that the only way to continue would be this way, almost like failing was not an option. I quit smoking as well as stop[ped] using any recreational drugs. I never drank alcohol so that was not a problem. I found it really easy to do this because it was the safest and healthiest thing for my baby.

Similarly, Cree-Wind expresses how health related behaviours that are otherwise difficult if not impossible to change for the sake of oneself suddenly become matters of fact and necessity due to motherhood. In the passage below Cree-Wind explains how she changed her eating and food preparation habits for the sake of her children’s health and well being.
Cree-Wind

My eating habits are now orderly planned and very nutritious ever since I became pregnant. I really started to believe in healthy food, healthy choices, healthy mind and soul so I knew I needed my body to be healthy so I could do my part and make a healthy baby. To this day I make sure that my toddler and baby have healthy food in them. My eating habits before, well let’s just say they were bought at fast food joints or they never took longer than 15 minutes to prepare.

Another serious health behaviour/problem that Cree-Wind changed and gained control over when she became a mother for the third time was her habitual and debilitating use of substances (see pp. 16 - 17). Evidence of the severity of her struggles and the extent to which her substance use made it impossible for her to function as a parent and behave responsibly and conscientably towards her children occurred prior to her most recent pregnancy when her oldest child had to go and live with members of her family due to her use. Interestingly, the power of both substances and motherhood to control and/or motivate behaviour unconsciously are contained and juxtaposed in Cree-Wind’s pregnancy story and her movements between street life and family life. This same movement between realms and identities exists in the stories and lives of other participants as well, as most reported experiencing conflict between old and new ways of being. While participants reported significant changes in their lives when they became mothers, it seems likely that they will experience times in which old attitudes and behaviours associated with their adolescence will resurface and conflict with intents and purposes in the present. Participants’ stories of transition from adolescent girls to adult mothers offer vivid illustrations and insights into the fluid and multiplicitious nature of identity, and the unconscious, nonlinear processes involved in learning, behaving and changing.
Changes in Perspectives on Relationships with Partners, Friends and Parents

Other changes that seemed necessary and thus easier to make due to motherhood involve relationships and social affiliations. In the passages below Elle comments on how her feelings about her family have changed, while Megan and Lisa describe how their perceptions about the quality of their relationships with the fathers of their children have changed, and Jessica reflects on her relationships with friends in adolescence. In all cases perspectives on relationships changed significantly since participants became mothers.

Elle

I was surprised to see how my entire outlook on life changed. I now see things from a parents’ perspective. I used to think that everyone was out to get me, my parents, teachers and such. Now I see how they were looking out for my best interest. Also my priorities totally changed. I used to only always want to party and hang out with my friends, I never wanted to be home or with my family. Now, my favorite thing to do is spend time with my family.

According to Elle, becoming a parent allowed her to understand her parents and other adult points of view that she formerly could not. Gaining this expanded perspective lead her to value of her relationship with family and enjoy their company.

In the passages below Megan describes her hopes for the future of her relationship with her child’s father while Lisa looks back, and reflects on her relationship with the father of her child and the her decision to become a mother so early in her life.

Megan

I would hope that me and John (her boyfriend and father of her child) would be more trusting in each other, and maybe we’ll get married, of course... not at this moment in my
life but later on… and another one would be building a better relationship and working on our communication.

Lisa

…It’s so confusing. But, after all the drugs and stuff and after my parents split up I met (boyfriend’s name) and we were dating for five months before I got pregnant…. He’s two and half years older than me. Yah and umm I don’t know what I was thinking back then. He said that if I have the baby or if I don’t he’ll always love me and then later on after I had the baby he says, “yah, if you keep him I would have gotten rid of you” and stuff. He’s very manipulative and till this day I’m still wondering whether I made the right choice, or if I was ready at all. (to have a child) Yah, yah, so it’s difficult. But, I don’t know. I decided to keep him. I don’t know what choices I made then….I don’t know what I was thinking.

Megan, unlike Lisa, was optimistic about the future of her relationship with her boyfriend and seems to know exactly what was needed to improve it. Alternatively, Lisa appeared to be confused, conflicted and regretful about her relationship with her child’s father and disillusioned by her position as a single parent. More specifically, she seemed deeply hurt and saddened by the fact that she did not have the love and support of the young man she conceived her child with. Her statement about not knowing whether she made the right choice by “keeping” her son is the only one of this kind made by a participant in this study. Only Lisa expressed any doubt whatever about the decision to become a mother as a teenager. My discussion with Lisa about her feelings stands out due to the deep sense of sadness I felt she emanated. Further, her predominantly pessimistic outlook on life and comments she had made about being ill at one time, but not specifying what with, made me think that she might have been suffering with
depression. If this were the case, it may be that her comments about doubt were generated from this general state of deeply felt sadness.

In a discussion about her past lifestyle involving hanging out with friends and excessive “partying” and substance use, and the loss of a beloved extra-curricular activity, Jessica also expressed regret, confusion and disillusionment over her choices and behaviours. However, Jessica’s attitude towards the “mistakes” she made, unlike Lisa’s, is forgiving and optimistic. As the following passage conveys, Jessica viewed her experiences as “eye opening” lessons that increased her awareness about the distinct lack of discernment she exercised, and the extent to which she was completely unaware of what was motivating her to behave as she did.

*Jessica*

I was hanging out with people down town and that sort of weird, you know, lifestyle and I just thought it was fun, and life’s stress-free and I had control of my life. But it was really quite opposite. It was really out of control, but you don’t see it that way…. I was like “oh my god, what did I do”, you know, like I totally had a horse, I had a horse, what was I thinking! So that was a bit of an eye opener to like, to know like, to really think you know, before you do stuff like that. I don’t know, maybe it was time for me to move on from her, my horse, but at the same time I probably would have had so much more fun just continuing on with it, but we all make mistakes right!

Across cases participants reported that their pregnancies and roles as mothers raised their sense of self-awareness and allowed them to gain insight into the values and qualities of their lives and relationships. Even in Lisa’s case, and in spite of her sadness over the current state of her relationship and quality of life, she too gained an understanding about these issues.
Summary of Pregnancy and Post-Pregnancy Findings

According to participants, their new identities as mothers resulted in significant positive changes in lifestyle, relationships, and life goals. These changes of behaviour in social and interpersonal realms did not occur seamlessly and/or without conflict, as participants reported feeling like their identities and desires as adolescents collided with their maternal, adult impulses and responsibilities. As participants dealt with these dual roles and embraced their parental responsibilities they became increasingly appreciative and understanding of their parents’ and other adult perspectives. This recognition of their parents often resulted in participants reconciling with their parents and developing a renewed sense of connection and belonging to them.

In retrospect, most participants expressed a sense of confusion, and lack of awareness about what propelled them to think and behave the way they did prior to their pregnancies. Further, they assigned negative and/or unhealthy values to these ways of being and acting. While participants described themselves and their past behaviours as ‘bad’, and their thought processes as confused and/or irrational, all but one believed that the decision to become a mother so early in life was healthy and positive. In light of participants’ admission that they didn’t know what they were doing or why they were doing it, and that they felt, after pregnancy, a greater sense of self-awareness, it is interesting that only one participant questioned the extent to which she was capable of making a conscious, sound decision, and was adequately equipped to raise a child.

Discussion

Key findings from this study that are consistent with literatures related to adolescent health are that (1) adolescent health related behaviours (both healthy and unhealthy) cluster and arise from the same underlying causes (Flay & Phil, 2002; Wilson, Syme, Boyce, Battistich &
Selvin, 2005); (2) social groups (family, friends, school, workplace) play a critical role in providing adolescents with the social support they need to construct and express individual and group identities (Gee, 2006; Godin, Anderson, Lambert, & Desharnais, 2005), develop and establish health related attitudes and behaviours (Demaray, Malecki, Davidson, Hodgson, & Rebus, 2005; Stahl, Rutten, Nutbeam, Bauman, Kannas, Abel, Luschen, Rodriguez, Vinck, & van der Zee, 2001), and/or literate practices (Hinchman, & Chandler-Olcott, 2006; Moje, 2000b), and meet basic psycho-social needs (Kerr, Preuss, & King, 2006); and (3) adolescents’ health related attitudes and behaviours and/or health literate practices are socially situated, valued and dependant on their changing sense of identity (Gee, 2006; Low, 2005; Stroud, & Wee, 2005).

A finding from this study that seems inconsistent with current conceptualizations of adolescent health and the constituents of health literacy, literacy learning and health literate practices is (4) the extent to which participants reported being unaware of their psycho-social needs (Deci, & Ryan, 2000; Ralye, 2005), and thought processes and/or motives for behaviour, particularly prior to pregnancy and motherhood. This finding, which encompasses the roles of unconscious needs and processes in literacy learning (Bandura, 1977; Berk, & Winsler, 1995; Halliday, 1969; Lave, & Wenger, 1990; Piper, 1998; Vygotsky, 1987), and in motivating, regulating and determining health related attitudes and behaviours (Bargh, & Chartrand, 1999; Muraven, & Baumeister, 2000; Reyna, & Farley, 2006; Sagarin, Sherman, Cialdini, & Rice, 2002) is not commonly identified as a key factor involved with adolescent health literacy and literate practices, unless is it associated with a lack of literate knowledge and skill. That is, health related attitudes and behaviours learned by adolescents informally, unconsciously and effortlessly that are noncompliant with mainstream values, behavioural social norms and conceptualizations of health are, for the most part, attributed to a lack of health literate
knowledge and skill, or a lack of ability to access, understand, evaluate and communicate health information. While the existence and dominance of these innate needs and unconscious, automatic processes are widely recognized in the fields of psychology as key determinants of human health (Deci, & Ryan, 2000; Field, & Hoffman, 1997; Ralye, 2005), and determinants of many, if not most, human attitudes and behaviours (Bargh, & Chartrand, 1999; Muraven, & Baumeister, 2000), they have not been clearly identified as critical components of adolescents’ health literate practices. The absence of these fundamental aspects of human cognition, behaviour, health, and literacy learning has resulted in unrealistic expectations being placed on adolescents in terms of their ability to control and regulate their health and behaviour autonomously through conscious effort and/or healthy, right decision making.

Clustering Health Related Behaviours and Underlying Causes

That all behaviours (those considered both healthy and unhealthy) cluster and predict each other (Flay, & Phil, 2002; Wilson, Syme, Boyce, Battistich & Selvin, 2005) is well documented over many years and in many fields of study on adolescents. Indicating this are studies confirming correlations among and between so-called problem behaviours such as cigarette smoking and early pregnancy, school problems, stealing, delinquent and violent behaviors, depression, and substance use (Chang, et al, Sherritt, & Knight, 2005; Wilson, Syme, Boyce, Battistich & Selvin, 2005). This clustering of behaviours, their relationships, and the social environments and conditions within which they often occur are clearly reflected in this study’s findings, as participants reported taking part in problem behaviours (alcohol and drug use, early sexual involvement, criminal activity, dropping extra-curricular and out of school) during times of conflict at home, and disconnection from parents, schools, and structured extra-curricular activities (Darling, 2005; Darling, Caldwell, & Smith, 2005). Similarly, during and
after pregnancy participants’ attitudes and behaviours changed in clusters, and in ways that were congruent with mainstream values and constructions of health and healthy behaviour. These healthy changes in behaviour resulted in the restoration of relationships with family and reentry into school. While variations existed in the sequencing of behaviours, and the degree to which participants took part in them, without exception health related behaviours changed in clusters relative to shifts in identity, social contexts, and interpersonal relationships.

Changing Social Identities, Health Behaviours and Sources of Social Support

The extent to which adolescents (including the participants in this study) depend on social support from families, friends (Godin, Anderson, Lambert, & Desharnais, 2005), schools, and various social/community groups to construct (Stahl, Rutten, Nutbeam, Bauman, Kannas, et al, 2001) their identities, develop a sense of self-esteem (McGee, Williams, Howden-Chapman, Martin, & Kawachi, 2006; Torres, & Fernadez, 1995), form attitudes and behaviours, and meet their psycho-social needs cannot be overstated (Godin, Anderson, Lambert, & Desharnais, 2005; Hurtes, 2002; Kerr, Preuss, & King, 2006). During adolescence, development of these processes and fulfillment of these needs, including autonomy, competence, relatedness, (Deci & Ryan, 2000) belonging (Baumeister & Leary, 1995), and mattering (Marshall, 2001) is often sought in broader social and societal contexts that extend beyond the realms of family and school (Fromm, 1941, as cited in Rayle, 2005; McGee, Chapman, Martin & Kawachi, 2006). Further the multiple implications and impacts of transitioning identity has been documented and discussed across health disciplines (Banister, 1999; Kralik, Visentin & van Loon, 2006), and in numerous studies on North American adolescents relative to its effects on health and health problems (Goodman, Huang, Schafer-Kalkhoff & Adler, 2007), adjustment (Darling, 2005; Darling, Caldwell, & Smith, 2005; Demaray, Malecki, Davidson, Hodgson, & Rebus, 2005), marginalized and
minority youth (Beers, McDonald, Quistberg, Ravenell, Asch, & Shea, 2003; Porr, Drummond, & Ritcher, 2006; Wong, Eccles, & Sameroff, 2003), parental and/or family involvement (Novilla, Barnes, De La Cruz, Williams, & Rogers, 2006), leisure behaviour (Percy-Smith, 2007; Peterson, Lowe, Peterson, & Janz, 2006; Valentine, Harris Cooper, Bettencourt, & DuBois, 2002; Wharf-Higgins, Gaul, Gibbons, & Van Gyn, 2003), and academic performance (Alim, 2004; Baugh, 2004; Fordham, 1999; Wassink & Curzan, 2004). Indicative of findings from studies in these areas, this study found that participants’ health related attitudes, leisure behaviours, relationships, and academic performances shifted in tandem with their sense of identity, and the groups they related to most, and/or those they felt competent within, and supported by. Participants also reported experiencing conflict between Discourses and their associated communities (mothers, fathers, boyfriends, and friends) as they moved from one discourse community to another. Before becoming pregnant, this meant conflict among and between Discourses related to home, school and groups of friends. After pregnancy, conflict arose between Discourses and literate practices related to motherhood and domesticity and those related to rebellious teenage hood and partying. As participants embraced and took on social identities and Discourses they felt supported by and competent within, they simultaneously dropped, resisted and rebelled against those they felt unidentified with, unsupported by, and incompetent and powerless within. Taking on and moving between diverse social identities, social realms and Discourses, each with its own set of human, social, economic and political values and implications is known to create conflict for those who use and move between them, and/or those who recognize their meaning. Explaining this component of literate Discourses, Gee (1989) explains that:
Discourses, which constitute each of us as persons, are changing and often are not fully consistent with each other; there is often conflict and tension between the values, beliefs, attitudes, interactional styles, uses of language, and ways of being in the world which two or more Discourses represent (p. 7).

This finding related to conflicting discourses is consistent with the experiences of African American students and the sense of conflict they felt when bidialectic programs required them to “code switch” (Fordham, 1999, p. 273) between their home Discourse and the Discourse of school. While the issues surrounding Discourse conflicts of African American students are different from those faced by the teen mothers in this study, both involve conflict over their identities, roles, discourse communities and the legitimacy of their literate practices.

In this study groups and environments within which participants experienced the most conflict were those associated with home and school, and these conflicts usually involved breakdowns in relationships with parents and other adults in positions of leadership and authority. Reports of disconnection and estrangement from parents and school were common when participants became involved with older, deviant groups (deviant refers to attitudes and behaviours that are nonconformist, and/or noncompliance with social norms or socially acceptable behaviors – these standards are established by the dominant culture), and their social activities (smoking, drinking and using drugs, having sex, dropping out of school and committing crimes). Considering the extent of participants’ needs and disassociations from childhood roles, relationships and activities, as well as their changing sense of identity, it seems reasonable that they would seek out and associate with groups that provided them with critically important opportunities to define themselves in
new ways, and gain the sense of autonomy, relatedness, competence and acceptance that they perceived they were unable to acquire at home and at school.

**Health Behaviours as Literate Practices - Questions of Value and Legitimacy**

While adolescents’ literate practices in and out of school contexts have long been recognized as being directly linked to identity by scholars such as Delpit, Finders, Gee, Hagood, Luke, Nixon and many others, this relationship and the process by which socially situated health related behaviours are designated as health literate practices remains undefined in the field of health literacy. Also widely acknowledged in literacy research are the social and political implications, and value laden nature of adolescents’ literacies and literate practices, as they are known to signify social class, social status, social affiliations, social solidarity and social rebellion (Alim, 2004; 2004; Billings, 2005; Cousins, 1999; Dagenais, Day, & Toohey, 2006; Fordham, 1999; Gee, 2006; 2000; Marsh, & Stolle, 2006). Literacy research on adolescents that illuminates some of the social and political issues involved with literacy and the acquisition of literate status include research on African American students and their literate practices, studies on media and adolescent heath and media literacy, and health literacy research on the literate practices of adolescent drug users.

More than any other group of adolescents studied in relation to the politics of identity in determining the legitimacy of literacies and literate practices are African Americans. The emphasis on African American youth grew out of concern for their consistently low performance and graduation rates. The disparity between the performances of white students and those of low-resourced racial and ethnic minorities is a well-documented problem in America that Kozol refers to as "the shame of the nation" (as cited in Wamba, 2006). In defense of his " powerful indictment of the blatant inequalities in public schools" (as cited in Farahmandpur, 2006), Kozol
reports that the "graduation rates for white and Asian students are around 75 and 77 percent respectively", while "in schools where 90 percent of the students are children of color (African American, Hispanic, Native Americans, Pacific Islanders)" the graduation rate is only 42 percent (as cited in Wamba). Likening the current state of public schools in America to apartheid, Kozol asserts that public schools are segregated on the basis of race and social class, in spite of democratic values, principles, laws, and government policies that attempt to legislate equality (as cited in Farahmandpur). This recognition of the way public schools and other institutions function to legitimize dominant forms of discourse by valuing and perpetuating them, and devaluing and marginalizing others that do not serve the interests of the capitalist consumer culture and economy, and those in power (Bauman, 2000; Burkitt, 2005; Frith & Frith, 1993; Gee, 2006; Parsons, as cited in Shilling, 2005), is of central importance to this study because it illustrates how identity and the social, political and economic factors associated with it influence the way literate practices of adolescents are constructed, perceived and valued.

Another out of school literacy context within which informal settings, informal learning and health related behaviours have been investigated is related to various forms of mass media. Studies on media and adolescent health, and media literacy have explored and discussed informal health messages imbedded in mass media and their impact on adolescents’ self-perceptions, and adolescent perspectives on social norms and health behaviours. Health behaviours and health problems related to media use and consumption include: violence and aggression resulting in injuries and death (Brown, & Witherspoon, 2002); sexual activity resulting in unwanted pregnancies and STIs (Brown, Halpern, & L’Engle, 2005; Kaplan, & Cole, 2003); lack of physical activity and unhealthy diets resulting in obesity, diabetes, (Janssen, Katzmarzyk, Boyce, King, & Pickett, 2004; Motl, McAuley, Birnbaum, & Lytle, 2006) and eating disorders
(Hargreaves, & Tiggemann, 2002; Munro, & Huon, 2005; Stice, Spangler, & Agras, 2001; Tiggemann, 2005; Utter, Neumark-Sztainer, Wall, & Story, 2003); and finally alcohol and tobacco use resulting in traffic fatalities and chronic illnesses such as lung cancer and emphysema (Gruber, Thau, Hill, Fisher, & Grube, 2005; McCool, Cameron, & Petrie, 2005; Stern, 2005). Studies conducted over the past 40 years have shown consistent patterns in media content, particularly in its depiction of a "world in which unhealthy behaviors such as physical aggression, unprotected sex, [and] smoking and drinking are glamorous and risk-free" (Brown & Witherspoon, 2000, 153). That frequent viewing of media generated images and the ideas, attitudes and beliefs they represent increases the likelihood of youth internalizing and emulating them is well established in the literature (Brown, Halpern, & L’Engle, 2005; Brown & Witherspoon, 2002; Clay, Vignoles, & Dittmar, 2005; Gruber, Thau, Hill, Fisher, & Grube, 2005; McCool, Cameron, & Petrie, 2005; Stern, 2005). Also well documented is that youth represent the most readily persuaded group in society, and the group most frequently targeted by commercial media (Choi, Ahluwalia, Harris, & Okuyemi, 2002; Gruber, Thau, Hill, Fisher, & Grube, 2005; McCool, Cameron, & Petrie, 2005; Stern, 2005; Straub, Hills, Thompson, & Moscicki, 2003). It is worth considering the possibility that the health related behaviours and problems associated with media viewing, media use, and a lack of formal instruction in critical media literacy, might be viewed alternatively as a form of social and cultural literacy. This sense of literacy may be evident by the fact that many problem behaviours, values, and attitudes exhibited by adolescents are congruent with what is portrayed in Western media and the world view it constructs and transmits. Rather than viewing these attitudes and behaviours as indications of literate deficiencies, they might be viewed as an astute and innate form of literacy that relies on unconscious mental processes and needs to function. What is significant here, and
what may lend support to the notion that the constituents of health literacy require reconsideration is the extent to which unconscious needs and mental processes are fundamental in learning and determining the health literate practices of adolescents.

In the field of health literacy, informal settings and sources of health information in youth drug culture have been explored by researchers such as Allaste (2005), Salasuo (2005) and Virokannas (2005), although work in this area is not extensive. In these studies the points of view of adolescent users are identified, and in some cases discussed as health literate practices. For example, Salasuo explains that his study “presents a substance-specific analysis of users’ health-related experiences, practices and knowledge…” with a focus on “ecstasy users, their perceived health risks, identification of such risks, health problems caused by the use of the drug and the users’ own efforts to prevent and reduce their risks” (139). Studies like this indicate that the views and practices of adolescents are increasingly being observed, documented and incorporated into current concepts of health literacy and health literate practices. However, most adolescent health related behaviours that are noncompliant and/or conflict with mainstream values and health agendas continue to be defined as unhealthy and defiant (Benford & Gough, 2006; Moje, 2000), and unofficial sources of information that are accessed within socially unsanctioned social environments and/or settings, such as those derived within adolescent drug cultures, (Allaste, 2005) are viewed as unreliable and illegitimate. The primarily negative and dismissive values assigned to these adolescent contexts and information sources are clearly indicated by terms such as problem behaviours, and deviant behaviour, and by their occurrences being attributed to a lack of health literate skills and information.

While many of the attitudes and behaviours reported by participants prior to their pregnancies can be, and often are undeniable harmful to physical and mental health (Kolbe,
2005), they may also be viewed as beneficial, if not vital, to their health and sense of well being if their psycho-social value is recognized. Many of the behaviours and ways of being that participants, and many other adolescents, took part in prior to pregnancy; including substance use, skipping and dropping out of school, ceasing extra-curricular activities, leaving home, moving in with friends or boyfriends, becoming sexually active with older males, and taking part in criminal activities may have satisfied needs that were not being met in socially sanctioned environments. Further, these behaviours were socially situated and revolved around forming and expressing identity and social bonds, as well as fulfilling psycho-social needs which Deci and Ryan assert “specify the necessary conditions for psychological growth, integrity and well-being” (2000, p. 227).

**Unconscious Processes and Needs**

Another significant finding from this study that suggests current conceptualizations of health literacy and the constituents of literate practice require further examination is the extent to which participants reported being unaware their decision making processes and psycho-social needs. As one participant said with regard to her attitudes and behaviours during adolescence, “I don’t know what I was thinking”. That many, if not most human behaviours are learned unconsciously, and informally in social setting, as well as motivated and governed by unconscious, automatic cognitive processes that function to fulfill basic human needs is widely acknowledged in the fields of adolescent and social psychology, as well as some areas of literacy unrelated to health literacy. For example, In *Relevant Models of Language* Halliday (1969) posits that children learn what language is, and what it is for by using it to meet their needs (p.27). Halliday explains that children use language “for the satisfaction of material and intellectual needs, for the mediation of personal relationships, the expression of feelings…” (p.27). Due to
these direct experiences using language to meet needs, children are, according to Halliday, “subconsciously aware that language has many functions that affect [them] personally. Language is, for [children], a rich and adaptable instrument for the realization of [their] intentions; there is hardly any limit to what [they] can do with it” (p.27). Acknowledgement of these unconscious processes, needs and functions of literacy is precisely what is absent from discussions on adolescent health literacy and literate practice.

In spite of that fact that participants were not consciously aware of their psycho-social needs or making any conscious decisions about their behaviours prior to their pregnancies, when these factors are considered with the circumstances of their lives, primarily their disconnections from family and school (their primary sources of social support), one can understand why their problem behaviours may have actually helped them to maintain their health, cope, learn and grow. One can also imagine why participants in this study decided to become mothers, as motherhood represents status, respect, responsibility, purpose, competence, mattering, belonging, and relatedness. In light of their unmet needs and unstable situations, the choice to create and/or recreate themselves and their lives by becoming mothers can be viewed as healthy and sensible. While becoming a mother as a teenager is not viewed favorably by many and the decision to do so was likely made in spite of being informed about the enormous trials of motherhood without the benefit of a stable relationship and partner, financial support, adequate housing, an education, and reliable employment and child care, it seems that something innate and of much greater meaning to the young women in this study motivated them to go through with their decision. When unconscious processes and needs are considered as fundamentals of health literacy, behaviours that otherwise seem contradictory, illogical, and self-destructive can to be understood.
Conclusion

These findings raise important questions about current conceptualizations and constituents of adolescent health and health literacy and the processes by which adolescent health-related behaviours are, and perhaps should be, considered healthy or unhealthy and the result of health literacy or a lack of it. While scholars across disciplines acknowledge that much of what determines adolescent health and health-related behaviour is dependent on social and environmental factors that are outside the control of any individual, current methods of health literacy education and promotion continue to discuss and treat health, health literacy and health-related behaviour as self-determined, monitored and maintained by willful, conscious, healthy decision making. Further, it seems that the only attitudes and behaviours considered ‘healthy’ and health literate are those delivered in formal school settings that reflect mainstream values and official sources of health information. While the need to address issues of autonomy, power, legitimacy and difference have been identified and discussed by many researchers in the field (Allaste, 2005; Burkitt, 2005; Curwen Doige, 2001; Grote, 2006; Salasuo, 2005; Stewart, Riecken, Scott, Tanks, & Riecken, 2008; Virokannas, 2005), and the need to expand health literacy definitions has been called for, much of what has been stated in this regard is based on recognition and inclusion of differences among people, with an emphasis on culture. The primary difference between this stance and the arguments put forth in this study is that they are based on recognition of sameness in terms of basic human needs and conditions, as opposed to an emphasis on the recognition of differences.
Chapter 5

Implications and Recommendations

Findings from this study that suggest current conceptualizations of adolescent health literacy and health literate practices require reconsideration and integration with knowledge derived from other literacy fields and disciplines are the extent to which social identities, social contexts, and unconscious cognitive processes and psycho-social needs seemed to play significant roles in motivating and determining participants’ health related attitudes, behaviours and/or their health literate practices. While identity, and/or “social identities” have been acknowledged as critical determinants of adolescents’ literate practices within “new literacies” contexts by scholars associated with the New London Group, and unconscious cognitive processes and psycho-social needs have been recognized as integral to literacy acquisition, functioning and development by theorists such as Vygotsky and Halliday, these fundamental aspects of adolescent literacy have not yet been incorporated into current understandings of health literacy.

This chapter will outline key problems inherent in current health literacy definitions and education methods including the emphasis they place on individual responsibility, conscious self-control and self-regulation, and the homogenous and fixed values they imply and assign to adolescents’ health related behaviours. To address these issues, recommendations for future research and practice will be suggested including the need to teach adolescents about the roles of psycho-social needs and unconscious cognitive processes in determining their health related behaviour and/or literate practices, provide instruction in critical media literacy within health contexts, seek and incorporate broader and more diverse perspectives on health and the constituents of health literate practices (Brown, Teufel, & Birch, 2007), and create reliable, yet
flexible measures of health literacy. The overall goal here is to integrate literacy knowledge across disciplines and literacy fields in an effort to create a more unified and comprehensive understanding of various literacies and the human functions they serve and needs they fulfill.

Key Issues and Recommendations

Problems with Self-Responsibility and Self-Control

As Nietzsche once stated in *Human, All Too Human*, “The strongest knowledge- that of the total unfreedom of the human will-is nonetheless the poorest in successes, for it always has the strongest opponent: human vanity” (as cited in Bargh, & Chartrand, 1999, p. 462). Indicative of Nietzsche’s assertion is the assumption that individuals create and maintain their own health by acts of will and rational decision making, when in fact “unconscious mental systems perform the lion’s share of the self-regulatory burden, beneficently keeping the individual grounded in his or her current environment” (Bargh, & Chartrand, 1999, p. 462; Muraven, & Baumeister, 2000). Extensive evidence derived from literatures on human behaviour motivation, self-regulation and self-control has shown that “most of a person’s everyday life is determined not by their conscious intentions and deliberate choices but by mental processes that are put into motion by features of the environment that operate outside of conscious awareness and guidance” (Bargh, & Chartrand, 1999, p. 462; Deci, & Ryan, 2000; Muraven, & Baumeister, 2000; Bargh, Jonides, Naveh-Benjamin, & Palmer, & Kahneman, & Treisman, as cited in Wegner, 1994). Further, “the resource needed for self-control is a limited, consumable strength” that is weakened in situations demanding two or more consecutive acts of self-control (Muraven, & Baumeister, 2000, p. 248), as “after one act of self-control, the self-control of other, unrelated behaviours is worse” (p. 252). As Bargh and Chartrand point out in *The Unbearable Automaticity of Being*, mounting evidence from studies in contemporary American psychology has challenged the long standing assumption
that people “are consciously and systematically processing incoming information in order to construe and interpret their world and to plan and engage in courses of action” (p. 462). In reality, human beings’ distinct lack of ability to exercise self-control has led researchers to conclude that “self-control failure is central to many of the personal and social problems that plague modern Western civilization” (p. 256). When the limits of self-regulation and control are considered in conjunction with the extent to which health and health literacy are constructed as matters of individual responsibility, individual choice and individual conscious decision making, and even perhaps empowerment, problems with these constructs and the expectations they place on adolescents become clear.

A negative and common outcome of placing undue emphasis on self-control and personal ability and responsibility in maintaining health is that individuals who are well informed of the potential risks and consequences of their health related behaviour, but who still find themselves unable to manage and/or control it, regard themselves and others like them as careless, lazy and/or inadequate (Benford & Gough, 2006). Thoughts and beliefs like this are inaccurate and counter to the realization of desired health outcomes. Further, they stigmatize certain forms of illness, such as mental illnesses, addictions and obesity, and this often deters people from acknowledging their health problems and getting the professional help they may need (Benford & Brendan, 2006).

This is not to say that adolescents should not be encouraged and taught to be accountable for their actions and the state of their health, but such accountability should be realistic and reasonable. It is to suggest however that if the goal of health literacy education is to teach adolescents to be more knowledgeable about health and act in ways that are more health conscious; that is, to act in ways that are in alignment with what they know and are taught about
the health risks of certain behaviours, then much more than providing them with health information, they must be educated about the power of their unconscious minds to motivate and resist various behaviours. If adolescents are educated about the nature and existence of their conscious and unconscious mental processes and their limits, it seems much more likely that they might progressively gain higher degrees of control over them and their behaviours.

Problems with Rationality, Difference, Value and Legitimacy

Another problem with assuming that health and health literacy are achieved solely through conscious effort, self-control and by the ability to behave rationally and/or on the basis what is “healthy” is that differences exist between peoples’ perceptions of rational behaviour and what is healthy at any given time (Reyna & Farley, 2006). These differences in perception emerge when there are significant differences in peoples’ social status, age, cultures, social situations and environments (Flick, Fischer, Neuber, Walter, & Schwarts, 2003; MacLachlan, 2006; as cited in Stewart, Riecken, Scott, Tanks, & Riecken, 2008). While human health has its basic requirements, certain needs pertinent to it are subject to change and may become more or less pronounced depending on numerous interacting biological, environmental, social and situational factors. For example, many youth find listening to loud music, eating ‘junk food’, and staying up late drinking and smoking with friends exceedingly enjoyable and therefore reasonable. Youth engagement in behaviours such as these makes sense for them because taking part in them gives them a strong sense of belonging (Baumeister & Leary, 1995), relatedness, autonomy and social competence (Deci & Ryan, 2000; Sheldon, Elliot, Kim, & Kasser, 2001; Sheldon & Niemiec, 2006), thereby building their self-esteem (Bowker, 2006; Torres & Fernandez, 1995) and meeting, albeit and perhaps momentarily, their psycho-social needs which are critical to their health sense of well being. As this example suggests, for many adolescents a
sense of well being is rooted in social acceptance and the immediate social moment to the exclusion of most other considerations (Reyan & Farley, 2006). Alternatively, some adults feel “good” about themselves and their health if and/or when they learn to manage and/or regulate themselves and their behaviours by subduing their immediate desires in favour of attaining longer term health, personal growth and well being goals (Bauer & McAdams, 2004; Muraven & Baumeister, 2000). Many adults, unlike many adolescents, feel healthy by getting sufficient rest and exercise, eating a healthy diet and avoiding smoking and drinking to excess. As current methods of adolescent health education have not taken these differences in perspectives into account, and instead have attempted to promote behaviours that are sometimes “at odds with those selected for by evolution (e.g. early procreation)” (Reyan, & Farley, 2006, p. 2), and/or at odds with the fulfillment of adolescents’ basic psycho-social needs, they fail to yield changes in adolescents’ health related attitudes and behaviours. Further, current approaches misunderstand and misrepresent common adolescent “problem” behaviours by discussing them as though they are void of any positive, literate value and/or health benefit. If the role of innate, unconscious processes and needs were acknowledged for their roles in motivating behaviour as well as their role in literacy acquisition perhaps such behaviours could be understood in more accurate and complex terms. While the primary goal of many adolescent decisions is “to maximize immediate pleasure” (Reyan & Farley, 2006, p. 2), this drive, rather than being irrational and reckless without any purpose, may actually function to fulfill basic human needs.

Other differences among various groups and segments of society that make the concepts of personal responsibility and ability to maintain health problematic are those that result in significant inequalities and disadvantages which impair ‘ability’. As it is currently used in the literature on health literacy and in health curriculum, the term ‘ability’ connotes a ‘natural’
and/or an innate quality; will or ‘power’, implying that it exists and functions independently
from social factors. Evidence of these implied meanings can be found in the Concise Oxford
Dictionary which defines ability as, “sufficient power, capacity (to do something); legal
competency (to act) cleverness, talent, mental power, (his undoubted ability...)”. These
connotations make the use of this term in health literacy contexts inappropriate for describing the
human and social conditions required to create health, improve literacy.

As other forms of adolescent literacy and literate practice are thought to be socially
situated, mutable and known to develop and function through conscious and unconscious
cognitive processes, perhaps health literacy could incorporate these factors into its definition. For
example, health literacy might be defined as the extent to which individuals are aware of, and/or
adapt their attitudes, values and behaviours in response to various socio-cultural groups and
contexts to survive and/or meet their immediate health needs (psycho-social, physical, emotional
and mental). Critical health literacy then might be defined as the extent to which individuals
become increasingly aware of and concerned with the broader implications of their lifestyles and
health related behaviours, and the social, political and economic factors that shape and impact
their health and that of others. Further, being critically health literate might be defined as
behaving and living in ways that are congruent with what one values, knows, thinks, and
believes.

Recommendations and Future Research and Practice

Recognizing the Roles of Social Support and Psycho-Social Needs

Good health and a sense of well being are created and maintained, in large part, by the
extent to which people’s basic human needs are met. When the intensity and urgency of psycho-
social needs and developmental processes during adolescence are recognized, one begins to
understand why many youth, particularly those who identify with “subordinate groups” who, like them, feel they lack social support, social status and social competence in the context of dominant, mainstream literacy environments such as schools and classrooms (Chen, 2005, p. 11; Delpit, 1989; Gee, 1989; Heath, 1983), choose to spend their time and take part in socially unsanctioned environments and activities (Flay & Phil, 2002). Regardless of which groups adolescents identify and associate themselves with, and regardless of the behaviours they participate in to demonstrate their social affiliations, most youth fulfill their immediate psycho-social needs through their social interactions and/or social activities and behaviours with others.

When health related behaviours (both those considered problematic and healthy) are viewed from this perspective, they can be seen as rational (Reyan & Farley, 2006) literate practices (Delpit, 1989; Finders, 1997; Gee, 2000; Heath, 1983) that sustain health, instead of irrational, entirely unhealthy acts that occur due a lack of information and literacy skills.

**Seeking a Broader Perspective on Health Literacy**

When the perspectives of adolescents like the participants in this study are accounted for, and juxtaposed with current conceptualizations of health and the constituents of health literacy and health literate practices, problems with these concepts become evident. Specifically, the values and concerns of many adolescents seem absent from current concepts and discussions of health literacy, and definitive values, such as healthy and unhealthy, are readily assigned to health related behaviours of adolescents based on singular (un)healthy outcomes (such as smoking causing lung cancer) without consideration of other health benefits related to those behaviours and/or specific situations and circumstances surrounding their occurrences. Other factors that require consideration and research are alternate, informal sources of health information used by adolescents, informal and unconventional learning environments, and social
realms and/or situations within which various behaviours take place (Benford & Gough, 2006; Brown, Teufel, & Birch, 2007).

**Providing Critical Media Literacy Instruction within Health Contexts**

Commercial mass media is a socio-cultural entity and transmitter unique and powerful in its ability to shape worldviews and cross geographical, cultural, socioeconomic, racial, ethnic, and social boundaries (Borzekowski, & Rickert, 2001; Hargreaves, & Tiggemann, 2002; Munro, & Huon, 2005; Stice, Spangler, & Agras, 2001; Utter, Neumark-Sztainer, Wall, & Story, 2003). For this reason its impact on adolescent health and influence on health related attitude and behaviours cannot be under-estimated. Current approaches to health literacy education and promotion neglect to educate youth about the extent to which media constructs and influences their perceptions of health and behaviour norms (Levin Zamir, 2007) and a serious consequence of this is that many North American adolescents are unaware of, and therefore powerless against, its influence on them. Further, many adolescents believe that their attitudes and behaviours are entirely self-generated and self-determined and that they are essentially impervious to media’s influence (Begoray, Cimon, & Wharf Higgins (in press).

Addressing issues of empowerment through critical media literacy relative to health, Bergsma (2004) asserts that “powerlessness is a significant health risk factor and conversely, opportunities to experience power and control in one’s life contribute to health and wellness” (p. 152; Deci, & Ryan, 2000). Defining empowerment, Rappaport explains that it as “a process by which people, organizations, and communities gain mastery over issues of concern to them” (as cited in Bergsma, p. 155). Similarly, Zimmerman describes psychological empowerment as a construct that “integrates perceptions of personal control, a proactive approach to life, and a critical understanding of the sociopolitical environment” (as cited in Bergsma, p. 155).
According to Bergsma, the primary result of this form of empowerment is social change through thought and behaviour, and this, asserts Bergsma, is “the focal point of media literacy” (p. 155). Without adequate instruction in critical media literacy offered within health contexts, youth cannot be expected to perceive differences between what is implied about health and normative behaviour, and what is stated about these subjects explicitly. Currently most adolescents are not critically equipped to access, understand, evaluate and communicate about health messages embedded in various forms of media. Further, many adolescents are unaware of the broader social, economic and political implications of the behaviours, attitudes and values they adopt, and perpetuate, as a result of engagement with media.

*Creating Reliable, Flexible Measures for Health Literacy*

Health status is influenced by individual characteristics and behavioural patterns (lifestyles) but continues to be significantly determined by the different social, economic and environmental circumstances of individuals and populations. The relationships between these social factors and health, although easy to observe, are less well understood and much more difficult to act upon. Consequently they have been given much less attention as a basis for public health intervention than have individual behaviours in recent past.

(Nutbeam, 2000, p. 260).

As Nutbeam’s comments indicate about the difficulty involved in understanding, studying and acting upon the determinants of health status, the constituents of health literacy are equally difficult to grasp and measure due to the multiple, interacting factors that inform and determine it. In order to better understand the basic constituents of health literacy and literate practices, concise, reliable yet flexible measures of it must be created and developed (Hemming &
Langille, 2006; Frankish, 2007; Levin Zamir, 2007; Nutbeam, 2008). A critical first step in creating a health literacy measurement tool is careful examination of current definitions of it and consideration of “what goes into a definition and what stays out” and/or what people believe are its essential components (Frankish, 2007, p. 7). With this thinking in mind, this study considered how and on what basis literate knowledge, skills and status are assigned to certain adolescent behaviours and withheld from others. Doing this seemed to reveal much about why such designations of value exist and whose interests they serve. For example, health literate knowledge, skill and status seem only to be designated to socially sanctioned behaviours that are compliant with mainstream health agendas and sources of health information that are accessed in formal learning environments, while low literacy and/or a lack of health literate knowledge, skill and ability are readily assigned to behaviours that are noncompliant with mainstream health agendas and behaviour norms, and unofficial sources of health information accessed in informal, social learning environments. While the need to address issues of difference, empowerment and legitimacy have been identified and discussed by many researchers in the field (Allaste, 2005; Burkitt, 2005; Curwen Doige, 2001; Grote, 2006; Nutbeam, 2008; Salasuo, 2005; Stewart, Riecken, Scott, Tanks, & Riecken, 2008; Virokannas, 2005), and the need to expand health literacy definitions has been called for, much of what has been stated in this regard is based on recognition and inclusion of cultural differences in health literacy concepts (Stewart, Riecken, Scott, Tanks, & Riecken, 2008). While cultural differences in health perspectives definitely require attention and exploration, it is also pertinent to locate and define aspects of literacy that can be identified in various social settings across cultures and modes. Perhaps health literacy measures can be created that highlight and focus on sameness in terms of basic human health
needs and conditions they serve, rather than measures that attempt to account for a multitude of differences.

Conclusion

One of the primary problems created by over-specialization in literacy fields and a lack of interdisciplinary knowledge integration is that essential aspects of literacy are absent from discussions of health literacy. This has resulted in health education and promotion programs that place unrealistic expectations on individual adolescents, to use their conscious cognitive skills and abilities to exercise control over their health by regulating their own behaviour and making conscious, “healthy choices”. Exacerbating this is that healthy choices are presumed to be those based solely on official sources of health information which represent a singular, homogenous view of health that does not account for socially situated actions and/or discern the value of behaviours on the basis of multiple interacting social and environmental factors. To address these problems greater recognition of diverse points of view on health derived in various informal social settings are needed, as well as exploration and acknowledgement of unofficial sources of health information. Investigations into the roles of conscious and unconscious cognitive processes and needs in determining health literacy among adolescents are also needed. To reach these research goals it is imperative that researchers and educators across disciplines and literacies work together with adolescents to access their views and create more cohesive and unity in understandings about the functions of literacy (Marx, Hudson, Deal, Pateman, & Middleton, 2007; Nutbeam, 2000; Percy-Smith, 2007; Rootman & Ronson, 2005).
References


http://qhr.sagepub.com/cgi/content/abstract/9/4/520


http://intertwining.org/dissertation/Chapter1.htm


http://edrev.asu.edu/reviews/rev468.htm


http://www3.interscience.wiley.com/journal/118563472/abstract?CRETRY=1&SRETRY=0


Appendix A – Introduction Letter
February, 2007

Dear Participant:

We are pleased to introduce you to the HOPE (Health Opportunities for Parents Expecting) project! The purpose of the project is to provide young mothers with access to health related information in key areas such as nutrition, exercise, pre-natal and post-natal care, via an interactive website. The website will be targeted toward young women as they are completing their high school education.

Our intention is to design a website that is both informative and relevant for young women, and that would support the health curriculum in your school. We would therefore like to include the ideas and contributions of teenage, new and expecting mothers. Your participation will include an initial focus group where you are introduced to the project and then invited to discuss your ideas of health for you and your child and your sources of health information. You will receive a $25.00 honorarium for your participation in the focus group.

From these focus groups a small number of participants will be invited to join our ‘consulting team.’ This consulting team will meet with the HOPE project staff members twice a month from March 2007 until June 2007 for approximately 10 hours per month at the University of Victoria, and will help to design the HOPE website. We will do our best to schedule meetings so that they are convenient for you. Each participant will receive a $400.00 honorarium for their participation on the consulting team ($10/hour) to help pay for your time and expenses related to travel and daycare. If there are more than 10 people interested in being on our consulting team, we will randomly draw names.

You should know that your participation in this study is completely voluntary and that you may withdraw at anytime without explanation. You will be paid for the time you have spent involved with the research project at the time of your withdrawal at $10/hour.

In terms of protecting your anonymity, you will not be identified as a participant in this study in any way. You will be asked to think of a pseudonym to which all your comments will be matched for the duration of the study. If you agree to participate, we will ask you to sign a consent form that fully explains how we will protect your identity throughout the study.

In addition, each participating school/daycare centre will receive a computer workstation in order to provide access for young women like yourself to utilize the interactive web technology.

If you are interested in participating, or want more information please contact Monica Cox, Project Coordinator, at phone 598-7720 or email: mcrumrine@shaw.ca

Sincerely,

Dr. Joan Wharf Higgins, Dr. Alison Preece, and Dr. Ted Riecken
Appendix B – Initial Focus Group Consent Form

**Participant Consent Form**

**HOPE (Healthy Opportunities for Parents Expecting)**

You are being invited to participate in a study entitled HOPE that is being conducted by Drs. Joan Wharf Higgins, Ted Riecken and Alison Preece.

Dr. Joan Wharf Higgins is a faculty member in the department of at the University of Victoria and you may contact her if you have further questions by phone (250-721-8377) or email jwharfh@uvic.ca.

This research is being funded by an Act Now grant provided by the British Columbia Ministry of Advanced Education.

The purpose of this research project is to identify health issues that are important to young mothers and provide them with access to health related information in key areas such as nutrition, exercise, pre-natal and post-natal care, via an interactive website. This website will be targeted toward young women as they are completing their high school education.

This project will engage research participants in the design of web-based technology to address their identified health issues. Health education and communication strategies need to reflect the needs and preferences of the audience and are most effective when designed by members of that audience. We will want to evaluate the effectiveness of the web-based technology in promoting the health of teenage moms who might otherwise not have access to health education.

You are being asked to participate in this study because you are an expecting teenage mother or a mother with preschool child(ren) who is currently attending a high school education program and/or whose child is attending a community daycare centre.

If you agree to voluntarily participate in this research, your participation will include attendance at one two hour focus group meeting. We will also be making notes at our meeting to document the advice and preferences that you tell us about regarding website design and content.

Participation in this study may cause some inconvenience to you, including making personal travel and child care arrangements.

There are no known or anticipated risks to you by participating in this research.

The potential benefits of your participation in this research include experience in team based work and development of your communication skills. You will also gain valuable knowledge of pre and post-natal health issues. If approved by your teacher, you may also be able to use the experience to get credit for part of Planning 10 in your school.

As a way to compensate you for any inconvenience related to your participation, you will be given a $25.00 honorarium. This includes any costs for travel or child care. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be
a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data we will ask for your permission to use what we have gathered up until that point.

In terms of protecting your anonymity, you will not be identified as a participant in this study in any way. You will be asked to think of a pseudonym to which all your comments will be matched for the duration of the study. Only the researchers and research assistant will have access to the consent forms, the full list of participants and the assigned pseudonym. For accurate data collection, we would like to audio-tape the focus group discussions and will ask your permission to do this before the start of the focus group. Should you not want us to record the discussion, we will take notes instead. Transcripts of the focus group will not include any real names or other identifying information. No true names will appear in any written report. If there are audio tapes of the focus group, they will be erased following transcription. You will be given the opportunity to review transcripts and minutes, and change anything that you feel identifies yourself. If you take part in a focus group, complete anonymity cannot be guaranteed since others in the focus group will hear what you say. We ask everyone to not repeat what others say outside of the focus group: however you should know that other group members may know who you are and will hear what you say. Even though your name will not be used in any reports or discussions outside the focus group, please understand that within the group, you will not remain anonymous.

Your confidentiality and the confidentiality of the data will be protected by storing all the focus group information securely in a locked room with no identifying information. Following collection of the data, only the researchers will have access to the information which is to be stored in the researchers’ office at the University of Victoria. In final reports, the information collected will be grouped together and there will be no discussion or reporting of the findings about a single person. Data from this study will be disposed of five years following the completion of the project by shredding focus group transcripts/notes and deleting text/analysis files from computer hard drives, CDs and discs.

It is anticipated that the results of this study will be shared with others in the following ways: directly disseminated to participants, at presentations at scholarly meetings, in published articles, and/or chapters in books, in the media (e.g, newspaper, radio, TV) and on the internet.

Individuals that may be contacted regarding this study include:
Monica Cox, Project Coordinator, phone (250-598-7720), email mcrumrine@shaw.ca
Mimi Cimon, Research Assistant, phone (250-382-1620), email mimic@uvic.ca
Wing-Lam (Betty) Kwan, Technical Assistant, phone (250-732-3884), email laaaam@uvic.ca

In addition to being able to contact the researcher at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
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A copy of this consent will be left with you, and a copy will be taken by the researcher.
Appendix C – Case Study Informed Consent Form

Participant Consent Form

HOPE (Healthy Opportunities for Parents Expecting)

You are being invited to participate in a study entitled HOPE that is being conducted by Drs. Joan Wharf Higgins, Ted Riecken and Alison Preece. Dr. Joan Wharf Higgins is a faculty member in the department of at the University of Victoria and you may contact her if you have further questions by phone (250-721-8377) or email jwharfhi@uvic.ca. This research is being funded by an Act Now grant provided by the British Columbia Ministry of Advanced Education.

The purpose of this research project is to identify health issues that are important to young mothers and provide them with access to health related information in key areas such as nutrition, exercise, pre-natal and post-natal care, via an interactive website. This website will be targeted toward young women as they are completing their high school education.

This project will engage research participants in the design of web-based technology to address their identified health issues. Health education and communication strategies need to reflect the needs and preferences of the audience and are most effective when designed by members of that audience. We will want to evaluate the effectiveness of the web-based technology in promoting the health of teenage moms who might otherwise not have access to health education.

You are being asked to participate in this study because you are an expecting teenage mother or a mother with preschool child(ren) who is currently attending a high school education program and/or whose child is attending a community daycare centre.

If you agree to voluntarily participate in this research, your participation will include attendance at twice monthly focus group meetings from March 2007 until June 2007 (maximum 32 hours including travel time) at the University of Victoria, as well as keeping notes in a journal about your experiences searching for and using health education on the web (maximum 8 hours). We will also be making notes at our meetings to document the advice and preferences that you tell us about regarding website design and content.

Participation in this study may cause some inconvenience to you, including making personal travel and child care arrangements. There are no known or anticipated risks to you by participating in this research. The potential benefits of your participation in this research include experience in team based work and development of your communication skills. You will also gain valuable knowledge of pre and post-natal health issues. If approved by your teacher, you may also be able to use the experience to get credit for part of Planning 10 in your school.

As a way to compensate you for any inconvenience related to your participation, you will be given an honorarium of an hourly wage of $10 for the time commitment of up to 10 hours a month including any costs for travel or child care. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.
Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data we will ask for your permission to use what we have gathered up until that point. You will be paid for the time you have spent involved with the research project at the time of your withdrawal at $10/hour.

In terms of protecting your anonymity, you will not be identified as a participant in this study in any way. You will be asked to think of a pseudonym to which all your comments will be matched for the duration of the study. Only the researchers and research assistant will have access to the consent forms, the full list of participants and the assigned pseudonym. For accurate data collection, we would like to audio-tape the focus group discussions and will ask your permission to do this before the start of the focus group. Should you not want us to record the discussion, we will take notes instead. Transcripts of the focus group will not include any real names or other identifying information. No true names will appear in any written report. If there are audio tapes of the focus group, they will be erased following transcription. You will be given the opportunity to review transcripts and minutes, and change anything that you feel identifies yourself. If you take part in a focus group, complete anonymity cannot be guaranteed since others in the focus group will hear what you say. We ask everyone to not repeat what others say outside of the focus group; however you should know that other group members may know who you are and will hear what you say. Even though your name will not be used in any reports or discussions outside the focus group, please understand that within the group, you will not remain anonymous.

Your confidentiality and the confidentiality of the data will be protected by storing all the focus group information securely in a locked room with no identifying information. Following collection of the data, only the researchers will have access to the information which is to be stored in the researchers’ office at the University of Victoria. In final reports, the information collected will be grouped together and there will be no discussion or reporting of the findings about a single person. Data from this study will be disposed of five years following the completion of the project by shredding focus group transcripts/notes and deleting text/analysis files from computer hard drives, CDs and discs.

It is anticipated that the results of this study will be shared with others in the following ways: directly disseminated to participants, at presentations at scholarly meetings, in published articles, and/or chapters in books, in the media (e.g, newspaper, radio, TV) and on the internet.

Individuals that may be contacted regarding this study include:
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Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Signature</th>
<th>Date</th>
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A copy of this consent will be left with you, and a copy will be taken by the researcher.
Appendix D – Receipt of Honorarium Forms

Receipt of Focus Group Honorarium

My signature below indicates that I received $25 for participating in a focus group for a study entitled “HOPE – Healthy Opportunities for Parents Expecting” on February 22, 2007.

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Appendix E – Journal Prompts

Introduce Journal and Prompts: Please bring your journals (with your completed entries) to all consultation meetings. Everything you write and/or draw will be kept anonymous. Please write double spaced, don’t worry about grammar and write a minimum of one and a half pages per topic. Drawings and/or pictures are welcome.

March 12, 2007

7. What is the biggest, most surprising, or most important thing you have learned or changed about yourself, your health or your life since you’ve become pregnant or become a mother? What things matter now that may not have mattered to you before?

March 26, 2007

8. Find an image or a picture in a magazine or on a website that reflects your idea of a healthy family lifestyle. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of a healthy lifestyle. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.

April 2, 2007

9. Find an image or a picture in a magazine or on a website that reflects your idea of a healthy mother and child relationship. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of this relationship. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.
April 16th, 2007 - Following 4 journal entries presented with disposable cameras

10. Find images in magazines and/or on the internet that you think send unhealthy and/or confusing messages to children and/or youth. Cut them out and write a journal entry explaining what you think the image is saying and why you think the message is unhealthy or harmful. (This was originally a journal prompt but I decided to pose this question in a focus group instead. I provided magazines.)

11. Photograph people and things in your life that represent healthy living to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you. Make sure to state which parts of healthy living your pictures show.

12. Photograph people and things in your life that represent healthy relationships to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you.
Appendix F – Focus Group Questions

10. Tell us about a typical day for you and your child(ren): what happens when you get up until you go to bed? (e.g., probe for when and what is eaten, play time/leisure activities, who cares for the children when the mother is in school/work, sleep patterns, media use)

11. Compared to others your age that you know, how would you rate your health – excellent, good, fair or poor? Can you tell us why you gave yourself that rating – that is, what about your life led to a rating of ‘good’?

12. Compared to others your child’s age that you know, how would you rate their health – excellent, good, fair or poor? Can you tell us why you gave your child that rating – that is, what about his/her life led to a rating of ‘good’?

13. What does your child’s health mean to you?

14. Do you think about your health or the health of your child(ren) a lot? What kinds of issues concern you or are you interested in finding information for? When would you look for information about health – only when you or your child is sick or to help prevent illnesses or promote health?

15. How do you find answers to your health related questions? What sources of information did you use (e.g., friends, doctor, magazines, the internet)? How do you know if the information you are finding is accurate and trustworthy?

16. What was your first thought or biggest concern when you first found out you were pregnant and how did you go about figuring out what to do about your concern. If and how have your concerns changed since you’ve had your child, or since you found out you are pregnant? What things do you think about now that you didn’t think about before you had your child, and/or before you became pregnant?
Appendix G – Individual Interview Questions

9. Tell me the story of your life so far. Where and with whom did/do you live? (location, socio-economic status, neighborhood, community)

10. What were your home life and upbringing like? (Extra-curricular, substance use, number of parents at home)

11. How were your relationships with family and friends?

12. How did you do at school, what kind of student were you?

13. What circumstances and events led you to become pregnant?

14. Tell the story of the rest of your life. If you could do anything you wanted to do, anything at all, what would it be? Do you think this life is one you could make happen for yourself in actuality, why or why not? What would you have to do to get to where you want to go and what would be your biggest obstacle to overcome in getting there?
Appendix H – Team Meeting Agendas and Notes

Consulting Team Meeting 1 - March 12, 2007

1. **Business:** Consent forms signed, honorarium forms signed, meetings scheduled and confirmed. Expectations outlined.

2. **Ice Breakers and Introductions:** Participants pair up with someone they don’t know and choose pseudonyms. After asking each other why they chose their pseudonym, and to describe one thing about themselves that others might not be able to tell about them by looking, participants introduce their partners.

3. **Confirmation of Themes and Issues:** Eating and Nutrition; Exercise; Substance Use (cigarettes, alcohol and drugs, children mimicking their parents’ behaviours); Sleep; Relationships (parenting, home environments, communication of feelings); Stress

   - Ask participants if our research team accurately understood issues raised at initial focus group meetings.
   - Ask is there is anything further they would like to add, elaborate on, or omit from themes identified. Establish consensus on these topics.

4. **Pregnancy Stories:** Respond one at a time first, then free flow conversation.

   - What was your first thought or biggest concern when you first found out you were pregnant and how did you go about figuring out what to do about your concern. If and how have your concerns changed since you’ve had your child, or since you found out you are pregnant? What things do you think about now that you didn’t think about before you had your child, and/or before you became pregnant?

5. **HOPE Logo Favorites Reviewed and Chosen:** Choices may change

6. **Introduce Journal and First Prompt:** Please bring your journals (with your completed entries) to all consultation meetings. Everything you write and/or draw will be kept anonymous. Please write double spaced, don’t worry about grammar and write a minimum of one and a half pages per topic. Drawings and/or pictures are welcome.

   - What is the biggest, most surprising, or most important thing you have learned or changed about yourself, your health or your life since you’ve become pregnant or become a mother? What things matter now that may not have mattered to you before?
Notes for March 12, 2007

**To Do/Get for Next Meeting**

- Parking passes needed for participants
- Disposable cameras
- SIN numbers still needed for some participants
- Emails seem wrong, clarify.

**Introductions**

**Bambi:** Has a bachelors of science. Has a 10 month old boy

**Jemma:** Likes horses. Is pregnant. Has only gained 25 pounds, due July 9th

**Elle:** Has a 5 month old daughter

**Emily:** Is 100 percent Native. People often think she’s Chinese.

**Mandy:** When she has to lie about her name, she chooses Mandy and has five sisters.

**Cree-Wind:** Her cousin’s name is Cree-Wind and she likes it. She is secretly engaged to be married.

**Confirmation of Themes and Concerns Identified at Initial Focus Groups**

**Health Themes**

<table>
<thead>
<tr>
<th>Initial Focus Group Themes</th>
<th>Themes Added at Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating, nutrition and fast food</td>
<td>Breast feeding</td>
</tr>
<tr>
<td>Exercise, sleep and stress</td>
<td>Alternative medicines and information (homeopathic)</td>
</tr>
<tr>
<td>Smoking, drinking and drug use (partying)</td>
<td></td>
</tr>
<tr>
<td>Relationships (baby and mom, mom and partner, others)</td>
<td></td>
</tr>
<tr>
<td>Happiness, positive atmosphere in the home</td>
<td></td>
</tr>
<tr>
<td>Role modeling healthy habits (relationships, eating and smoking) for children</td>
<td></td>
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<tr>
<td>Keeping a clean, germ free home</td>
<td></td>
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</tbody>
</table>
### Sources of Health Information

<table>
<thead>
<tr>
<th>Initial Focus Group Themes</th>
<th>Themes Added at Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elders, friends and parents</td>
<td>Doctors, nurses and specialists (hip doctor)</td>
</tr>
<tr>
<td>Internet</td>
<td>Naturopath</td>
</tr>
<tr>
<td>Nurse Health Line</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>BC Health Guide</td>
<td>Pharmacist</td>
</tr>
<tr>
<td>Books and Magazines</td>
<td>Classes: Baby massage</td>
</tr>
<tr>
<td>Television: Nanny 911 and A Baby Story</td>
<td>AIDP (Aboriginal Infant Development Program)</td>
</tr>
</tbody>
</table>

### Types of Information Sought

<table>
<thead>
<tr>
<th>Initial Focus Group Themes</th>
<th>Themes Added at Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting advice</td>
<td>Culturally (multi-cultural) specific traditions on pregnancy, motherhood and parenting</td>
</tr>
<tr>
<td>Breast feeding</td>
<td>Pre-natal exercise and nutrition</td>
</tr>
<tr>
<td>Tanning</td>
<td>Sexual health and healthy sexuality: as mom, partner and individual. How to balance roles.</td>
</tr>
<tr>
<td>Nutrition: preparation of foods that appeal to babies, how to introduce new foods, foods to avoid</td>
<td>Myths, Wives Tales and Facts: This could be approached from the stand point of entertainment, like interesting stories and tales. However the girls stated that they would like a facts separated from fiction approach…Both could be honoured.</td>
</tr>
<tr>
<td>Medication and vitamins: side-effects, benefits</td>
<td></td>
</tr>
<tr>
<td>First nations teachings and traditions on pregnancy and motherhood</td>
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</table>
Consulting Team Meeting 2 - March 26, 2007

**Business** (30 minutes)

- Introductions and Pseudonyms for new participants
- Consent and cheque requisition forms for new participants
- SIN numbers still needed for some participants
- Email clarification (ask Monica and participants)
- Journal collection
- Parking passes needed for participants
- Attention to time

**Participant Feedback on Betty’s Website Prototypes** (20 minutes)

- Participants look at each site collectively (?) and comment on favorites via a comment sheet (Betty will provide this)

**Introduce Search Activity** (5 minutes)

**Search** (25 minutes) Based on a scenario

- Participants work in pairs and search for information on a topic/scenario
- Researchers observe and take notes (amount of time it takes to find info and complete the task). Offer assistance if requested.
- Participants record search terms and ‘search journey’ on sheet provided
- Participants choose 2 sites, an excellent one and a poor one noting which features they liked and didn’t like. On sites liked, record info on what parts of the site they explored and took information from.

**Report Findings** (28 minutes – 7 minutes per pair, 4 pairs, 8 women in total)

- Report to rest of group about the process and the sites chosen and why – refer to sheet.
- Researchers ask questions here in case people are stuck about how to report?
- Ask if participants are satisfied with the information they got, or if more is needed?

**Wrap up and Journal Topic for Next Meeting** (10 minutes)

Find an image or a picture in a magazine or on a website that reflects your idea of a healthy family lifestyle. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of a healthy lifestyle. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.

At our next meeting we will look at these pictures and talk about them as a group.

Notes from March 26, 2007
To Do/Get for Next Meeting

- Disposable cameras (for next time April 2)
- SIN numbers still needed for some participants
- Email clarification (ask Monica)
- Journal collection
- Parking passes needed for participants
- Attention to time

Review information collected at last meeting

View and discuss pictures from journals

Have participants use disposable cameras to photograph things around them that influence their health, clarification needed here. Journal again based on pictures…

Journal Themes

Desire to improve education and health habits (stop using drugs, drinking, smoking)

Ask why education important? What does an education do for one’s health?

Taking responsibility for health and lifestyle

Is one’s lifestyle decided solely by individual? Explain why or why not.

Tendency to not care for self and/or health when childless.

Willingness to engage in risky behaviour before child in the picture.

Attention to quality of relationships increased when baby comes, as recognition that the individual and relationship with another affects the child’s well being too. (Father figure)

Greater understanding/empathy and patient toward self and others.

Awareness that parent’s behaviour influences child’s behaviour.

So from the picture chosen tell us what factors create and/or support a healthy lifestyle. What things are in your control and what things are not? What are the essential elements for health? Converse.
Consulting Team Meeting 3 - April 2, 2007

Business (10 minutes)

- Journal collection
- Parking passes needed for participants
- Attention to time

Participant feedback and verification of information collected during last meeting’s web search (30 minutes) use white board or other board

- Add anything we missed in areas of Why they stayed on a site, why they did not stay on a site, satisfaction with the information, and accuracy of information

Review generally themes from first journal entry and ask series of questions to probe further into answers (connection between health, control, lifestyle, living conditions and education)…record responses digitally

Journal prompt from March 12: What is the biggest, most surprising, or most important thing you have learned or changed about yourself, your health or your life since you’ve become pregnant or become a mother? What things matter now that may not have mattered to you before?

Journal themes (bulleted) and questions (in bold)

- Desire to become more educated

Why is becoming more educated important to you and your child?

What does an education allow a person to do in terms of improving their health?

- Desire to take control of and responsibility for health (stop smoking, drinking or drugs) and lifestyle (education, employment, income and future prospects).

What conditions and things go into creating a healthy lifestyle?

What conditions and/or things do you need or want to fulfill your idea of a healthy lifestyle that seem to conflict with the realities or practicalities of your current situation?

What parts of your lifestyle are created and/or controlled solely by you?

What parts of your lifestyle are not in your direct or immediate control?

How do you deal with or resolve the differences between what you need or want and the realities of your life?
• Before having a child, tendency to not care for self and/or health as well as one does during pregnancy and after the baby is born. Having a child brought personal health into awareness. (Willingness to engage in risky behaviour before child in the picture).

• Attention to quality of relationships increased when baby expected or present, as recognition that relationships with others effects a child’s well being. (Father figures)

Why do you think your health and the quality of your relationships mattered to you less when you not a mother, or expecting?

What specific aspects of your relationships (or types of behaviour) became unacceptable to you and had to change when you became a mother or found out you were pregnant?

• Development of understanding, empathy and patience toward self and others.

• Awareness that parent’s behaviour influences child’s behaviour.

Betty ask about changes to website (ask about First Nations symbol). Some statement about copyright and desire to create a look for the site that represents us all…

Wrap up and journal topic for next meeting (10 minutes)

Ask girls to date their journal entries
Tell them they can draw or include photos if they want

Find an image or a picture in a magazine or on a website that reflects your idea of a healthy mother and child relationship. Cut it out and bring it to the next meeting along with a journal entry explaining how and why the people and things in the picture represent your idea of this relationship. If you can’t find one picture that satisfies your vision of a healthy life, make a collage using parts of a few different pictures and paste it in your journal.

At future meetings we will:

• Review themes identified in previous journal entries and discuss them.

• As a group, look at and talk about the significance of the pictures and images brought in by participants. Later we will do something with them like create two collages, one representing an ideal family life, and another representing our real lives…We will identify what factors are essential for optimal health?
Consulting Team Meeting 4 - April 16, 2007

**Business** (10 minutes)

- Journal collection (email any absent girls with journal entries they need to complete – Emily away at court!)
- Email girls to remind them to bring journal entries

**Preview Website** (50 minutes to an hour)
Using laptop and projector, Betty shows participants website prototype. Monica, Mimi and Joan ask question and take notes on the following…

- Joan’s opening blurb for website
- Headings and sub-headings (Language and Font)
- Types of information
- Presentation of info (short and sweet, or more in-depth?)
- The look and format (colour, images) Ask about First Nations symbol?
- Additional ideas for content: (Printable stuff to put on fridge – affirmations?; Top Ten Lists -quick and dirty facts…

**Remaining 4 journal entries and cameras** (20 minutes)

Hand out disposable cameras and instructions for remaining journals. Remind one and a half pages minimum, drawing and collage O.K., dates and pseudonyms on entries. Generally, 2 of your journal entries will involved photographing and writing about the people and things in their life that support theirs and their child’s health. Specific aspects of health will be addressed.

Have participants take pictures of (specify number of pictures according how many on the camera divided by 2 prompts that address themes on website)

**Journal Prompt #4 (Due April 30th):** Find images in magazines and/or on the internet that you think send unhealthy and/or confusing messages to children and/or youth. Cut them out and write a journal entry explaining what you think the image is saying and why you think the message is unhealthy or harmful.

**Journal Prompt #5 (Due May 14th):** Photograph people and things in your life that represent healthy relationships to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you.
Journal Prompt#6 (Due May 28th): Photograph people and things in your life that represent healthy living to you. Write a journal entry to accompany the pictures explaining how and why the pictures mean this to you. Make sure to state which parts of healthy living your pictures show.

Last journal Prompt #7: Write a description about yourself and/or summary of your life story in relation to your health and growth as a person. For our uses in the literature, not on the website. (this one will not be assigned until May 28th).

At a future meetings we will:

- Review themes identified in previous journal entries and discuss them and tie them together in reference to website. Have an unveiling party.

- As a group, look at and talk about the significance of the pictures and images brought in by participants. Later we will do something with them like create two collages, one representing an ideal family life, and another representing our real lives…We will identify what factors are essential for optimal health?
Consulting Team Meeting 5 - April 30, 2007

**Business** (10 minutes)

- Collect Journal #4 and cameras (collect missing prior entries, in any)
- Cameras for Joan for processing – make sure names of participants on cameras.

**HOP Activity with Monica in the gym** (30 minutes) Joan book gym?

**Review Themes from Journal 2** (30 minutes) Ask Questions and for clarification? **If time.**

**Preview Changes to Website** (50 minutes to an hour)
Using laptop and projector, Betty shows participants website changes. Monica, Mimi and Joan ask question and take notes on the following…

- New Headings and sub-headings (Language, Font, Organization)
- Other “Special” categories? (Learning disabilities, Illnesses, …)
- The look and format (colour, images)
- Ask about First Nations symbol?
- Joan’s opening blurb for website
- New Name other than HOPE?
- Ask about BIO idea. If they like it, tell girls to think about what they might want to put in their bio as we will write these together next time. One piece of advice for other moms?

**For next meeting:**

- Copy and code journal 4, and compose list of questions to ask based on responses and themes. Review themes identified in previous journal entries and prepare to review and discuss them and tie them together in reference to website.
- Book computer room for May 14th meeting
- Ask participants what kind of food activity they would like information about or recipe they would like to see prepared? Mimi makes sushi? Get a speaker to come and talk about another topic from the headings, like communication techniques, or Sue Foot second step?
- Betty compile list of websites for participants to use for search activity at next meeting, maybe they could rate them, top three?
Consulting Team Meeting 6 - May 14, 2007

**Business** (10 minutes)

- Give photos from cameras, tell
- Collect any past cameras?/journals, remind journals #5 and #6 due May 28th (collect missing prior entries)

**Sue Foote “Second Step”** (1 hour) Introduce Sue and how I met her at SJD Out-Of School Club. She has been a school counselor for 30 years and worked with children K-12. Second step is a method we used on a daily basis at the centre, and I believe teachers used it to, to help kids develop and vocabulary for expressing their feelings and recognizing other people’s feelings (empathy training) and an effective means of problem solving…

**Search and Website Activity** (60 minutes) in computer room with list of sites provided. Ask girls to raise hands and let us know when they’ve come across something on the sites they like. (Joan and Mimi take notes)

http://www.angelfire.com/ny4/justforteenmoms/ (personal stories)

www.teenwire.com

www.teenmoms.ourfamily.com (religious –emotional content; personal stories)

- Ask them how these sites differ from the ones we asked them to visit before and whether they would be likely to visit them.
- Which sites are you most drawn to and why?
- Do you see yourself in the personal stories?
- Additional ideas for content: (Printable stuff to put on fridge – affirmations? Top Ten Lists -quick and dirty facts…
- Add these sites as links on ours (message boards, inspirational stories, resources).

**Participants BIO** (20 minutes) on computers, compose bios of themselves and one piece of advice/inspiration for other moms in their positions. Print and collect.

How would they characterize what its like to be in there positions as teen moms. So that young women who visit our site know it’s for people like them.

(Aggregate story?)
Consulting Team Meeting 7 - May 28, 2007

Business (10 minutes)

- Collect journals #5 and #6, and photos (email any absent girls with journal entries they need to complete and collect missing prior entries, in any)
- Arrange meetings to make up for meetings/journals missed? Maybe two different focus groups as the girls seem more open when among the girls they know (one GAP girl meeting and another Friendship Centre one?)

HOP Activity (40 minutes in the gym)

Search and Website Activity (60 minutes) in computer room with list of sites provided. Ask girls to raise hands and let us know when they’ve come across something on the sites they like. (Joan, Monica, Betty and Mimi take notes)

http://www.angelfire.com/ny4/justforteenmoms/ (personal stories)

www.teenwire.com

www.teenmoms.ourfamily.com (religious – emotional content; personal stories) ASK…

- How are these sites different from the ones we asked them to visit before? Would they be likely to visit these new sites, why for what purpose?

- Which sites are you most drawn to and why?

- Do you see yourself in the personal stories? What do these stories do for visitors, how do you feel when you read these? How would they characterize what it’s like to be in there positions as teen moms. So that young women who visit our site know it’s for people like them. Should we have this sort of thing on our site/

- Additional ideas for content: (Printable stuff to put on fridge – affirmations? Top Ten Lists – quick and dirty facts…

- Add these sites as links on ours? (message boards, inspirational stories, resources).

Participants BIOS (20 minutes) on computers, compose bios of themselves and one piece of advice/inspiration for other moms in their positions. Print and collect – assign for next time? Or better yet tell these stories? Make an “Aggregate story?”

For Final Meeting

- Review Themes from Journal #4, 5 and 6 (40 minutes) and/or Conduct a Critical media Literacy activity…Consult Deborah and Call Jim Pine?
• Copy and code journals 5 and 6 for review at meeting. Compose questions to ask where needed.

• Remind participants to hand in any missing journals and pictures

• Create an anonymous response sheet for website evaluation.

• Fill in gaps in journal (literacy) questions.

• Tell us about your life before you had your child. Did you use substances, how were your relationships with parents, friends and school? What circumstances led you to become pregnant so early in life?

SITES

http://www.angelfire.com/ny4/justforteenmoms/ (personal stories)

www.teenwire.com

www.teenmoms.ourfamily.com
Consulting Team Meeting 8 - June 11, 2007

**Business** (10 minutes)

- collection journals #5 and #6, (email any absent girls with journal entries they need to complete and collect missing prior entries, in any)
- Re-print Elle’s pictures
- Arrange meeting with Joan and Monica about contents of individual interviews (Fill in gaps in journal (literacy) questions.

**Participants BIOS** (30 minutes)

- For those who have not written stories, compose them on the computers.
- Have participants tell their stories aloud (record) and collect them.
- Discuss revisions if necessary?
- Make an “Aggregate story?”
- Ask; what are these stories really about? “The story is never about the story”. Talk about the value of these stories and ask what they think other girls get from reading them?

Tell the story of the rest of your life. If you could do anything you wanted to do, anything at all, what would it be? Do you think this life is one you could make happen for yourself in actuality, why or why not? What would you have to do to get to where you want to go and what would be your biggest obstacle to overcome in getting there?

**Thank Participants - Preview HOPE Website** (50 minutes to an hour)

Using laptop and projector, Betty shows participants website prototype. Monica, Mimi and Joan ask question and take notes on the following…Ask how meetings could have been improved?

**Over the summer**

- Arrange a de-briefing meeting to review project and reflect. (what to do if participants do not hand in journals and pictures, and/or come to interviews.

- Copy, Organize and Code Data

- Collect info for site

- Create an anonymous response sheet for website evaluation for final meeting Monica? With scale from 0 – 5.

- Discuss how things will proceed in the Fall…
Appendix I – HOPE Documents and Data Inventory - July 2007

Initial Focus Groups

Questions Addressed: Daily routines, health status and concerns and info sources, media habits and its role in health.

Documents: Initial Focus Group Questions (9)

<table>
<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
<th>Data Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAP - February 26, 2007 4 Researchers Approx 7 Participants</td>
<td>Voice Recording Joan’s Field Notes Betty’s Field Notes</td>
</tr>
<tr>
<td>Friendship - Centre February 27, 2007 3 Researchers (Joan absent) Approx 3 Participants</td>
<td>Voice Recording Betty’s Field Notes</td>
</tr>
<tr>
<td>SAEC - March 5, 2007 4 Researchers 3 Observers Approx 7 Participants</td>
<td>Voice Recording Transcription of Digital Recording Betty’s Field Notes Mimi’s Field Notes</td>
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</tbody>
</table>

Meeting 1

Questions Addressed: What was your first thought or biggest concern when you first found out you were pregnant and how did you go about figuring out what to do about your concern?

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<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
<th>Data Types</th>
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<tbody>
<tr>
<td>UVIC - March 12, 2007 3 Researchers (Monica absent) 6 Participants</td>
<td>Voice Recording Summary of Themes from Initial FGS Mimi’s Meeting Notes Transcription of Pregnancy Stories (6) Journal #1 Assigned (6 received)</td>
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</table>

Meeting 2


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<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
<th>Data Types</th>
</tr>
</thead>
<tbody>
<tr>
<td>UVIC - March 26, 2007 3 Researchers (?)</td>
<td>Recording of Participants’ Summaries of Search Activity (5)</td>
</tr>
</tbody>
</table>
5 Participants
Search Activity Questionnaires (5)
Mimi’s Field Notes
Monica’s Summary of Internet Activity
Monica’s Revision of Internet Summary
Monica’s Field Notes on Internet Activity
Computer History Print-off
Betty’s Summary of HOPE Site Preferences
& HOPE Site Prototypes
Journal #2 Assigned (4 received)

**Meeting 3**

*Questions Addressed:* Themes from Journal #1 reviewed and discussed (education, healthy lifestyles, and degree of control over health factors, finances, relationships, and substance use).

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<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
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<tbody>
<tr>
<td>UVIC - April 2, 2007</td>
<td>Voice Recording</td>
</tr>
<tr>
<td>4 Researchers</td>
<td>Joan’s Field Notes</td>
</tr>
<tr>
<td>5 Participants</td>
<td>Mimi’s summary of Journal #1 themes</td>
</tr>
<tr>
<td></td>
<td>Journal #3 Assigned (3 received)</td>
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**Meeting 4**

*Questions Addressed:* Preview HOPE site. Participant feedback on headings, sub-headings, types of information, format, color, images, First Nations symbol.

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<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
<th>Data Types</th>
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</thead>
<tbody>
<tr>
<td>UVIC - April 16, 2007</td>
<td>No Digital Recording here</td>
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<tr>
<td>4 Participants</td>
<td>Mimi’s Notes on Website Layout Sheet</td>
</tr>
<tr>
<td>4 Researchers</td>
<td>Journal #4 Assigned (1 received)</td>
</tr>
<tr>
<td></td>
<td>Joan’s Field Notes</td>
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<tr>
<td></td>
<td>Monica’s Field Notes</td>
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</tbody>
</table>

**Meeting 5**

*Questions Addressed:* Viewed revised HOPE site based on participant recommendations. Further feedback on headings, sub-headings, types of information, format, color, and images. Responses and feedback on HOPE Introduction.

Reviewed Journal #2 themes (healthy family lifestyles, togetherness, happiness, finances, home, environment, communication). Viewed images from magazines in reference to Journal #4 and related to “healthy living” category; relationships, eating, body image, activity, and parenting.
Meeting 6

Questions Addressed: Sue Foote’s visit and discussion of parenting styles; giving orders, giving in and giving choices. Parenting skills and how participants’ were raised.

Locations, Dates & Attendees

UVIC - May 14, 2007
2 Participants
2 Researchers (Monica and Betty absent?)

Meeting 7

Questions Addressed: Viewed and discussed different types of sites designed specifically for teen moms. Particularly stories of their lives, photos and preferences.

Locations, Dates & Attendees

UVIC - May 28, 2007
2 Participants
3 Researchers? (Monica absent?)

Meeting 8

Questions Addressed: Tell the story of your life so far. Tell the story of the rest of your life.

Locations, Dates & Attendees

UVIC - June 11, 2007
1 Participant
4 Researchers

Individual Interviews, Emails and Team Reflections

Locations, Dates & Attendees

GAP - June 18, 2007
2 Recorded Interviews
Various dates

| 2 Media Questionnaires                  |
| Story of Life and Future (2)           |
| Emails                                 |

**Other Documents and Forms**

<table>
<thead>
<tr>
<th>Locations, Dates &amp; Attendees</th>
<th>Document Types</th>
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<tbody>
<tr>
<td>Participant Attendance &amp; Info</td>
<td></td>
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Anyone “Pissed-Off” at the “Inequities” at the Conference, lets meet to discuss action and mobilization. Meet at the Ontario Health Promotion Booth in Hall B (Exhibition Area) at 5:30pm today.

Some examples are inaccessible conference events, lack of diversity in speakers, “privileged” attendees have free access to all events/allotted space/time to network/socialize, etc., lack of participation of communities we work in, workshops dealing with race/diversity/culture have no speakers, race not promoted as a social determinant of health, etc…etc…

Email me at taarac@gmail.com if you can’t make it to support an action before the conference is over.