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Parental Education as Health Protection Factor in Vulnerable Childhood and Adolescence

M^a Cruz MOLINA¹, Crescencia PASTOR², Verónica VIOLANT³

Abstract

Family education is considered a protection factor with regards to the healthy development of children, especially in social risk situations. In this paper we present the results related to the family's role in the healthy development of their children, from two works that stress on two moments of special difficulty for families, as the birth of a child and the adolescence. They are part of the strategic lines on sexual and reproductive health of the Autonomous Government of Catalonia (Spain), and of the Spanish State. Such works try to explore the families' guidance needs to outline a program on parenthood education and, to analyse the needs of teenagers in vulnerable situation in relation to sexual and reproductive health to develop a strategic action plan. A research-action methodology was applied with focal groups with 56 professionals and 13 families in the first work, and 48 professionals and community workers with 72 teenagers in the second group. The results show that the families feel insecurity and anxiety before the birth of a child, especially, in relation to how to look after him/her or for family pressure. The teenagers demand a better communication with their parents in sexual health issues; and the professionals suggest the development of family guidance programs, especially in risk situations.

Keywords: Sexual and reproductive health; health protection factor; healthy development; health education; parental education; vulnerable childhood and adolescence.

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Parental education in healthy development of infants and adolescents

Research has shown that the family has an important role in children's health and that it represents an important social support group. Parental skills have an influence on children's emotional state, social relationships and academic achievement. Social changes require an active role of the family to promote healthy and responsible values, attitudes and behaviour. However, families do not always receive any specific training to improve their skills and resources.

The development of parental skills is seen as a protector factor with regards to the healthy development of children, especially in social risk situations. Maíquez, Rodríguez and Rodrigo (2004) highlight the family's active role to promote values, attitudes and healthy responsible behaviour, how they educate and their ability to face adverse situations. Their own way of life represents a behaviour pattern that has an influence on the children's and adolescents' adoption of habits and values, and it becomes a protector factor when facing vulnerability. According to Bellver (2006) the family's function is emotional, social and educative, and he highlights as significant factors in the intra-family relationships: a) the degree of control over their children's behaviour; b) the communication between parents and children; c) the requirements of maturity d) a relationship of affection. However, families do not always feel capable or do not receive the specific training to improve their skills and resources.

The family, from the moment of their child's birth, and even before, has to face difficult situations in critical periods of mother and fatherhood, for which they are not always prepared. The emotional links and the intra-family relationships are often damaged when the families are in social risk situations, the family can feel unprotected and insecure if they do not have social support available. At the time of birth, for example, in premature situations, with children of low birth weight or when the parents have difficulties in looking after their children, they require educative programs to develop their parental skills. For example, the SORT – System of Risk Triage proposed by Laadt, Woodward & Papile (2007) to attend the premature child, identifies risk factors through a triage that takes into account not only the medical side but also the psychosocial risk factors.

High risk factors in the family are those related to a low level of education, having multiple maternal responsibilities, difficulty in the learning of basic care routines, an ambivalent perception of pregnancy and drug abuse. There is a further risk (higher risk) of having a background of regular violence and a life organized around drug abuse. Smith (2010) suggests ideas to improve parenting of newborn babies and in infancy from programs based on a practical application of skills, as they are more effective than the theoretical programs or those based only on advice. Nowadays, a way to consider parental skills in neonatology are through the patterns of "care centred on development (CCD) and on the family" and,

especially, from the “Neonatal Individualized Developmental Care and Assistance Program” system, suggested by Als (1986) and de Vonderweid and Leonessa (2009). A system implemented in several hospitals in Argentine, Spain, The United States of America, France, Holland, England and Sweden.

The family support programs during the transition to parenthood have acquired great relevance in Spain in recent years (Menéndez, Sánchez, López and Hidalgo, 2004; Hidalgo and Menéndez, 2009; Amorós, Martínez, Miralpeix, Molina and Privat, 2010), as an answer to the families’ needs to face parenthood with satisfaction and confidence. Given the importance of the first years of life in later development, the necessity of supporting families during this critical period has gained strength. For Kotliarenco, Gómez, Muñoz, and Aracena (2010), this challenge is even more significant in the most vulnerable population sectors. Furthermore, Haragus (2010) shows in his work some negative repercussions in later years as a consequence of the family vulnerability, as for example, an early maternity.

Although it is necessary to propose family education as a process that must be started at early infancy, better even from birth, it is essentially relevant to develop parental education in the families of adolescents. This is an especially vulnerable phase, where risk behaviour for health is most often observed, above all related to sexual and reproductive health. The latter has gained special importance, at an international level with the increase of adolescent maternity and paternity. Rodríguez, Rodrigo, Correa, Martín and Maíquez (2004) observed a higher level of self-sufficiency, internal locus, co-parenthood and a higher use of inductive practices in the families of social risk, who had participated in a personal and family support program in comparison with the control group.

In Catalonia-Spain, the pregnancy rate in teenagers has shown an important growth during the last decade. In the youngest group, from 14 to 17 year olds, the pregnancy rate has gone up from 4.9 per thousand in 1996 to 11,7 per thousand in 2008 (Maternal-infancy Health Registry, DGSP and IVE Registry, State Public Health Department). Likewise, in the group from 15 to 19 year olds it has risen from 17.5 per thousand in 2000 to a 29.2 per thousand in 2008. This increase in pregnancies, general all over Spain, has resulted in both a higher birth rate and an increase in voluntary termination of pregnancies.

Recent works confirm the relationship between adolescent pregnancy and social type determining factors as, for example, the links with the school and the low expectations of future employment (Fletcher, 2008). Swan et al. (2003) state that there is a higher pregnancy risk in certain situations like being homeless, of academic failure, being the daughter of an adolescent mother, belonging to an ethnic minority or being involved in serious criminal situations. Other works related it to genre violence (Manseau, 2007 and O’Keefe, 2005). Several qualitative studies provide data about the factors that teenagers relate to adolescent

pregnancy: little motivation and interest in school, an unhappy childhood, poor home conditions, as well as low future expectations and aspirations (Harden, 2009). In girls, good academic achievement, positive plans for the future, and strong links with the family, the school and the religious community are highlighted as factors that reduce the adolescent maternity rate (Kirby, 2007).

When looking at other scientific research we find different authors that point out as protector factors in the risks of sexual behaviour and adolescent pregnancy family relationships based on the communication of values, in the expectations and concern in an affective atmosphere and the close relationship between parents and children. (Cleveland, 2003; Kirby, 2007; Marston, 2006; Miller, 1988; Stanton et al., 2003 and Swan, 2003). A good relationship and communication with their children helps to reduce anti-social behaviour and health risk, (Bellver, 2007). Through communication the family establishes rules and limits among its members. The communication about sexual aspects also has certain influences on their sexual relationships. Research work carried out in England with teenagers from 10 to 15 years old (The Kaiser Foundation 1999) shows that more than half of them say that if they have doubts of a sexual nature they would speak first to their father or mother. In the teenagers from 15 to 17 interviewed, of which 56% had already had a sexual relationship, more than half admitted that they have never spoken to their parents about when a teenager is ready to start having sex (The Kaiser Family Foundation, 2002). According to Welling et al. (2001), speaking to parents about sexual issues is an important protector factor in connection with pregnancy, as it is associated with the use of some type of contraception in first sexual intercourse. However, the family's perception about the communication related to sexuality does not always coincide with the findings of the research. Some families do not speak about the use of contraception, because they are afraid of raising the interest in sexual intercourse. Kirby (2007), however, shows that speaking about abstinence and contraceptive methods does not bring forward the start of sexual activity, not the frequency of the relationships or the number of partners. On the contrary, some show the opposite tendency, as the expression of negative opinions about the use of contraceptive methods.

Another determining factor is the control the family has over their children's lives. Vézina (2007) and Miller (1998) point out that the teenagers that are supervised by their parents tend to start their sexual experiences later and present a lower pregnancy risk.

On the contrary, and according to recent information, there are pregnancy risk factors related to the family such as problems in family relationships, the family structure and the parents' difficulty in communication (Allen, 2007; Bearing, 2007; Cleveland, 2003; Kirby, 2007; Marston, 2006; Miller, 1988; Minister for Children, 2006 and Swan, 2003). At the same time, Vézina (2007) and Miller (1998) point out that an extremely strict vigilance is also related to a higher pregnancy risk in adolescents.

We can summarize that, in general, the quality of relationship and the communication in the family nucleus is a protective factor in adolescent pregnancy. According to Blum (2002) parents should speak in a clear and sincere way to their children about sex, love and relationships for the benefit of their sexual and reproductive health.

Methods

The works presented⁴ are in the sexual and reproductive health strategic lines, both on a national (Health and Social Policies Department, 2010) and autonomous level (Autonomous Government of Catalonia, 2010), and emerge from the demand of a Maternal-child Health Program, from the Health Department of the Catalan-Spanish Governments, with the support of the Catalan Midwives Association, Barcelona University and the Health and Social Services Department, to respond to the current families' support needs and to health promotion issues. In this work the research team (GRISIJ)⁵ Socio-educative Intervention in Infancy and Youth Team, is formed by researchers from Barcelona University and Lleida University, as well as health, education, social services and community workers. These projects follow a common pattern based on the combination of scientific evidence and the needs analysis observed by the experts involved (intervention experts and the people to whom the program is addressed).

The research method applied was the action participative research in the cooperative modality with the involvement of all the participants. In the first case, the professionals (midwives) and the mothers; and, in the second case, the professionals and the adolescents. The research was developed in five phases: 1) Review of scientific literature; 2) Preparation of the tools for the gathering of data and negotiation with the institutions participating to have access to the subjects of study; 3) Analysis of the needs through discussion groups; 4) Analysis of data; 5) Report on results and conclusions. This participative process allowed us to define the action proposals to improve the health of the teenagers involved influencing on the families and, in this way, to change the intervention methods.

The following objectives were established: 1) To identify the families' guidance needs to be able to prepare a parental program; 2) To analyse the sexual and reproductive needs of teenagers in situations of risk in order to outline a strategic action plan.

⁴ "The Birth Preparation Program: maternal education" and the "Pregnancy and sexual infections transmission strategic action plan for teenagers in social risk situations", both by the demand of the Health Department of the Autonomous Government of Catalonia.

⁵ The GRISIJ team is a consolidated research group on socio-educative action in childhood and young (2005-2008; 2008-2011)

Participants

In the analysis of the families' guidance needs in facing the birth of a child, 56 professionals from 39 health centres from different Catalan provinces and 13 families have taken part. Among the professionals, the midwives, the average age was 43.71 years old with an average professional experience in maternal education of 16.68 years (minimum 10 months – maximum 30 years). In the families, the mothers' average age was 33.15 years old, (the youngest 20 and the oldest 41 years old).

For the teenagers' needs analysis related to sexual and reproductive health, 48 professionals, and social workers from the health, education and social fields took part, 75% of them were women and 25% were men. 72 teenagers from three contexts considered of special social vulnerability: teenagers under protection or in fostering care, immigrant teenagers or teenagers from deprived neighbourhoods, 62.5% of girls and 37.5% of boys.

Data Gathering and Analysis

A qualitative research outline was applied, through focus groups. The aim of this research is to develop the possibility to create alternatives to bring the theoretical world and the real world closer and to work as a training process from the reflexion on what is practised and the resources used (Padilla, 1993, Vaughn et al., 1996, Wilkinson, 2003). To carry out the focus groups a guide of questions was prepared for each different group, as well as an identity card for the participants with a basic profile, and a results form with the main groups' contributions and the moderators' opinions about the dynamics and atmosphere in the discussion group. The question guide included some questions considered of basic importance by the researchers. In the case of teenagers, three sets of questions were prepared according to their ages: from 12 to 14 year olds, from 15 to 17 year olds and from 18 to 20 year olds.

Each discussion group was monitored by two professionals and recorded on tapes with the previous agreement of both parties. The content analysis was carried out by the Atlas ti 5.0 qualitative data analysis program, after the transcriptions of the audio files. To make the participants' profiles the SPSS 12.0 qualitative data analysis program was used.

Two focus groups were formed with the families, which were selected by the professionals from the Catalan Midwives Association who took part in the research. All women were pregnant and belonged to maternal education groups. The midwives took part in 5 focus groups.

The professionals and social workers from the different health, educative institutions and youth associations got in touch with the teenagers, and 10 focus

groups were formed (5 with immigrant girls, 3 with girls from deprived neighbourhoods and 2 from girls in care in Educative Action Residential Centres). Furthermore, 8 focus groups were formed in which professionals from the health sector (45.8 %) educative sector (33.3%) and social sector (20.9%) took part. For the work with the families the content analysis for midwives and mothers was carried out bearing in mind the conditions of the pregnancy, the labour, the puerperal situation and the psycho-physical preparation. The categories related to the puerperal factors were presented as shown in Table 1 below.

Table 1. Puerperal length categories

Category	Category definition
PP-Physical	Puerperal physical aspects
PP-Psycho	Psychological puerperal aspects
PP-Social	Puerperal social and family aspects (family's support or intrusion)
PP-Baby	Attention received by the baby: baby's features, first caring at hospital, baby's general treatments, and aspects to deal with at home
PP-Breast feeding	Breast feeding aspects: typology, breast feeding problems, breast feeding promotion...
PP-Behaviour	Newborn's behaviour (crying, sleeping types...)
PP-P	Partner's role
PP-Emotions	Emotions related to labour

In the teenagers' study the content analysis of the professional focus groups was carried out through the dimensions related to sexual and reproductive health promotion, the programs performance, the teenagers' needs, their suggestions, strengths and weaknesses.

The content analysis in the teenagers' focus groups was carried out from the information received, the risks, the pregnancy and the proposals. In table 2 the information related to dimension categories is presented.

Table 2. Information dimension categories

Category	Category definition
General Information	General information that adolescents have about sexual and reproductive Health.
Affectivity Information	Information and believes the teenagers have related to affectivity.
Contraceptive Methods Information	Information the teenagers have about contraceptive methods.
Source of Information	Person or people, institutions and actions that have provided them with the information.
Reliable Information Sources	Reliability of the information sources.
Actions and Resources received	Actions and resources related to sexual and reproductive health that the teenagers have received or used.
Useful information and issues of interest	Teenagers' assessment about the information they have got and about issues of their interest.

Results

The results of two of the most significant works carried out about the specified dimensions are shown below.

Family guidance needs related to puerperal time

According to midwives and mothers, the care of the newborn baby and the family reorganization from the moment the parents go back home is one of the most difficult times for the family. With regards to the physical, psychological and social changes, mothers express a lack of information about their own recovery, because they focus on the newborn baby and do not look after themselves properly.

*“I found I needed somebody to explain to me how to take care of myself”
(mothers, Barcelona)*

With regards to psychological changes, the feelings that arise in the new situation and the number of changes can produce problems.

“You have to accept a new situation” (mothers, Blanes-Barcelona)

“It affects you psychologically because when you have a child, it is a very important change and not many people are aware of what it implies” (midwives, Girona)

On a social level, there are also changes that are necessary to assume and face. The mother’s time to dedicate to her partner, the home logistics, the time, social relationships and, maybe, there are family pressures, that transmit worries and information not always appropriate for the new mother, ending, some times, with the family’s privacy:

“There are some times in which help is like a competition to see who does more... and sometimes I say: “well, I appreciate it a lot, but go away” (mothers, Blanes-Barcelona)

“It is necessary to find moments to look after the baby and be with your partner” (midwives, Sabadell-Barcelona)

“A difficult change is when the partner has to accept the attention given to the baby. During the first month the attention to the baby is constant. This, sometimes, causes aggressive behaviour in the partner” (midwives, Girona)

According to midwives the aspects for which girls do not feel confident are breast breeding and the baby’s care, when they have to face this situation on their own.

“They worry if the baby cries, if he/she has little spots... they are very anxious” (midwives, Lleida)

“Mothers and fathers have doubts as how to look after their baby” (midwives, Girona)

The new mothers express that it is especially distressing to receive advice from different sources and not know how to behave with the baby, how to care for him/her, how to have a relationship with him/her. The contradictory information they receive from informal sources caused them great confusion and worry. They also have difficulties organizing themselves, feeling that their emotions are out of control and they do not think about asking for real and effective help to family support services and close relatives.

Being with the partner during the puerperal time is very important to reduce the insecurity and the fear of not been capable of looking after their babies properly. When the couple has received guidance the support is more effective

and shared. If tasks are shared, the emotions and experiences of motherhood are more positive.

“When you have to feed the baby..., because when you leave the hospital you are very worried...it is good for you to have your partner with you, to help you, that he understands what happens” (mothers, Barcelona)

“In the past, mothers helped a lot, but I think the situation has changed now. It is the partner who helps” (midwives, Girona)

Despite everything, midwives agree that mothers generally have an idealized perception of maternity until they find themselves in that situation daily.

“You need to adapt yourself to the situation” (mothers, Blanes-Barcelona)

“The puerperal time is very hard, and depression can become an illness” (midwives, Sabadell-Barcelona)

“Co-responsibility is not only with the men... it also happens to many mothers... even though it is them who are pregnant, when the child does not stop crying at night what they want is a dummy that makes him/her stop. Sometimes, there is a very idealized image of maternity” (midwives, Tarragona)

In the midwives' groups contributions were made related to introduce elements to improve the maternal preparation programs and to be able to meet the current needs:

The information. It was considered important to maintain the basic contents, for example, feeding, due to the great ignorance and false beliefs that there are about this subject. The importance of feeding during early infancy should be considered for later physical development and the adoption of nutrition habits.

The real image of the process. Even though maternity and paternity must be lived as a positive experience, it is important to avoid excessive idealizations and to acquire skills to face the difficult situations that can emerge.

Preparation is not only to inform but to reinforce the confidence to make decision in an independent way.

To work with group dynamics, requiring the preparation to know the group and to monitor it.

To propose timetables compatible for the families.

To encourage the partner's participation.

To have suitable material available, updating existing ones and taking into account cultural diversity.

The family's role in teenagers' sexual health

The most significant results obtained by the professional groups that refer to the family's function and its guidance needs are presented below. The professionals who took part in the focus groups mentioned several means of sexual and reproductive health, from which, only in the one related to the neighbourhoods some plan addressed to the families was mentioned, for example, the *parents' schools*. This fact explains, in part, the value given to school attendance as a measure to compensate the family relationship difficulties, and the lack of the family's intervention. In fact, the teenagers at risk who give up school also present a greater lack of information relating to sexual and reproductive health (Serrano, 2007).

“What worries me is not the children at school who are protected, but those who do not have any sex education information and this can be a more serious situation” (Immigrants).

Both the professionals and the social workers in the three fields (neighbourhoods, immigrants and CRAE) agree with the need and effectiveness of working with the families. They consider it especially necessary, as the sexual and reproductive health depends on the parents' attitudes, practices and values.

“When we realized we only worked with the parents we saw that we were not doing it well, as we had left out the children. You have to work with children and parents at the same time, and there must be communication between them...” (Professionals from socially deprived districts).

“I have found that if we speak to groups with certain social deprivations, on some occasions we have met teenagers who are 17 or 18 years old who ask questions more appropriate to 11 or 12 year old children, about menstruation, how to use a tampon... I suppose that there are probably some educative values that are learnt in the family. A person who has not had a certain family structure, who is in an institution, or who is homeless... has not had anyone to learn about these things from (...)” (Professionals from socially deprived districts).

They also refer to the need of working with the families, bearing in mind the culture of origin and the length of stay in the country, due to the importance these factors have in the socialization context and the family acceptance of the culture, above all, in these issues.

“Not all immigrants are the same. A Latin American girl does not need the same as a Moroccan girl who has grown up here, but who has parents who want her to behave like in Morocco. Here there are problems that can be prevented, generational problems” (Professional, immigrants).

According to professionals from the centres of state protection, the teenagers’ different needs compared to those who live with their families are due to the abuse or abandonment the teenagers suffered from their families. In these cases the risk behaviour of wanting to become pregnant or the submission to their partner is a way of replacing the emotional deprivations they suffered from their early childhood or a tendency to repeat behaviour, for example, premature pregnancies, difficult and conflictive relationships, promiscuous behaviour and, in other cases, because they have suffered sexual abuse. Family education in early childhood can be a support tool to reduce these situations.

“One sometimes realizes that when they are just about to go into a care centre they change boy/girlfriend... they take what they can because, what can I do after five or more years living in the centre? So, I cling on to the person I have, even if he/she is a sexual object, and in this way I feel loved or think that I am loved. It is their best idea of a future” (Professional from CRAE).

In general, professionals reiterate the need to work on a network and to increase the coordination of all the community services, by means of the creation of guidance services for families. In this way, they highlight the importance of the programs that are being carried out as a socio-educative process that aims to work with teenagers and their families.

In all the teenage groups, the family was observed as the most common source of information, together with school and friends, although this varies according to the culture of origin and the time they have spent in our country. Immigrant boys and girls aged 18 to 20 say they have less information, which could be due to the fact that 76.9% spent most of their infancy and youth in their countries of origin. In some cultures, as the Moroccan, sexuality is a taboo issue in the family environment.

“Me, from my parents. 8. me, from a book, Carlota’s red diary which I have read and which tells you about sexuality. It explains more or less what sexuality is, contraceptive methods and other things.... At school and at the hospital... From the television.... From my friends, in the street and experience. In magazines” (12 to 14 year old boys, CRAE).

“At school they teach you a little when you are young, your parents sometimes. With friends. Yes, above all with friends. It is where this subject is spoken about every day. On TV, the Internet... that’s it more or less” (Boys of 18 to 20, districts groups).

The dialogue with fathers and mothers seems difficult for teenagers of between 15 and 17. Differences according to the culture origin were also observed in these groups, greater difficulties being found in families from Asia and Africa.

“We get information everywhere, from our parents and at school. You can get information at hospitals. Lots at the same time: You do not speak to your parents” (Boys from 15 to 17, neighbourhood groups).

“(Asia): I cannot speak to my father or to my mother. I speak to my cousins, but to my parents, never. 4. (Asia): Yes, I also speak to my cousin. (Africa): Better to speak to friends” (Boys of 18 to 20, Immigrant groups).

The teenagers who participated show a great variety when considering the reliability of their information sources. Despite that, they agree that fathers’ and mothers’ influence is one of the most common, as that of friends. Even though these are the most frequent sources, very different opinions are generated about the credibility, although in the cases of some female friends with a good family relationship, in an indirect way, this source can be very reliable.

“I trust more in what my family says or in a book than in what my friends tell me. I prefer to trust my parents more than my friends, magazines... I can trust what doctors say. I trust my mother...” (Boys from 12 to 14, CRAE group).

“If I can choose, I think that the most reliable would be the school, because I suppose that it would be truthful information. More professional about the subject. The things that are said in the streets are not always true. They are things that they believe, so you take the opinion of a non professional on the issue, and TV, the Internet, they often tell the truth, but other times they only want to sell things or give you the wrong idea. With the family it is more difficult, it depends on the family. I think that the only true information is the one you get at school and it has been a great help to us” (18 to 20 year old boys, neighbourhood groups).

We were especially interested to learn from the young people about how they think their emotional and sexual education should be and their suggestions. In this respect we found no differences between cultural origin, their different situations or sex.

When they were asked who they would speak to about these issues, they mentioned three criteria to choose the person: somebody they trust, the responsibility these people have over them and their knowledge on the subject. In the first two cases they mentioned the family and, in the latter, the health and education professionals. The girls showed preference for their mothers or other women in the family. On the other hand, they said that many times they cannot speak about these issues due to problems in the relationships within the family.

“Health centres, a centre with doctors, speaking about this with your father or mother makes you feel uncomfortable. The school... Better doctors, they know more. Me, with a doctor. Me, with a doctor. 6. Parents because they have the duty to speak to their children because they go out and get pregnant and do not know how to take care of themselves. Yes, me with my parents.” (Boys of 18 to 20 years old, immigrant Group).

“Cannot speak to my parents about this, but I can with my tutor and doctors, they explain it better than parents. Me, with my mother. Me too. Me, with my sister-in-law, my friends. I with my parents. I with my aunt. I don't know. I with my sister. I with my parents, I trust them more, and they have more experience. If they have not done it, well, they can tell you to ask somebody else. I keep everything to myself, my things are mine. Me, with my mother and my psychologist. Me, with my aunt and my mother. Me, with my aunt and my grandmother” (Boys of 12 to 14 years old, CRAE Group).

When they are asked where they would prefer to speak about sexuality, they say their homes, and one of the issues that they would like to be discussed in the sexual education programs is how to dialogue with their families.

“At home. In places like this. At home would be the best option. I don't speak about this to my family. At school or in centres like this (It is a youth resources centre) I feel embarrassed. I feel more shy than pregnant. I don't want them to think the worst of me.” (boys of 15 to 17 years old, neighbourhood groups).

In the “Spanish Young Institute” Work (INJUVE) (Serrano, 2007) teenagers considered it important that their fathers and mothers received sexual education, as they think that they have had a traditional education and they are old fashioned in this subject.

Conclusions

Our results show that to prepare families through educative actions to face new situations, especially difficulty ones, as for example the birth or their children's adolescence is a need perceived by the professionals, the families and the teenagers.

It has been proved that families do not feel confident when they have to face the changes that parenthood involves, for instance, at personal, couple, family and social levels. To this feeling it should be added the difficulty to make decisions, due to the pressure and recommendation they receive from the people close to them. Families express their fears and their low self-efficiency perception in issues related to care, and it is obvious, that they take on an excess of responsibility for the multiple tasks they have now, without thinking of asking for help to their partners or to the people they have near.

Another identified aspect is maternity idealization during pregnancy, what can lead to frustration when the family has to face reality and their initial expectations are not exactly fulfilled. Maternal education must prepare with information and reflexion about the changes that it implies at physical, emotional, couple and social relationships levels. It is necessary to offer information, but it is even more important that the families acquire strategies to allow them to reduce and self-regulate their negative emotions, fears and insecurities to deal with the changes and to make efficient decisions. Parenthood as a positive experience will be possible if the family feels capable of facing the difficulties and of enjoying the experience.

The educative patterns and the family life models from the time of birth have an influence in the children's development and in their behaviour patterns through their development, an aspect that health professionals and social workers who work with teenagers in social risk situations highlight. They also express the need of working with the family and the children from an early age, above all, in cases of immigrant population. With regards to teenagers under protection who live in centres, there exist a series of risk factors associated to the reproduction of models they have lived, as for example, sexual abuse, difficult relationships and premature pregnancies, in some cases to meet their emotional deprivation, for which it should be appropriate to develop specific projects for teenagers under protection.

The need to improve the parental skills to promote the dialogue in the family is also observed. There is a request for proposals related to the fathers and mothers training on communicative abilities to be able to communicate with their children about sexual issues. It is probable that in social risk families, for reasons of negligence or for culture barriers, there has not been a fluid communication about this issue. Teenagers express this need and their wish of a higher opening and presence with regards to their needs. The family education actions that are

developed during the infancy and the adolescence development are especially significant to lower the consequences of certain risk practices, as, for example, pregnancy in teenagers and sexual transmission infections.

The needs identified in our work inevitably lead us to consider, on the one hand, the relevance of guidance actions for the family from the same moment of birth until adolescence, to contribute to the establishment of affective bonds and to direct our efforts towards educative styles based on the communication and the dialogue, with the aim of encouraging a healthy development. On the other hand, we point out the importance of introducing group didactic methods in the family guidance programs, as well as motivating didactic resources that bear in mind the culture diversity.

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