THE ADOLESCENT FEMALE'S EXPERIENCE OF PREGNANCY

by

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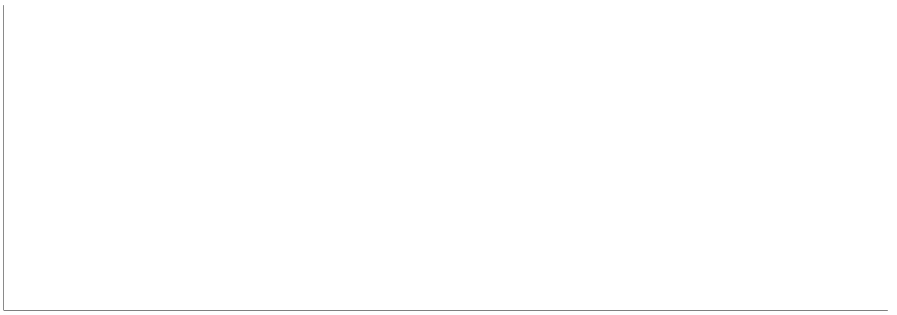

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Abstract

Adolescent pregnancy is of concern to health professionals, adolescents themselves, and the communities in which they live. Much of the concern centers around health and social issues for the adolescent and her child. Adolescent females who become pregnant experience two developmental events simultaneously: adolescence and pregnancy. This makes their experience unique from other pregnant females. In order to optimize the health of adolescents and their infants during pregnancy, nurses need to understand the experience from the teens' perspective. Few studies have examined this experience from the adolescent's perspective. There is a paucity of discussion about nursing's role in the vast body of literature on adolescent pregnancy.

The qualitative research method of phenomenology was utilized to investigate the female adolescent's experience of pregnancy, because it allowed the researcher to gain insight into the participants' lives as they were lived. Data were obtained from eight female adolescents during audio-tape recorded interviews. Trigger questions were used to explore the adolescent's perceptions of their experience of pregnancy. The interview audio-tapes were transcribed verbatim immediately following each interview. Giorgi's (1985) method of analysis was used to identify themes in the data. Second interviews were used to explore, clarify, and validate the emerging themes.

Two central interrelated themes emerged from the data analysis. First, the young women described ambivalent feelings that they experienced throughout their pregnancies. Secondly, they viewed their pregnancies as a life changing event. The life change was characterized by five phases: (a) suspecting the pregnancy, (b) confirming the pregnancy, (c) making decisions about the pregnancy, (d) living the reality of the pregnancy, and (e) experiencing a changed life. Each young woman's experience of pregnancy was shaped by identified environmental and other factors that were important to her.

The findings can assist nurses to provide better care for adolescents and their families. Two major conclusions were identified: (a) pregnancy and motherhood provided young women from unstable environments with meaning and a sense of purpose, (b) ambivalence captured the emotional impact of experiencing pregnancy and adolescence simultaneously for this vulnerable group. A variety of implications for nursing practice, education, research, and public policy are discussed.

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CHAPTER ONE

INTRODUCTION

Background to the Problem

The phenomenon of adolescent pregnancy has concerned teachers, social workers, physicians, nurses, parents, and teenagers themselves (Barr & Monserrat, 1986; Bergman, 1988). A report by Health and Welfare Canada (1990) noted that in Canada there has been a shortage of data on adolescent sexual and reproductive health, as well as inadequate use of this data by health care professionals.

The British Columbian Experience

In 1989, women under 20 years of age accounted for 5.8% of all births in British Columbia (B. C. Vital Statistics, 1989). In the same year there were 3,075 births to mothers aged 12 to 20 in the province of British Columbia (B. C. Vital Statistics, 1989). In the city of Vancouver alone, during 1989, 3 females who were 10 to 14 years of age and 209 females who were 15 to 19 years of age gave birth (Blatherwick, 1989). Rekart's (1988) population forecast for 1986-2011 projected that the rate of teenage births for the city of Vancouver would remain at current levels. This information suggests that a significant number of pregnant adolescent females will continue to require nursing care in the foreseeable future.

Attitudes Toward Adolescent Pregnancy

Nursing care of adolescents who become pregnant is influenced by the attitudes of society toward adolescent pregnancy. Prior to the 1970s, pregnant adolescents were viewed as social deviants (Humenick & Wilkerson, 1991). Phipps-Yonas (1980) in a review of the North American literature of the 1970s, concluded that characterizing teenagers who had conceived at a young age as deviant was not supported by empirical data. In the 1980s, adolescent pregnancy was portrayed as a phenomenon that was a problem for adolescents and these adolescents were portrayed as a problem for the communities in which they lived (Chilman, 1980a; Davis, 1989; Grinstaff, 1988; Mercer, 1985). Teenage pregnancy was frequently characterized, in the literature, as being of epidemic proportions (Adams, 1983; Grinstaff, 1988; Miaoulis, 1989; Stafford, 1987). It was thought that the epidemic of adolescent pregnancy could be remedied by sex education and by making contraceptives available (Humenick & Wilkerson, 1991). In the 1990s attitudes are changing. There is a recognition that the problem may be related to environmental influences, and not be totally with the adolescent herself. Humenick and Wilkerson have presented adolescent pregnancy in the 1990s "as a symptom of both rural and urban, family and community, [and] socioeconomic problems" (p. x). This approach acknowledged that a variety of social and psychological factors influence the

occurrence of adolescent pregnancy and affect the health of an adolescent and her expected child.

Health and Social Implications of Adolescent Pregnancy

The literature indicated that adolescent pregnancy results in increased health risks for both the mother and infant. Four common health risks have been identified: (a) anemia, (b) toxemia, (c) premature deliveries, and (d) low birthweight babies (Breedlove, Judy, & Martin, 1988; Stafford, 1987). Lee and Corpuz (1988) noted that pregnant teenagers appear to be at higher risk than older women for bearing low birthweight babies. They stated that this contributed to a higher incidence of neonatal mortality.

The literature also noted that low birthweight infants are at risk for developmental and long-term behavioral problems (Reedy, 1991). Reedy suggested that once these children enter school they may display hyperactive or impulsive behavior, and have poorer communication and reading skills than their peers. In addition to the children's intrinsic difficulties, their behaviors relate to the adolescent mother being less accepting, less cooperative, engaging in less communication, and being less sensitive to her child than a mature woman (Reedy, 1991).

The literature stated that teenage parents are more likely to have problem marriages and to neglect or abuse their children (Stafford, 1987; vonWindeguth & Urbano, 1989). In addition,

adolescent females who become pregnant disrupt their education and often obtain less post-secondary education than their peers; consequently, they have limited labor force participation which usually results in low incomes (Moore & Burt, 1982; Ruff, 1987; vonWindeguth & Urbano, 1989).

Poverty and unemployment have been identified as factors that influence early sexual intercourse and childbearing in adolescence (Flick, 1991; Frager, 1991). Flick (1986) noted that "poverty is associated with early sexual activity, decreased use of contraceptives, and lower abortion rates, regardless of race" (p. 142). In addition, Reedy (1991) suggested that the younger a woman is when her first child is born, the greater the risk of poverty and her need for social assistance.

While working as a community health nurse, this researcher identified a discrepancy between teens' concerns and the concerns of health care workers in teen pregnancy programs. While the literature has explored the changing attitudes and the health and social implications of adolescent pregnancy for mother and child from the professional perspective, there remains a gap in information from the pregnant teenager's perspective. Consider, for example, the work of Foster (1988), a social worker, who carried out phenomenological research with pregnant adolescents. Although her report is very informative on social issues and chronicles several young women's experiences of bearing children

as teenagers, it did not specifically address the adolescent's perceptions of being pregnant. Exploring the adolescent's perception of pregnancy benfits health care workers, because the information could be useful in identifying some of their prenatal care needs, in assisting adolescents and their families to cope with pregnancy, and in viewing the efficacy of current programs for females in this developmental stage.

Problem Statement

Adolescent females who become pregnant experience two developmental events simultaneously: adolescence and pregnancy. Thus their experience differs from that of other pregnant females. Although health care providers have devised special programs that attempt to address this phenomenon (Chilman, 1980a; Mercer, 1979b; Phipps-Yonas, 1980), there has been little documented research that speaks to the experience of pregnancy from the teenager's point of view (Anderson, 1985; Blum & Smith, 1988). Humenick and Wilkerson (1991) noted that even though it is recognized that adolescent pregnancy puts the adolescent female and her child at risk, there has been a paucity of discussion of the clinical implications for nursing. If the nursing research literature does not address the phenomenon of teenage pregnancy from adolescents' perceptions, programs will continue to be designed without addressing adolescents' views of their

experiences. To optimize adolescents' and their infants' health during pregnancy, nurses need to work with the adolescents to attempt to meet their needs as they perceive them. Therefore, research exploring the adolescent female's perspective is warrented.

Purpose

The purpose of this study was to describe the experience of pregnancy from the female adolescent's perspective.

Research Question

What is the experience of pregnancy from the female adolescent's perspective?

Definition of Terms

Adolescent - a female who reads and speaks English, ranging in age from 13 to 16.

Pregnant adolescent - an unmarried female adolescent in her last trimester of pregnancy (i. e., between 33 and 40 weeks gestation), who intends to keep her baby.

Nurse - nurse will refer to a Registered Nurse.

Significance of the Study

Understanding how the adolescent female experiences her pregnancy is beneficial for the following reasons: (a) to provide current information regarding the pregnancy experience for a group of adolescents in Vancouver in 1991; (b) to increase understanding of why adolescents do or do not access antenatal services; (c) to provide information from which prenatal programs can be designed to address the identified concerns of the pregnant adolescent; (d) to provide information that can be used to consider the efficacy of current programs for pregnant adolescents; and (e) to assist nurses to view the experience of adolescent pregnancy in a holistic way.

Overview of Method

This study was guided by the interpretive approach of phenomenology. Phenomenology seeks a fuller understanding through description, reflection, and observation of a phenomenon to ascertain the multiple meanings of the phenomenon (Ray, 1990). The purpose is not to ask the "how" of something from the cause and effect perspective, but rather what is the nature of the experience or meaning of the phenomenon so it can be better understood (Ray, 1990). This method is useful to nursing researchers, because it focuses on how the phenomenon is perceived by the person living it. Omery (1983) noted that the

phenomenological method assists the researcher to understand both the cognitive, subjective perspective of the person who has the experience and the effect their perspective has on his or her behavior.

Assumptions

The author made the following assumptions: (a) the pregnancy experience of the adolescent who is unmarried is different from that of the married adolescent; (b) the pregnancy experience is different for the adolescent female than for the adult; and (c) the adolescent who is interviewed will present an honest factual account of her experience.

Limitations

The sample size was small and included a specific segment of the population, which limits the extent to which the study findings can be generalized. These study findings can be related to English speaking female adolescents 13 to 16 years of age living in an impoverished urban environment, experiencing a pregnancy and choosing to keep their babies. It is an accepted premise that data obtained utilizing the phenomenological method are biased toward individuals who are describing their experience, but this is precisely the reason that it was chosen (Field & Morse, 1985).

Organization of the Thesis

The first chapter has provided an introduction to the research study. The introduction has included a discussion of the background to the problem, problem statement, purpose of the study, research question, the significance of the study, definition of terms, an overview of the research method, assumptions, and limitations. Chapter Two presents a critical review of the literature relevant to the proposed study. Chapter Three outlines the inductive research methodology, phenomenology, and describes in detail sample selection, procedures for the protection of human participants, data collection, data analysis, issues of scientific rigor, and the characteristics of the participants. Chapter Four presents the findings of the study and discusses them in relation to pertinent literature. Chapter Five presents a summary of the findings and conclusions that arise from the study as well as implications for nursing practice, education, research, and public policy.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

In this chapter, relevant literature about adolescent sexuality and pregnancy will be discussed. Due to the substantial body of literature on adolescent sexuality and pregnancy, only articles that illustrate the areas related to this research will be included in the review. Literature from the following areas will be reviewed: (a) adolescent growth and development, (b) factors in the adolescent's biological and psychosocial development that influence pregnancy, (c) factors influencing adolescent decision-making about sexuality, (d) environmental factors including--poverty, family, and peers, (e) choices for pregnancy resolution--abortion, adoption, or keeping, and (f) responses of the health care system to adolescent pregnancy. The information gained from this review will familiarize the reader with the current state of knowledge about adolescent pregnancy, and place the research question in the context of the literature.

Growth and Development

Puberty, the period when secondary sexual characteristics develop, is a biologic process that occurs for females between the ages of 8 and 14 (Reedy, 1991). As a result of the body changes

that occur in puberty, the young person becomes physically able to reproduce. While puberty is a biological process, completing adolescence is both a biological and a psychological process.

Adolescence is the period when rapid physical growth and social and psychological maturation take place simultaneously and generally occurs between the ages of 12 and 19. Johnson (1986) refers to adolescence as a social-psychological process during which individuals accomplish two major tasks: (a) emancipation--separating themselves in thought from the group who has nurtured and supported them throughout childhood, usually their family; and (b) formation of a sexual, an intellectual, and a functional identity.

Adolescent growth and development constitutes a complex and demanding time in an individual's life (Adams, 1983; Fuller, 1986; Mercer, 1979a, 1983; Nelms, 1981). Mercer (1979a) has identified six tasks, associated with the biological and psychological growth that occur during the period of adolescence, which have expanded on Johnson's (1986) work: (a) gaining comfort with and acceptance of body image, (b) internalizing a sexual identity and role, (c) developing a personal value system, (d) preparing for productive citizenship, (e) striving to achieve independence from parents, and (f) developing an adult identity. During this period the adolescent also develops skills in

decision-making and problem-solving. This is a person who is in the process of becoming an adult.

The process whereby an adolescent evolves from childhood into adulthood can be subdivided into three phases: early, middle, and late adolescence. In early adolescence, young teens struggle with their identities. They are concerned about their body image, whether they are developing normally in comparison to their peers (Reedy, 1991). "The peer group is a key factor in adolescent development because it provides opportunity for modeling and practice by doing" (Reedy, 1991, p. 216). This is the time when adolescents begin to assert their independence from their parents (Nelms, 1981). Early adolescents are concrete thinkers; they live in the here and now, and they have not yet developed the ability to conceptualize the future (Reedy, 1991).

In middle adolescence, conflicts arise as teenagers strive to disengage from their parents. Reedy (1991) noted that during this turbulent period some adolescents run away from home. The adolescent's peer group is very important to them for defining behavior and dress (Reedy, 1991). Development of heterosexual relationships are also important to middle adolescents; they frequently date a series of their peers during this stage (Mercer, 1979a). Middle adolescents are developing formal operational thinking. Their reasoning ability still involves trial and error, but this enables them to conceptualize their own thoughts and to

begin to conceptualize the thoughts of others. They are, however, limited in their abstract reasoning which involves applying information to future events (Reedy, 1991).

In late adolescence, teens focus their attention on careers or life work and on the ability to maintain stable relationships (Mercer, 1979a). They are able to make purposeful decisions while considering long-term implications (Reedy, 1991).

As adolescents mature, proceeding from early to middle to late adolescence, their cognitive development undergoes the changes previously described. Orr, Brack, and Ingersoll (1988) in studying the relationship between puberty and cognitive development of 135 students aged 11 to 19, measured general intelligence (IQ), cognitive complexity (conceptual level), cognitive style (perceptual field dependence-independence) and sexual maturity (Tanner stage). The quantitative data suggested that changes in cognition occur in adolescence in relation to chronological age. When the effects of age were controlled, physical growth and development were not found to be a predictor of mature cognitive development. This study indicated that the level of cognitive maturity may not be concurrent with sexual development, and that cognitive maturity may be overestimated in relation to early sexual development in the adolescent.

In understanding adolescent behavior, adolescents' evolution from complete egocentricity to less egocentricity, must be

recognized. Elkind (1967) described early adolescents as egocentric, having difficulty differentiating between the cognitive concerns of others and those of themselves. This adolescent egocentrism gives rise to two mental constructs, which Elkind calls "the imaginary audience" and the "personal fable" and these help to account for certain forms of adolescent behavior.

Adolescent egocentrism is the result of the adolescent failing to differentiate between what others are thinking, and his or her own mental preoccupations (Elkind, 1967). Consequently adolescents construct an "imaginary audience" for whom they are the focus of attention, which is usually not true (Elkind, 1967). Risk-taking behavior is often done to gain the attention of the "audience", particularly when the teen is struggling with his/her independence from his/her parents. It also serves to affirm the teen's sense of identity. Risk-taking is a normal behavior used by adolescents to develop independent decision-making skills. Unfortunately, the consequences of this method of establishing independence for the young woman may be an unwanted pregnancy.

A "personal fable" is another mental construct adolescents use to reflect their belief that their feelings are unique and that they themselves are immortal (Elkind, 1967). Elkind suggested that many young women become pregnant because their personal

fables convince them that while others may get pregnant they will not, and so need not take precautions.

Another model of explaining adolescent behavior is offered by Erikson (1963). Erikson has defined the developmental stage that occurs in adolescence as identity versus role confusion. The middle adolescent, in passing through this stage, completes two developmental tasks: (a) achieving independence from parents, and (b) the formation of a self-identity (Alexander, McGrew, & Shore, 1991; Johnson, 1986; Mercer, 1979a). These developmental tasks affect the decisions adolescents make regarding their sexual behavior; decisions that can result in pregnancy (Holt & Johnson, 1991). Shaw (1991) pointed out that a key to understanding adolescents is to recognize their search for identity and their increasing desire for independence. In searching for their identity adolescents experiment with sexual values and behaviors.

Sexual values and behaviors are related to cognitive and moral development. A component of the adolescent's intellectual identity is their moral development, which is developed at the same time as their personal value system. Chilman (1980b) noted: "Moral development, like cognitive development, proceeds sequentially from simplistic, present-oriented concepts of rights and wrongs to more abstract, complex principles" (p. 107).

Adolescence is a maturational event, whereby individuals become independent from parents, and form self-identities

composed of sexual, moral, and intellectual components, and prepare for future work. Reedy (1991) stated that adolescence is a developmental process that needs to be completed by each individual. Failure to complete the process results in a postponement of adolescence, which means the individual will live out their adolescence at another point in their life. Reedy suggested that the 33-year-old "runaway housewife" who wants to find herself and have a life, and the 40-year-old married man who buys a sports car, gets a divorce or a mistress, and "sows his wild oats" are two examples of postponed adolescence. Reedy believes, and this author concurs, that this process would disrupt these individuals' and their families' lives. Thus it is important that adolescence be experienced during the teenage years rather than being delayed until adulthood, because adolescent pregnancy can disrupt development, it may not be completed until a later time. In the next section the interaction between growth and development and adolescent pregnancy will be explored.

Growth and Development Interacting with Adolescent Pregnancy

There is an increasing awareness in the professional literature that pregnancy is connected to the adolescent's biological and psychosocial development. A teenager's ability to respond to pregnancy varies according to the stage of adolescent development she has reached. Adolescent development can be

subdivided into three stages: early, middle, and late. In early adolescence, the adolescent is struggling to establish her identity, while her body is undergoing physiological changes (Mercer, 1979a). Pregnancy complicates her ability to establish her identity and further changes her already changing body image. Although she seeks out friendships with same sex peers, she is still reliant on her parents for some decision-making. Pregnancy can alter all these relationships.

In middle adolescence, the teenager is striving to disengage from her parents and to develop heterosexual relationships. Pregnancy can reestablish her dependance on parents and interfere with heterosexual relationships. The teen begins to develop cognitive abilities for problem solving. However, pregnancy adds more and different problems for the teen to solve, and may challenge her problem-solving capabilities. As development occurs, egocentricity decreases and the teen becomes more aware of others. Pregnancy can increase egocentricity as the teen experiences body changes and increased attention from others wanting to help her.

In late adolescence, the young woman strives to achieve the ability to maintain stable relationships and to prepare for a career and community responsibilities (Mercer, 1979a; Nelms, 1981). Pregnancy can interfere with establishing stable heterosexual relationships and career plans.

When pregnancy occurs during adolescence, formation of the young woman's self-identity is complicated. The young woman, already engaged in the developmental tasks of adolescence now has, in addition, the developmental tasks of the maternal role to think about. Rubin (1984) describes the psychological process involved in maternal identity formation as a self system composed of three interrelated selves: the ideal self, the actual or known self, and the body image self. The ideal self is the image of who the woman wants to be as a mother; it draws on a variety of the individual's life experiences. The actual or known self is how the woman views herself at a given time in a certain situation. The body image self refers to physical sensations and activity changes that occur as a result of the growing fetus. While the adolescent experiences these selves in a similar way to adult women, she is simultaneously struggling with the developmental tasks of adolescence. In addition, she has also had fewer life experiences than an older woman to prepare her for motherhood.

Pregnancy in adolescence cannot be viewed, therefore, as an isolated problem, but one that is interconnected to other issues within the adolescent's world (Alexander et al., 1991; Holt & Johnson, 1991; Johnson, 1986). Flick (1986) identified four steps leading to adolescent pregnancy and parenting: "becoming sexually active, not using or incorrectly using contraceptives, carrying rather than aborting a pregnancy, and parenting rather than

placing a child for adoption" (p. 132). An adolescent's biological and psychological development, as well as a variety of factors in her social environment, will influence which path she takes and when these steps are encountered. Obviously, the earlier these steps arise the less ready an adolescent will be to deal with them.

Biological Development

Zuckerman, Walker, Frank, Chase, and Hamburg (1984) noted that there are no intrinsic biological barriers to satisfactory perinatal outcomes for young mothers and their infants. Low birthweight as an outcome of pregnancy is associated with various sociodemographic and health care factors, such as low income, single marital status, low educational level, smoking, drug abuse, inadequate prenatal care, and poor maternal weight gain in pregnancy, rather than biological maturity (Lee & Corpuz, 1988; Reedy, 1991). Several studies of programs that provide comprehensive prenatal care support the contention that teenagers bearing low birthweight infants reflect negative environmental and social influences, which can be ameliorated by the provision of social and economic support (Gale, Seidman, Dollberg, Armon, & Stevenson, 1989; Piechnick & Corbett, 1985; Smoke & Grace, 1988).

Even if there are no intrinsic biological problems related to pregnancy during adolescence, adolescents may engage in denial and present late for prenatal care, thereby placing their own

health and that of their fetus at risk (Hayes, 1987). Reedy (1991) identified the following possible health problems that could put the health of the mother and her fetus at risk: untreated sexually transmitted diseases, hypertension, preeclampsia, anemia, and poor weight gain. Trying to "stay thin" to hide the pregnancy may be another form of denial, which places the nutritional status of the mother at risk (Reedy, 1991).

Psychosocial Development

Every woman who becomes pregnant engages in a series of developmental tasks that prepare her for the maternal role (Barr & Monserrat, 1986; Rubin, 1975). Barr and Monserrat identified four psychological tasks of pregnancy: (a) pregnancy validation, (b) fetal embodiment, (c) fetal distinction, and (d) care-giving. The first task, acceptance of the reality that the pregnancy does exist, is usually achieved in the first trimester. A woman's acceptance of the pregnancy may be affected by her ambivalence about the pregnancy (Flagler & Nicoll, 1990). This author believes adolescents will be more likely to experience ambivalence, because of their under-developed value systems, in combination with their adolescent developmental tasks and cognitive development, as well as the acceptance of others.

The second developmental task involves recognizing that the fetus does exist as part of her body. Denial can delay this task

(Barr & Monserrat, 1986). Denying she is pregnant may prevent the young woman from accepting the pregnancy and forming an emotional bond with the expected child (Flagler & Nicoll, 1990). The adolescent reviews her own relationship with her mother, even though she may be feeling the need to be "mothered" herself (Barr & Monserrat, 1986). This occurs in the context of establishing independence, establishing a self-identity, and decreasing egocentricity.

The last two developmental tasks are: fetal distinction and care-giving. Fetal distinction, involves the woman recognizing the fetus as separate from herself with an identity of its own. Egocentricity may interfere with an adolescent's ability to view her fetus as a separate person (Reedy, 1991). She may experience a conflict between her own needs and those of her expectant child. The adolescent in accepting her pregnancy, needs to "grieve" the parts of her life such as school, dances, or sports that she has had to give up (Barr & Monserrat, 1986).

The young women may resolve some of their conflicts about becoming a mother and about viewing the fetus as a separate entity by participating in programs with other young expectant mothers (Barr & Monserrat, 1986). The fourth task, becoming a care-giving mother, occurs after the child is born. Following the births of their babies, as the young women care for their babies, they take on the role of care-giving mothers (Rubin, 1975).

Hayes noted that "studies of social and psychological factors associated with adolescents' sexual behavior concluded that self-perception (not self-esteem)--that is, the sense of what and who one is, can be, and wants to be--is at the heart of teenagers' sexual decision making" (1987, p. 120). Further research is required to understand how the variety of family background characteristics, psychosocial factors, and environmental factors influence young women's self-perceptions which, in turn, influence their sexual decision-making and risk for pregnancy.

Adolescent Decision-making about Sexuality

The decisions adolescents make about their sexuality include engaging in sexual intercourse, and use or nonuse of contraceptives. Intellectual development, as well as, the developmental tasks of adolescence influence their use of contraceptives.

Decision-making about Sexual Activity

Recently adolescent decision-making in general and, specifically, their decision-making about sexual activity have been studied as factors affecting adolescent pregnancy. Gordon (1990) provided an in-depth examination of the ways in which cognitive-developmental change mechanisms can initiate or hinder formal thinking about the consequences of sexual activity and

contraception. Important elements of formal operational reasoning include: (a) generating or envisioning alternatives, (b) evaluating alternatives, (c) engaging in perspective taking, and (d) reasoning about chance and probability (Gordon, 1990). Adolescents who have not attained these abilities are at risk for pregnancy (Gordon, 1990).

Intellectual development in the adolescent years is a factor in decision-making related to sexual behavior (Gordon, 1990; Holt & Johnson, 1991; Johnson, 1986). Holt and Johnson acknowledged that intellectual development is highly variable and not unidirectional. In times of stress all teens may revert to concrete thinking. Adolescents who think concretely about their sexual behavior do not consider the possibility of pregnancy and its long term consequences. The young female adolescent has not matured to the point where she can think about her actions as having consequences for the future. Whereas, teenagers who are using formal operational thinking are more able to explore multiple future options in relation to their use of contraceptives (Holt & Johnson 1991). Dysynchronous intellectual and physical development can create expectations that physically mature adolescents will think and reason as adults, when in fact they remain emotionally and cognitively immature (Alexander et al., 1991).

In the 1990s, the developmental tasks of adolescence have been considered as a factor in some adolescents' risky sexual activity (Alexander et al., 1991; Gordon, 1990; Holt & Johnson, 1991). The adolescent is striving to achieve the developmental tasks of: (a) independence from parents, and (b) formation of an "adult" identity by integrating a gender identity, an intellectual identity which incorporates moral and personal values, and a career or work role identity (Johnson, 1986; Mercer, 1979a). Evidence suggests that these developmental tasks influence some teens' decision-making related to sexual behavior (Alexander et al., 1991; Holt & Johnson, 1991; Johnson, 1986). Teens who do not feel a sense of independence or personal control often engage in behavior that risks pregnancy in attempt to fulfill the developmental task of achieving independence (Holt & Johnson, 1991).

Female adolescents who are experiencing role confusion may cling to a single intimate relationship, and use it to reflect, clarify, and integrate their identities (Holt & Johnson, 1991). Holt and Johnson noted that female adolescents who choose to engage in risky sexual behavior to accomplish their developmental tasks of achieving independence and forming their adult identity may do so consciously or unconsciously. There is little empirical research that supports this point of view. Ascertaining adolescents' perspectives about their decision-making regarding sexual activity

and contraception would enable adults to better understand adolescent behavior. More information about this area would be useful for health care professionals planning interventions to decrease the number of teenagers who become pregnant.

Decision-making about Contraception

Barr and Monserrat (1986) have identified eight reasons why teenagers get pregnant: (a) lack of knowledge in relation to the available methods of contraception and how to obtain them, (b) fear that the method will be discovered by a parent, (c) inconvenience in obtaining or inconsistent use of a method, (d) belief that using contraception will interfere with the spontaneity of sex, (e) belief that sexual pleasure will be diminished by using a contraceptive, (f) belief that use of contraception implies premeditated sex, (g) a need to engage in risk-taking, and (h) a conscious or unconscious desire to get pregnant to prove one's masculinity/femininity, self worth, or adult status.

Morrison (1985) examined the literature on adolescent contraceptive behavior published in psychology, sociology, medicine, demographic, and family planning journals. She concluded that adolescents are largely uninformed about reproductive physiology, and about the variety of contraceptives available. Morrison linked adolescents' negative attitudes toward

contraception, and its nonuse by sexually active adolescents to their level of information, beliefs, and attitudes. Reviewing the literature, she found relationships among contraceptive use and desire to become pregnant, limited educational goals, and low socioeconomic status (Morrison, 1985). These factors relate to the environmental influences described earlier and indicate that limited life opportunities affect contraceptive use. She concluded that adolescents do not like to use contraceptives, but the reason for this is unclear. "The failure to find specific negative attributes of contraception that are reliable across studies lends support to the hypothesis that some generalized negative affect toward sex-related topics is one component underlying adolescents attitudes toward using contraceptives" (Morrison, 1985, p. 564). She cited a need for future research to address the relationship among cognitive, emotional, and developmental factors related to contraceptive use.

Strauss and Clarke (1992) proposed a framework that examined the maturity of decision-making patterns of adolescents in relation to cognitive, social, and emotional issues. The framework is derived from the theoretical literature and research on adolescent development and problem solving. Three decision-making patterns were identified: immature, transitional, and mature (Strauss & Clarke, 1992). Middle adolescents use a transitional model of decision-making characterized by what Elkind

(1967) calls the imaginary audience and personal fable ("I didn't think it would happen to me"); they may not consider all the alternatives and their consequences when solving problems of contraception.

Norris (1988) proposed an approach to contraceptive behavior that draws on research and theory in the areas of memory and information processing. "The basic premise of this cognitive model is that a woman's contraceptive behavior is a function of the thoughts that are accessible at the time that she is presented with an opportunity to engage in sexual intercourse" (Norris, 1988, p. 136). While this model is heavily influenced by the social environment, it does take into account both adolescent and adult women's behaviors.

Urberg (1982) used a problem-solving framework to examine contraceptive behavior in both male and female teenagers. Contraceptive use by teens is determined by their self concept, cognitive skills, and knowledge; all of these influence their motivation. Motivation to use contraceptives is important but is also related to the teen's locus of control, the value of pregnancy, and the teen's vulnerability. All these factors will influence abilities to think about solutions to contraceptive problems, make decisions, and choose a solution (Urberg, 1982). Urberg raised an important point; different individuals may be contraceptive risk-takers for different reasons.

While the previous authors have focused on adolescent risk-taking from a personal decision-making perspective, Furby and Beyth-Marom (1992) suggested that the various aspects of the social-structural environment in which adolescents live may play an equally important role in decision-making competence. They analyzed the literature on risk-taking, cognitive development, and decision-making skills, and suggested that adolescents may be no greater risk-takers than adults, and that risk-taking may be beneficial for assisting adolescents to achieve their developmental tasks (Furby & Beyth-Marom, 1992). This perspective offers a different approach for understanding adolescent risk-taking as normal development, rather than a deviant behavior and suggests that adolescents' risk-taking in relation to contraceptive use may be influenced by the environment in which they live.

It is generally agreed that adolescents' development and their perceptions are dependent on a variety of psychological, social, and environmental factors (Alexander et al., 1991; Holt & Johnson, 1991; Mercer, 1979a; Shaw, 1991). Smith (1991) noted there are differences in the adolescent's perspective, her family's perspectives, and professional's perspectives. By focusing on "the deficits of adolescent mothers and the pathology of their families rather than on the possibilities and difficulties they experience in the midst of often formidable circumstances" (Smith, 1991, p. 163), the professional fails to understand how an

adolescent's environment may shape her experience of pregnancy. In addition, the research has indicated that the teen's social environment also influences the decisions they make about being sexually active and exposing themselves to the risk of pregnancy. In the next section, factors in the environment that influence a young woman's decision-making regarding risk of pregnancy will be discussed.

Environmental Factors Influencing Adolescent Pregnancy

How a young woman deals with the risks of pregnancy is influenced by social and psychological factors in her environment. Flick (1986) has identified the following sociocultural forces that affect the adolescent's risk for pregnancy: low socioeconomic status, metropolitan residence, and large family or single parent household. Speraw (1987) studied the cultural beliefs of Caucasian, African-American, Hispanic, and Pacific Asian adolescents and found that the adolescents' cultural backgrounds shaped their perceptions of pregnancy.

This section discusses the research related to the environmental forces which increase the likelihood that an adolescent will be at risk for pregnancy under three headings: (a) poverty, (b) family, and (c) peers.

Poverty

Living in poverty increases the likelihood of young women becoming pregnant. Zuckerman et al. (1984) noted that poverty may contribute to adolescent pregnancy "because economic disadvantage increases the risk of parental depression and family dysfunction and decreases the opportunities for alternate adolescent accomplishments" (p. 860). Similarly, Flick (1986) noted that adolescents who live in poverty may feel they lack control over their destiny and opportunities to be successful; they see pregnancy as a way of achieving these in adult roles. Hayes (1987) also noted that poverty and poor employment opportunities are closely associated with nonmarital childbearing, and suggests that adolescents living in poverty may view pregnancy as a way to be successful in their lives.

Young women living in poverty are more likely to have sexual partners who are poor and have less education than their peers who delay childbearing (Marsiglio, 1987). As a consequence, both the young women and their partners face long-term social and economic disadvantages. Hardy, Duggan, Masnyk, and Person (1989) when investigating the characteristics of men who had fathered children by very young women in Baltimore, found that the fathers had low levels of schooling and poor employment histories. Indeed, several had criminal records, and one in five had at least one other child by another woman. These factors

suggest that young women living in poverty may be at greater risk for encountering irresponsible partners who have poorly developed value systems and who have had more life experiences.

While these studies all suggested that poverty increases the likelihood that adolescents will be at risk for becoming pregnant and experiencing difficulty in their lives; they are from professionals' perspectives. Research that addresses young women's' perceptions of their socioeconomic status as a factor influencing their experience of pregnancy, would help health care professionals to understand young women's experiences.

Family

A great deal of research has been done to identify the factors in the family environment that influence adolescent pregnancy. Wattleton's (1987) study of American teenagers identified the following familial factors that influenced sexual activity leading to pregnancy: (a) parent(s) with a low socioeconomic status, (b) parents who are unemployed, (c) single parent families, (d) parents who are not college graduates and (e) families who do not value school attendance and making good grades. Because these factors are interrelated with the social environment in which the family lives, specifically poverty, it is misleading to suggest that these relationships are only attributed

to the family itself as opposed to the family's interaction with the community.

Pete and DeSantis (1990) interviewed five 14-year-old, African-American pregnant adolescents, and found that certain factors in the family unit intensified vulnerability, upset security and belonging, and increased the likelihood that young women would become sexually active. These factors were identified as: (a) lack of planned activities, (b) unsupervised time, (c) incongruencies between mother's wishes and daughter's behaviors, (d) mothers who are ineffective authority figures, and (e) lack of communication between mother and daughter about information on sexuality (Pete & DeSantis, 1990). They suggested that when these factors are present in a family, the young woman's risk for pregnancy is increased (Pete & DeSantis, 1990).

Not having a father figure present in their lives has been cited by several authors as a force that has increased the likelihood of a young woman being at risk for pregnancy (Raines, 1991; Robbins, Kaplan, & Martin, 1985). Robbins et al. noted that family stress is positively related to pregnancies occurring in early and middle adolescence. Testing multivariate models for predicting adolescent pregnancy, they found that there are differing psychosocial risk factors in early and late adolescence (Robbins et al., 1985). They also found a link between father absence, low self-esteem, and increased feelings of powerlessness

in the daughter, all of which led to an increased risk of adolescent pregnancy (Robbins et al., 1985). Raines reviewed the literature and found that there is an increased probability that fathers who are not involved in the lives of their adolescent children will have a daughter who experiences an unplanned pregnancy. She identified the following characteristics of fathers who are not involved: the father is physically absent, emotionally unavailable, or has a negative relationship with his daughter (Raines, 1991). The link between father absence and low self-esteem needs to be explored further to understand better the factors influencing this relationship.

Hayes (1987) offered an alternate view, that the adolescents' self-perception, not self-esteem influenced their expectations and perceptions of the risks of pregnancy and childbearing. These self-perceptions are influenced by the family of origin. "Race, socioeconomic status, family structure, family size, and parents' education are strongly associated with attitudes about sexual and fertility behavior" (Hayes, 1987, p. 121).

Alexander et al. (1991) cautioned that when genital sexual activity with a partner occurs in early adolescence it is often out of a need to enhance self-esteem; at the same time, exploitation by an older partner needs to be ruled out. Often these young adolescents come from families with multiple problems (Alexander et al., 1991). Alexander et al. suggested that young adolescents

involved in sexual intercourse need an opportunity to talk about how to build self-esteem in other ways, how they can gain coping skills to deal with their family problems, and how to be more assertive. The link between low self-esteem and social environment has been identified by health care professionals. This needs to be investigated from the adolescents' perspective in order for professionals to more completely understand how self-esteem influences teens' decision-making about their sexuality.

Another factor in adolescents' families is sexual abuse. Boyer and Fine (1992) examined the relationship between sexual abuse and adolescent pregnancy. Their findings indicated that coming from an abusive family (whether the abuse was physical, psychological, or sexual) is associated with having intercourse at an earlier age (Boyer & Fine, 1992). They suggested that physical maltreatment and sexual victimization (molestation, attempted rape, or rape) may disrupt adolescents' developmental processes and undermine their ability to make decisions about complex situations, putting them more at risk for pregnancy. Oz and Fine's (1988) findings also suggested that having lived in foster care, and having a father who was violent or an alcoholic increased the adolescent's risk for pregnancy.

The social environment of adolescents is linked to their family by culture. Hayes (1987) suggested that culture acted as a force on adolescent sexuality by creating values, norms, and

expectations about gender roles, sexual behavior, relationships, marriage, and parenting. For example, Faber's (1991) interviews of African-American and Caucasian unmarried adolescents revealed that family members influenced their decisions for pregnancy resolution. They also considered personal, familial, and religious values in deciding to bear and keep their children.

Warren and Johnson (1989) further investigated the interaction between family environment, demographic measures, and the decisions made by unintentionally pregnant 14 to 22 year olds regarding postdelivery plans. Ambivalence about their plans for pregnancy resolution was found to be related to the following family characteristics: nonsupportive and conflictual relationships among family members, lack of respect and support for functioning independently, lack of encouragement for expressing feelings, and a lack of interest in cultural and intellectual experiences (Warren & Johnson, 1989). The concept of ambivalence was not clearly defined, consequently, it is difficult to understand what the adolescents were experiencing as ambivalent feelings. The adolescents reported a low level of ambivalence (Warren & Johnson, 1989). Warren and Johnson noted : " . . . either these adolescents were not very ambivalent about their postdelivery plans or they were unwilling to report (or were unaware of) their true level of [ambivalence] . . . factors, such as unconscious denial . . . may have distorted the measurement of ambivalence"

(p. 516). This author believes the young women's denial of their pregnancies may have influenced their perceptions of the ambivalence they were experiencing, which may account for the low level of ambivalence that Warren and Johnson measured. The young women's denial may have also been related to their level of cognitive development. The study results were biased toward adolescents who continue their pregnancies; no comparative data were collected on those who chose abortion.

Several authors have suggested that quantitative research methods, like questionnaires, do not allow the researcher to make connections between variables in the same way that qualitative methods, like interviews do (Morrison, 1985; Warren & Johnson, 1989). In an interview the researcher can record how individuals perceive their experiences and their links among the variables as they describe them.

Peers

Another factor in adolescents' social environments are their peers. The developmental literature noted that concern with peer approval commonly affects sexual behavior in middle adolescence (Alexander, et al., 1991; Reedy, 1991). "Experimentation and risk-taking behavior, both in sexual behavior and in other health-related areas, are common at this stage and usually arise out of the developmental task of defining oneself socially"

(Alexander, et al., 1991, p. 1277). Adolescents look to their peers for recognition and acceptance of their behavior (Reedy, 1991). Although some teenagers in this age group have sexual intercourse out of curiosity, many have sexual intercourse out of a need to prove to themselves that they are lovable and accepted by their peers (Alexander et al., 1991). Generally, the literature has ascribed teenage pregnancy to teens' efforts to fulfill their needs for feeling loved or having someone to love (Steane & Heald, 1987). This perspective excludes the adolescent's own perspective of her experience.

The attitudes and behavior of peers are frequently cited as a factor influencing adolescent sexual behavior. Rogers and Rowe (1990) found that the behavior of siblings and best friends influenced adolescents' sexual behavior. Billy and Udry (1985) studied junior high school students to determine whether adolescents' best same-sex and best opposite-sex friends would influence their intercourse behavior. They found that the likelihood that respondents who were virgins would have sexual intercourse within two years increased if their friends were sexually experienced (Billy & Udry, 1985). While there appears to be a correlation between the adolescent and their friends' behaviors, it is unclear how individual adolescents are affected by their peers (Hardy & Zabin, 1991; Hayes, 1987).

Rather than seeking peer approval, late adolescents are more interested in forming an intimate relationship (Mercer, 1979a). In late adolescence, teens are also more cognitively mature. If pregnancy occurs, teens are better able to imagine their options and the consequences of their actions for their futures.

Choices for Pregnancy Resolution: Abortion, Adoption, or Keeping

"Adolescents who become pregnant have difficulty envisioning alternatives, evaluating alternatives via propositional logic, engaging in perspective-taking, and reasoning about chance and probability" (Gordon, 1990, p. 354). The adolescent uses a concrete form of decision-making to consider options associated with her pregnancy (Reedy, 1991). Some teenagers have reported that before they became pregnant they felt bored and saw few options for their futures; these teenagers hoped to find direction and purpose for their lives through their pregnancies and babies (Holt & Johnson, 1991).

Hatcher (1973) studied young women who had abortions, and suggested the experience of pregnancy and abortion is heavily determined by the stage-specific developmental conflicts of early, middle, and late adolescence. She found that young women who had abortions, experienced a variety of conflicts that were consistent with their developmental stage. In early adolescence, conflicts revolved around concern with body image as a

consequence of body changes (Hatcher, 1973). In middle adolescence, conflicts were centered around issues of independence. The adolescent was self absorbed in relationships with peers of both sexes (Hatcher, 1973). In late adolescence, the conflicts were centered around career goals and integration of a self-identity. These were issues for middle class adolescents with pregnancies ranging from 7 to 13 weeks (Hatcher, 1973). The interpretation of the findings from the study focused on the psychological development of the participants. This study did not take into account socioenvironmental influences affecting the teens' experience. Because the young women had made a decision to terminate their pregnancies they may have had a different perception of the experience than a teen who would decide to continue the pregnancy.

Zabin, Hirsch, and Emerson (1989) noted that approximately 40 percent of teenagers who get pregnant elect to terminate their pregnancies, but very little research has examined the effects of abortion compared to the effects of adolescent childbearing. Findings from their study indicated that the young women in the abortion group did not experience changes for the worse psychologically, in fact, they experienced fewer negative feelings than the other teenagers who chose to keep their babies (Zabin et al., 1989). Further research examining whether pregnant teenagers considered abortion as an option and exploring

decision-making by those who keep their babies may assist in illuminating these issues.

In a study of young women who choose not to abort, McLaughlin, Manninen, and Winges (1988) studied adolescents served by an agency with an open adoption policy. They found that adolescents from stable families with a higher socioeconomic status, and who felt they had more to lose by childbearing were more likely to place a child for adoption (McLaughlin et al., 1988).

Because a teenager is still dependent on her parents for some of her needs, she often experiences a conflict when she decides to continue her pregnancy, and keep her child. At times the conflict between the teen's needs and those of her fetus are intense. This conflict begins during pregnancy and continues after delivery. Sadler and Catrone (1983) presented a framework of observable adolescent behaviors that illustrate the conflicts between the teen's needs and those of her expected child. Seven developmental parallels of adolescence and parenthood were identified: (a) narcissism versus empathy with child; (b) egocentrism versus mutuality between mother and child; (c) identity formation versus maternal identification; (d) role experimentation versus maternal role definition; (e) formation of a sexual identity versus body-image changes associated with pregnancy; (f) emancipation from family versus reassignment of family role; and (g) transition from concrete to formal operations

versus problem solving and future planning skills necessary for child-rearing (Sadler & Catrone, 1983). The parallels were based on the author's clinical experience with adolescents living in an inner city neighborhood in the United States. Although, no mention is made of how the information was validated by the teens, the phenomena described are related to poverty and urban life, as well as the developmental tasks of adolescence and parenthood.

A developmental approach to adolescent parenthood highlights the practitioner's need to address the social, emotional, and cognitive issues that relate to the teenage mother's adjustment to the role of parent. Sadler and Catrone (1983) suggested that further research should be done to isolate these variables and to examine how they relate to the adolescent's adjustment to the role of parent. The adolescent's perception of herself as a parent begins during pregnancy. Researchers must focus, however, on the adolescent's perceptions of the early development of her maternal identity as a point which occurs during pregnancy. In the next section the responses of the health care system to adolescent pregnancy will be discussed.

Responses of the Health Care System

Concerns about early pregnancy and unintended child-bearing revolve around the immediate and long term impact

of the situation on the young woman, the child, the father, and other family members, as well as on society as a whole (Rothenberg & Sedhom, 1991). The impact of this phenomenon has been studied in terms of physical health issues, economic deprivation, marital instability, interrupted education, low socioeconomic status, child neglect and abuse, and implications for social policy (Moore & Burt, 1982; Rothenberg & Sedhom, 1991). Questions have been raised about whether current social and health care approaches to adolescent pregnancy are adequate.

The current health care system approaches adolescent pregnancy from three areas: prevention of pregnancy through education and contraceptive awareness, care of the pregnant adolescent, and interventions directed at decreasing repeat pregnancies in adolescence (Hayes, 1987). Each of these approaches have been evaluated for adequacy or inadequacy. The results of these evaluations and issues that affect health care delivery are discussed next.

Education and Contraceptive Awareness

Evaluation of preventative education programs has revealed that the reasons for teenage pregnancy are dependent on a number of interrelated variables (Hayes, 1987). Thomas et al. (1992) conducted an education program with 11 to 16 year olds in schools in Hamilton, Ontario. It was based on a

cognitive-behavioral model for preventing adolescent pregnancy. Evaluation of the 3,290 male and female participants revealed that "the program had no effect on rates of self-reported sexual intercourse, consistent use of birth control, or pregnancy" (Thomas et al., 1992, p. 49). But, the results did indicate that a number of different variables affected the sexual behavior of adolescent males and females (Thomas et al., 1992). The results indicated that education programs that do not address all the variables will not affect the rate of self reported intercourse and consistent use of birth control.

When medical care was added to an education program, a different result was found. Zabin (1992) evaluated a program that offered education, counseling, and medical services to 3,944 junior and senior high school students using a quasi-experimental design. A social worker and a nurse-midwife or nurse practitioner offered reproductive health education in the school in the morning, and contraceptive services in a nearby clinic in the afternoon (Zabin, 1992). The program was evaluated by survey questionnaires that compared students in other nontreated schools with students who had received combined education, counseling, and medical care. Records kept in the clinic were also used as a source of data. The results indicated that adolescents using the program postponed the onset of sexual intercourse, increased their

use of effective contraception, and reduced their rates of unintended pregnancy (Zabin, 1992).

Miller and Paikoff (1992) compared adolescent pregnancy prevention programs, and suggested that the difficulties experienced with designing and implementing programs to change behavior are similar to the difficulties experienced when trying to draw conclusions about the effects of the programs. In order to measure the effects of adolescent pregnancy programs, valid and reliable measures of sexual behavior, contraceptive use, and pregnancy resolution are required. Three of the most common problems with collection of this data are: parents who refuse to allow their teens to participate, nonvoluntary sexual experiences, and confusion about the wording of questions (Miller & Paikoff, 1992). Evidence to date indicates that modest reductions in the number of adolescent pregnancies can be achieved by prevention programs. There is still a gap in knowledge about how adolescents' socialization and cognitive growth affects their social skills (e. g., assertiveness and responsibility) and sexual activity.

At present, the health care system's response to adolescent pregnancy has decreased the number of late adolescents who become pregnant, but the number of early adolescents who become pregnant has increased (Flick, 1991; Hayes, 1987). This indicates that health care professionals may not adequately understand the perceptions of early adolescents who get pregnant.

Care of Pregnant Adolescents

Another area of health care service is the prenatal care of pregnant adolescents. Prenatal care has been evaluated by several researchers (Gale et al., 1989; Piechnik & Corbett, 1985; Smoke & Grace, 1988;). Piechnik and Corbett found that low birthweight can be ameliorated by a program that addresses the social, psychologic, and nutritional needs, and specific health problems of young pregnant women. Smoke and Grace's research provided further support for the premise that specialized prenatal care for pregnant adolescents has a positive influence on the outcome of the pregnancy for mother and infant. Gale et al. suggest that age is not a risk factor for teenage pregnancy, rather social and economic variables influenced the outcome for mother and infant.

Although many program interventions have been developed and implemented, few have been rigorously evaluated to identify outcomes and effectiveness. Hayes (1987) identified the lack of clearly defined objectives for measuring outcomes, and the failure to distinguish direct and indirect outcomes as the reason why evaluation data is missing. While comprehensive care programs have the potential to effectively help adolescents with the experiences of pregnancy, birth, and the first months of parenthood, there is no evaluative data that indicates the effects are long lasting (Hayes, 1987). The literature does not address

how variables in the adolescents' environments influence their perceptions of the pregnancy experience. More research is required to better understand how programs can address the problems young people experience in their lives while they are pregnant. Research indicates, young women who seek prenatal care early, can experience improved outcomes for themselves and their infants. Some adolescents, however, do not seek care until late in their pregnancies. All of the reasons why young women do not seek early prenatal care remain unclear and need to be further explored.

Interventions for Decreasing Repeat Pregnancies

Young women who begin having intercourse at an early age are at risk for repeat pregnancies in their teens, because they do not use, or ineffectively use contraceptives and have more years of sexual activity (Bassolone, 1989; Flick, 1986). Considering that teens under the age of 15 have a higher rate of abortions than births, research is needed to look at the issue of repeated pregnancies and not just those teens experiencing repeated births (Bassolone, 1989). Understanding adolescents' perceptions of pregnancy could provide information about why adolescents have repeated pregnancies in their teen years, which could assist health professionals to better understand this phenomena.

Issues that Need to be Addressed

The literature has identified the following issues that need to be addressed: barriers to successful program implementation, and variations in program utilization. Rothenberg and Sedhom (1990) identified the following barriers to successful program implementation: poor coordination, insufficient resources, inadequate access, and incomplete program information. Nichols (1991) also noted that with the exception of prenatal health care programs, prevention programs have been inadequately evaluated in relation to effectiveness and costs. Despite the voluminous amount of research on adolescent pregnancy, there is relatively little information on how the negative effects of adolescent pregnancy and childbearing can be minimized (Nichols, 1991). Without this information, there is not a firm scientific base for developing programs for prevention of adolescent pregnancy (Nichols, 1991).

The World Health Organization (1989) attributed a lack of involvement by young people in existing programs to the widespread lack of effective policies and programmes in relation to adolescent reproductive health care. Rothenberg and Sedhom (1991) acknowledged that nurses must be knowledgeable about policies relating to teenage pregnancy if they are to effectively use resources and participate in developing social policy and programs. Two priorities identified for nurses were:

(a) assistance with child care so that the young parents can continue their education or seek employment, and (b) outreach services to reduce early pregnancies (Rothenberg & Sedhom, 1991). Programs for pregnant adolescents need to incorporate five goals. First, early prenatal care must be provided to monitor complications for both mother and fetus. Second, nutritional counseling and supplements must be provided to reduce the effects of poverty. Third, educational and employment counseling is needed to enhance or optimize adolescent development. Fourth, support network building should be included with professionals, family, and friends. And fifth, the abilities of young women to care for their babies should be maximized (Rothenberg & Sedhom, 1991). Rothenberg and Sedhom acknowledged that in view of constantly changing societal values, policies and programs need to be evaluated frequently.

The literature also addresses the limited participation of pregnant adolescents in programs developed by professionals (Bergman, 1988; Wells, McDiarmid, & Bayatpour 1990). Researchers evaluating programs have found that some programs have been based on unsubstantiated assumptions about teenagers' actions, such as lack of sex education or access to birth control, or a low self esteem (Miaoulis, 1989; Stafford, 1987). These assumptions have not been based on research which addressed the adolescent's perspective. Burke and Mensah (1985), also noted there is a lack

of coordinated planning of health programs designed for pregnant adolescents, which results in a lack of program size, scope, and flexibility to meet the complex needs of these young women.

If prenatal care programs are designed to meet adult women's needs, young women will not participate. Young women have different prenatal care needs than older women. This has been explicated by Kelen, Hunt, Sibeko-Stones, and Varga (1991) who identified the following complex needs of young women: physical and emotional isolation, lower educational levels, restrictions on individual choices, and limited financial resources. Therefore, adolescents need special services. Brown and Urback (1989) have suggested that high risk teens need services that include: counseling, medical care, prenatal groups, school, parenting groups, nursery, housing, clothing, and respite care.

Bergman (1988) reported that issues of accessibility, stigma, and informal networks of support are factors that explain the variations in program utilization by pregnant teens. Many of the pregnant adolescents in her study were receiving informal support from family, boyfriends and friends. They reported they did not need or want special services designed for them (Bergman, 1988). Bergman noted the importance of investigating the needs and desires of adolescents as they perceive them, so that future program planning can incorporate these. Adolescent clinics will not be used if teens are not aware of them, feel they will be

labeled as deviants, or are too embarrassed to ask about services. Bergman suggested that the traditional perception of the doctor as the sole caregiver must change to include appropriate nonmedical service programs as well.

Mercer (1979c) pointed out that whether adolescents utilize a health care facility is dependent on factors, such as what the teen perceives as a health care need, accessibility, and whether the system's characteristics are congruent with the developmental tasks of adolescence. Adolescents seeking health care services want their privacy and issues of confidentiality respected. For example, a 15-year-old requesting the birth control pill will want to know if the health care provider will respect her wishes by not informing her mother that she is taking the pill. Middle adolescents are concerned about how they appear to others and want to know that others are truly concerned about them as persons (Mercer, 1979c). As adolescents strive to achieve independence they want to make their own choices and may rebel against parents or health care professionals who try to impose choices on them (Mercer, 1979c; Morgan & Barden, 1985).

Elster, Lamb, Tavaré, and Ralston (1987) studied the medical and psychosocial effects on adolescents in a program which provided a comprehensive adolescent pregnancy and parenthood program. They found that factors that were present prior to conception influenced a teen's ability to cope with the reality of

pregnancy, and her ability to adjust to parenthood. These factors included: socioeconomic status of the teen's parents, whether the teen received Medicaid, whether the teen was in school or working at the time of conception, maternal age, the week prenatal care was started, and the teen's relationship with the baby's father (Elster et al., 1987).

Limited data collected on teens' perceptions and their relationship to underutilization of programs supports the criticism that a discrepancy exists between teens' and health care workers' perceptions of the experience. Further research is required to explore teens' perceptions of their experience of pregnancy.

Summary

In this chapter, literature relevant to adolescent sexuality and pregnancy was reviewed. Initially, the literature on adolescent growth and development was described. The tasks of adolescent growth and development have been identified as: gaining comfort and acceptance with body image, internalizing a sexual identity role, developing a personal value system, preparing for productive citizenship, striving to achieve independence from parents, and developing an adult identity (Mercer, 1979a; Johnson, 1986). The literature indicated that adolescents experience sexual maturity and cognitive development at different rates which can lead to conflicts (Mercer, 1979a; Reedy, 1991). The research

identified discrepancies between biological and psychosocial development that influence adolescents' decision-making about sexuality and which can result in pregnancy (Alexander et al., 1991; Mercer, 1979a; Reedy, 1991). The event of pregnancy has been characterized by four tasks: pregnancy validation, accepting the baby as part of their body, acknowledging the baby is an individual, and becoming a care-giving mother (Barr & Monserrat, 1986; Rubin, 1975). The literature on pregnancy in an environmental context was reviewed. The environmental factors of poverty, family, and peers were examined. The coping behaviors used by adolescents during pregnancy were related to their maturational stage. Behaviors were influenced by their beliefs, and the social situation and circumstances in which they live. Lastly, the types of responses of the health care system, the adequacy or inadequacy of existing programs were assessed, and the current understanding of the issues that need to be addressed were critiqued.

In summary, despite the abundant research relating to pregnant teenagers, there is relatively little understanding about how the adolescent female perceives her pregnancy experience. There is a paucity of nursing literature describing the adolescent's perspective. Therefore, the study of the female adolescent's experience of pregnancy can provide information

necessary to better enable health care professionals to plan programs and provide care appropriate to their needs.

Chapter Three will describe the research method which enabled the researcher to investigate the female adolescent's experience of pregnancy.

CHAPTER THREE

METHODS

Introduction

Adolescent females who become pregnant have an experience that differs from adult pregnant females. They experience two developmental events simultaneously: adolescence and pregnancy. Although special programs have been developed by health care professionals to attempt to meet their needs, concern remains as to the appropriateness and effectiveness of these programs. Obtaining information about the meaning of adolescents' experience of pregnancy can provide information so that health care can be evaluated and changed.

The question addressed in this study was: What is the experience of pregnancy from the female adolescent's perspective? The research question is posed at the descriptive level, and requires a description of a specific phenomenon of human experience from the client's perspective. Phenomenology is an inductive, descriptive method that allows the researcher to investigate human experience as it is lived (Omery, 1983). Therefore phenomenology was the appropriate method to address this study's research question. Phenomenology enabled the researcher to provide a rich detailed description of the female adolescents' experience of pregnancy.

CHAPTER THREE

This chapter briefly outlines phenomenology as a method and describes the process employed in the study design, including sample selection and criteria, ethical considerations, data collection and analysis, and issues of scientific rigor for qualitative research. The chapter concludes with a summary of the characteristics of the participants.

The Phenomenological Perspective

The origins of phenomenology are in philosophy, it first appeared in the writings of Brentano in the last half of the 19th century (Ray, 1990). In the early 20th century phenomenology was further developed as a method by the German philosopher Edmund Husserl, who related phenomenology to the question of knowing (Ray, 1990). Merleau-Ponty, a French philosopher further expanded the method to focus on the perception of lived experiences (Oiler, 1986). Field and Morse (1985) have identified the goal of phenomenology to be the accurate description of the experience of the phenomenon under study, as opposed to the generation of theories or models, or the development of general explanations. The phenomenological research orientation differs from empirical research, in that it generates hypotheses, rather than testing hypothesis (Knaak, 1984). Oiler (1982) acknowledged that the nursing profession is concerned with the client's quality of life and the quality of the nurse-client relationship.

Phenomenology is consistent with a collaborative nurse-client effort that supports the individual's right to exercise control over his or her own health care (Oiler, 1982). The value of the phenomenological method lies in its holistic approach; that approach can effectively assist nurses in their goal to understand the experience from the individual's perspective who is living it.

Selection Criteria and Sample Selection

The sample was selected to be consistent with the requirements of the phenomenological method. Because researchers interested in phenomenology want to describe the meaning an experience has for those who are living it, they choose informants who have specific characteristics or knowledge that enhances the researcher's understanding of the experience (Field & Morse, 1985). The purpose of this study was to describe the experience of pregnancy from the adolescent's perspective. Initially, the plan was to interview young women, from a variety of social backgrounds who were experiencing pregnancy for the first time and were willing to talk about their experiences. This selection process sought the maximum illumination of the richness of individual experiences. In reality, there were few pregnant adolescents who met the study criteria and chose to carry their pregnancy to term. Thus, the study population ultimately consisted of a similar group of young women who were carrying a

pregnancy to term for the first time, and who were willing to talk about their experience.

Selection Criteria

Criteria for selection of study participants were determined prior to recruitment. To meet the study criteria, adolescents were:

1. in their last trimester of pregnancy (i. e., 33 to 40 weeks gestation),
2. able to read English,
3. 13 to 16 years of age,
4. not married, and
5. currently planning to keep the baby.

It was decided to interview young women who were in their last trimester of pregnancy, because they would have had a chance to have worked through their acceptance of the pregnancy. Therefore, they would be able to describe their perceptions of the experience more fully than if interviewed earlier. Young women were excluded from the study if they had already delivered their babies. One young woman who met the study criteria was not interviewed because she had delivered her baby the previous week.

Sample Selection

The sample of pregnant adolescents was drawn from an outpatient clinic of a tertiary facility and from three programs in the Vancouver Lower Mainland that offer services specifically to pregnant teens. Agency and program personnel recruited the young women for the study. Prior to the recruitment of the young women, the researcher met with the nurses in the outpatient clinic and provided information about the study. A Letter to Agency Personnel (Appendix A) was distributed to the nursing staff. This contact with the staff enabled the researcher to enlist the assistance of the staff and to involve them in the selection of the participants. A synopsis of the research proposal and copies of all consent forms and the trigger questions, as well as a list of the sampling criteria were left with the nurses in the clinic. A Letter to the Attending Physician (Appendix B) was also provided to be placed on the client's hospital chart so that the doctor would be apprised of the client's involvement in the research project.

The researcher also met with the program leaders of the selected programs to clarify their involvement in the selection of the participants. A Letter to Agency Personnel (Appendix A) was distributed to each program leader. In addition, a synopsis of the research proposal, copies of all consent forms and of the trigger questions, and a list of the criteria for recruitment of the young

women, were provided. At weekly intervals, the facilities were contacted to determine if any young women who met the study criteria were available for the study.

The clinic staff and program leaders were instructed to give the introductory letter to those clients who met the study criteria. Then, the nurses and program leaders were to describe the study briefly for the young woman, to provide her with a copy of the Letter to the Participant (Appendix C), and to determine if the young woman was interested in participating in the study. Each young woman then contacted the researcher or gave consent for the researcher to contact her.

The investigator followed up the initial contact by contacting each young woman to explain the study further and to obtain consent prior to each first interview (Appendix D). The researcher clarified her purpose: to interview the client and not to provide treatment. If a young woman was living at home, parental consent was obtained (Appendix E). Recruitment of participants for the study was complicated by the fact that some young women were "wards of the court", in which case consent of a young woman's social worker had to be obtained.

Recruitment of the young women and completion of the first interviews took place over six months. In retrospect the long recruitment period is not surprising, considering the difficulty accessing a small target population.

The sample size remained small, but that is consistent with the method. By coincidence, six of the young women had lived on the street in the previous year. This is a group who normally are not readily accessible nor involved in research.

It was difficult to predetermine the number of subjects required to describe the phenomenon of interest. Initially eight to twelve subjects were viewed to be adequate. For this study, eight female adolescents were interviewed. The sample size was determined by the number of informants necessary to describe the phenomenon that was being investigated. Guba and Lincoln (1981) noted that data collection can be ended when redundancy occurs or when only a small amount of new information is acquired with a substantial effort; they referred to this as saturation. Saturation of the data in relation to the phenomenon occurred when the same information was repeated in the interviews. The researcher noted after interviewing the sixth participant, that themes were starting to recur in the data. The data were beginning to reach saturation, but interviews continued to include an eighth participant.

The adolescents in this study were an especially difficult group to access and retain; they came from problem families and moved frequently. In addition some young women were not interviewed a second time, because they could not be located. Mercer (1991) acknowledges that attrition of subjects is a critical

problem for researchers studying pregnant adolescents and their families.

Procedures for the Protection of Human Participants

The issue of protection of human participants was addressed by following the guidelines established by The University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects (1989). Approval to conduct the study was obtained from The University of British Columbia Behavioural Sciences Screening Committee and from the Research Coordinating Committee of the hospital in which the outpatient clinic was located.

The young women were informed their participation in the study was voluntary and they were free to withdraw from it at any time. They were reassured that refusal to participate, a decision to withdraw from the study, or refusal to answer any questions would not jeopardize their health care. One young woman requested that specific information she had talked about with the researcher be removed from the tape; the researcher erased that section from the tape prior to transcription.

During the interviews, the researcher was cognizant that the young women might be upset by discussing their experiences, in which case a referral to an outside agency would be necessary. In reality, the young women had available resources in the form

of supportive program leaders and social workers, and no referrals were made.

The interviews were conducted at mutually agreeable locations. A copy of the consent form was given to each young woman (Appendix D). There were no known risks to the participants associated with the proposed research. On the contrary, the young women indicated that they benefited from their participation in the research and appreciated talking about their experiences with the nurse researcher. The young women dedicated between two and three hours of their time for the interviews. There was no monetary compensation.

Only the researcher and the thesis advisors had access to the data to maintain confidentiality. No personally identifiable information was included in the transcripts; the identity of the participants was coded, so that their true identity would only be known by the researcher. All data were kept in a locked file. Following completion of the study, the tapes and transcripts were destroyed by the researcher.

Data Collection and Analysis

In the subsequent sections data collection and analysis are discussed. The phenomenological method requires that data collection and analysis occur concurrently.

Data Collection

Data were acquired in two sets of interviews set up by the researcher. Interviews were conducted in a mutually agreed upon interview location, usually at a young woman's place of residence. The purpose of the first interviews was to develop rapport and to elicit the young women's descriptions of their experiences. To avoid jeopardizing rapport, sensitive questions about demographic information (Appendix F) were asked of each young woman at the end of the first interview. To elicit a young woman's viewpoint, the investigator used trigger questions (Appendix G). "The types of questions included are meant to be [a] provocative and creative means of getting informants to talk about their experience of the phenomenon" (Swanson-Kauffman & Schonwald, 1988, p. 100). The open-ended trigger questions were used to initiate conversation about a topic or to stimulate further exploration of the phenomenon. Reflective statements and requests for clarification were used to collect more "rich" data. For example, "When we talked before you were concerned about telling the baby, after she grows up, that you were a teenager when you had her--why?" "Tell me more about your feelings about this." Field notes were used to record the researcher's observations of the young woman, the environment, and the interview. The interviews ranged in length from approximately 40 minutes to 75 minutes. First interviews were done with eight young women. Two young

women moved away and were not available for a second interview. One young woman's baby required major surgery one month postpartum, and she declined a second interview. Five young women were interviewed a second time, with 5 to 16 weeks between the first and second interviews.

During data collection the researcher addressed the issue of the reluctant informant. One young woman was uncomfortable with talking at length about her experience of pregnancy; to facilitate this interview, the researcher found it helpful to ask more direct questions, such as: "How did that make you feel?" "Can you tell me more about ___?" "In what way do you see that?" "What was ___'s reaction?" "Why did you feel sad?" Field and Morse (1985) compared the bias of the reluctant informant to that of the "non-response rate". In qualitative research, some lack of response is to be expected and may be accepted as falling within "normal" limits. A clear description of those who refused to participate in the study can lend credibility to the study. The researcher did not encounter any young women who refused to participate in the study, but on one occasion a social worker refused consent for a 15-year-old female who was a "ward of the court" because she felt the young woman was too vulnerable to participate in the study.

The quality of the data in qualitative research reflects the participants' ability to articulate their experiences clearly and the

researcher's ability to gather the data relevant to the research question accurately and exhaustively. The young women were initially shy, but as each interview progressed they became more comfortable with the researcher and talked more freely about their experiences.

Initially, the researcher found it difficult to listen to the young women without interrupting with questions, but with practice, the researcher was able to listen to the young women and ask reflective questions that got at the deeper meaning the experience had for them. The investigator found that if too many questions were asked at once, the young women became confused and had difficulty responding. To remedy this situation the researcher repeated the questions one at a time or reworded questions in a less complex manner. For example, the first interview was started with: "So I'm basically interested in things like what is it like for you to be pregnant, what are your expectations about your pregnancy, how your pregnancy has changed your life, how you see it will affect you later on." The young woman had difficulty responding, so the questions were asked one at a time.

"Empathic and intuitive awareness" can be intentionally used by the researcher to enhance data collection (Oiler, 1982, p. 179). Allowing close relationships to develop between the researcher and the young women, resulted in the young women feeling the

researcher was truly interested in what they had to say, and in each expressing her concerns without fear of being judged. An example of an empathetic response occurred when one young woman shared how she had been rejected by her boyfriend following confirmation of her pregnancy. The researcher communicated that she understood that it was a difficult time for the young woman, but did not persist with questions when the young woman indicated she did not want to discuss it further.

Because she was cognizant that the young women might reveal certain information in one social context but not in another, the researcher chose interview locations and settings that would allow for privacy. For example, on one occasion, a young woman met the researcher in a restaurant, but this was a public place where the conversation could be overheard. Therefore, under the circumstances, the researcher suggested that the interview could be conducted in her car to maintain privacy and to allow the young woman to talk freely about her experience without fear of being overheard. The researcher was cognizant of the vulnerability of the adolescents when conducting the interviews. If the young women stated they did not want to discuss a topic or answer a question, their wishes were respected.

The interview transcripts were typed verbatim, by the researcher, using suggestions from Field and Morse (1985), and Reinman (1986). Typing the transcripts enabled the researcher to

become very familiar with the data of each interview. All exclamations, such as expletives and laughter were included. Pauses were denoted by dashes, and a series of dots indicated prolonged pauses or gaps. The interviews were typed single-spaced with a blank line between the researcher and participant, on sequential pages. Wide margins were left on the left side of the page for coding and on the right side for comments.

Field notes documented information about the interview setting, the young women's nonverbal communication, and the researcher's impressions. For example, nonverbal communication included one young woman rubbing her abdomen when she was talking about plans that she was making for herself and the baby, indicating acknowledgement of the fetus. On another occasion, the field notes identified who was present during the interview; specifically, because a foster mother was present the young woman was reluctant to talk about her relationship with her natural mother. Such notes were made immediately following the interview, because it was found to be distracting to the young woman if information was recorded during the interviews.

Following the first interview, the questions that were asked were reviewed by a thesis advisor and suggestions for improving the approach to questioning were incorporated in subsequent interviews. For example, a thesis advisor suggested the

researcher needed to ask deeper questions in order to access the data, so that the meaning the young women gave to their experiences could be more fully understood. So that: "Do you think that your family influences how you think about how you want to live after you have had the baby?" became: "Why do you think your childhood might have an effect on how you will mother your baby?" "What about your childhood makes you feel unsure about having a baby on your own?".

Data collected during the first interviews formed a tentative picture of what it was like to be an adolescent and pregnant. For example, it was a shock for the young women to find out they were pregnant. They were both scared and excited when they suspected they were pregnant. Prior experiences influenced how they felt about their pregnancies. They indicated they were unsure if they would be able to be all that was expected of a mother, but felt becoming pregnant gave their life new meaning.

In the second interviews, questions refined the data so that further abstraction of the data could occur and so that the meaning of the experience began to emerge. The researcher asked the young women to explain further their feelings and perceptions. Interpretations made by the researcher were validated with the young women. For example, the researcher asked a young woman how becoming pregnant had changed her life to a more positive course. The young woman was able to

respond to this theme by stating that it had allowed her to go back to school and make plans for her future rather than partying. "It gives you a reason to live for . . . Before I had him the biggest thing was going out and partying, being with my friends. And school wasn't one of those things, and not being responsible. And now that I have him I can get my education, at least I can do it, it's just with him it will take longer."

Because time elapsed between the first and second interviews, and the young women had delivered, the pregnancy experience blended into the adjustment to the parenting role. In the second interviews the young women also wanted to talk about how the baby was affecting their lives at present.

Concurrent Data Analysis

Field and Morse (1985) described the purpose of data analysis as twofold: (a) coding of the data so that categories can be recognized, and (b) developing a flexible data filing system that allows data to be retrieved from storage. In this study, the data were coded according to meaning units based on the significant statements, using Giorgi's (1985) method of data analysis.

Giorgi 's (1985) method of data analysis was chosen because it allowed the researcher to collect a naive description of a phenomenon from an individual via an interview (Omery, 1983).

Giorgi's method was used to develop a framework of themes from the interviews. This framework began by extracting significant statements, which were later transformed to meaning units. These significant statements were complied into lists for storage of the data. For example, the young women talked about family and friends who were supportive and nonsupportive. Supportive family was a heading for the following significant statements:

"My mom and step-dad really supported me a lot."

"[my mom] she was just there once I told her."

"My mom was the most support I had there."

"My mother was really understanding."

"My brother has actually been very understanding about it."

The meaning units were then clustered together to form subconcepts or phases that expressed explicit or implicit meaning. The subconcepts clustered as concepts, and the concepts were synthesized into broad themes that captured the essence of the participants' total experience. Each step of the analysis was guided by two concerns: (a) to characterize the essential meaning of the participants' descriptions of adolescent pregnancy, and (b) to remain as faithful as possible to the participant's original description (Reinman, 1986). The four steps of Giorgi's (1985) method of data analysis were followed: (a) the entire description of the experience was read to get a sense of the whole; (b) the description was read again to identify units of meaning in the

experience and to eliminate redundancies; (c) the subject's expressions were transformed into scientific language; and (d) the insights were integrated and synthesized into a descriptive structure to be communicated to other researchers (Giorgi, 1985).

First, to be able to read the entire description, the researcher had to transcribe the audio-tape recorded interviews. Transcription also provided an opportunity to become familiar with the data of each interview. Field notes were consulted to recall the atmosphere of the interview and impressions of the researcher at the time of the interview. After these activities, the researcher read the entire transcript while listening to the audio-tape to get a sense of the whole interview. The transcripts usually required three readings. Giorgi (1985) acknowledged that transcribed interviews may take several readings to get a sense of the whole.

The general sense that was grasped from the reading of the whole provided a basis for the next step: discrimination of the meaning units. The meaning units were discerned by reading and rereading each transcript and noting significant statements and then reflecting on the meaning of the significant statements for each young woman. Therefore the meaning units were derived from significant statements--phrases or sentences that could be extracted from the transcriptions--that exemplified the phenomenon being studied. The meaning units were listed in a column to the left of the data on the transcript. To the right of the data,

points for clarification in the second interview were noted on the transcript.

Points for clarification were used to make a list of new questions. These new questions were about specific concerns the young woman had discussed. New questions, in one case, concerned one young woman's relationship with her mother. "I'd like to know more about what it was like for you to live with your mother--the privacy and independence you felt." As well, general questions about the emerging meaning units and themes were asked of all the young women. In the second interviews, the young women were asked to validate whether or not the themes were similar to their experiences. If a theme did not seem relevant to data collected from a young woman previously, she was asked about the validity of the theme. Questions were also used to formulate meanings identified in specific statements. For example, "What about being pregnant was scary for you?" was used to assist in formulating meaning from her statement that she was scared about the pregnancy.

After the meaning units were explicated more clearly from significant statements and further questions, they were clustered to form subconcepts or phrases that expressed meaning. The subconcepts then clustered to form concepts. For example, although one young woman stated that being pregnant had changed her life, because she had to grow up quicker, and

although she had questions about her future, her description did not approach the complexity described by concepts such as experiencing a changed life. Subconcepts included experiencing hope, caring for the infant, caring for herself, changing living arrangements, and coping with the maternal role. The explicated meanings emerged during analysis from each young woman's description of her experience of pregnancy. These were validated in the data. In the first step, the language of the young woman had remained unaltered, but the meaning units moved beyond the significant statements. With subsequent analysis, the explicit or implicit meanings were explicated further; for example, living with the bodily changes included: "breasts got different, like totally different shapes", and "I'm always hot", and "I'm not used to carrying around all that extra weight".

This process became more complicated as the interviews progressed. The researcher compared one young woman's account to another young woman's account in order to identify and extract the common meaning units from each, and to ensure that the analysis was consistent for all the interviews. Then the extracted meaning units were compared to the transcripts. For example, the meaning unit of supportive friends included significant statements such as: "all my friends really supported me". Another young woman's account revealed similar significant statements: "and my

friends just listening, no one really judging . . . that is what helped me".

In step three, the young women's everyday expressions were transformed into language that provided a general description of the phenomenon being investigated. The researcher used both reflection and imaginative variation to transform the experience from the everyday language of the young woman to the psychological language of the researcher (Giorgi, 1985). The researcher interpreted what the young women had said about their experiences. It was both difficult and time-consuming to reflect on each meaning unit and to consider how each meaning unit could be explicated by concepts at a higher level of abstraction. For example, the young women's descriptions of what it was like to be pregnant--accepting the pregnancy, living with the bodily changes, forming a self-identity, thinking about pregnancy and parenting, dealing with support and lack of support, dealing with social and environmental influences--were transformed into living the reality of the pregnancy.

During step three discrepancies between extracted meaning units were also noted. For example, some young women felt their pregnancies had made them mature. One young woman disagreed that she had matured as a result of her pregnancy; instead, she stated she still wanted to be a teenager rather than an adult. Discrepancies were included as they addressed typical and

atypical elements of the data, and thus ensured that the description would be representative of a variety of experiences rather than a single experience. The discrepancies also helped the researcher by increasing insight into ambivalence because these feelings captured the tension between coping with adult responsibilities and remaining a teenager. Once the researcher had incorporated the discrepancies, then themes were extracted to provide a general description of the phenomena.

Second interviews were conducted to validate information compared across interviews and to clarify the description. For example, "From doing interviews with other young women of your age I understand that it was a shock for them to find out they were pregnant. Does this sound like your experience? How was your experience the same or different?" During this stage the data were refined and the accuracy of the language used to describe the phenomenon was increased. The meaning units clustered into subconcepts, the subconcepts clustered into concepts, and these clustered into themes. For example, not expecting the pregnancy to occur, and initially denying the pregnancy emerged as subconcepts. The subconcepts clustered to form the concept of suspecting the pregnancy. The concepts evolved into phases, which linked the concepts together and represented the dynamic qualities of the young women's descriptions. The phases identified were entitled: suspecting the

pregnancy, confirming the pregnancy, making decisions about the pregnancy, living the reality of the pregnancy, and experiencing a changed life. These concepts were synthesized into the themes of ambivalence and adolescent pregnancy as a life change event, which captured the adolescents' total experiences. The young women reflected on how pregnancy had changed their lives in part by describing their plans for the future. They felt positive about their pregnancies and stated that their lives would be improved by having a baby, at the same time they often felt ambivalent about the changes happening in their lives.

An important step in the analysis that allowed the description to evolve was the researcher's ability to synthesize themes from the participant's perceptions and intentions (Giorgi, 1985). The theme of ambivalence interwoven with the five phases of adolescent pregnancy as a life change event described the essence of the experience for pregnant adolescent females. The theme of ambivalence was integral to pregnancy as a life change event, and varied from high to low during the five phases of adolescent pregnancy, as the adolescents struggled with the overlapping tasks of adolescence and pregnancy. The phases indicated that the experience was progressive for the young women. The two themes that captured the participants' total experiences (ambivalence throughout adolescent pregnancy as a life change event) subsumed the concepts and subconcepts and

were validated in the data. The researcher then created a diagram which illustrated the themes and concepts. The interwoven nature of the themes is represented, as well as the conflict the young women experienced between their tasks of adolescence and pregnancy.

Finally in step four, the researcher explicated the structure of the phenomenon by writing the description. The description incorporated the themes, concepts, and subconcepts identified from all the data. Swanson-Kauffman and Schonwald (1988) have acknowledged that transforming the data of multiple informants' accounts into a theoretical model of a phenomenon is an intuitive process. They liken this process to trying to say how you know something and when you first recognized you knew it. "Intuiting concepts of the final model is an exercise that involves continuous critical reflection and discussion of the concepts as they emerge from the researcher's experience of the multiple informants' reality" (Swanson-Kauffman & Schonwald, 1988).

The researcher found that it was necessary to return to the interview transcripts to maintain clarity and validity, so that the themes represented their lives as the young women had described them. The researcher bracketed her personal perspectives throughout the analysis to decrease the potential for researcher bias. The emerging themes and the connections between the

themes became more obvious after the rereading, intuiting, and reflection.

One pitfall that can arise during the data analysis is data shuffling; that is, the researcher may shuffle the data from concept to concept if the data do not create a "total picture" representing the experience of the participants. Ammon-Gaberson and Piantanida (1988) note that qualitative data, unlike quantitative data, which lend themselves to clear-cut classification in mutually exclusive categories, often have more than one salient characteristic that could potentially fit into several different categories. To move beyond data shuffling, the researcher sought assistance from her thesis advisors in relation to phenomenological data analysis to ensure that the analysis was being performed correctly. Field and Morse (1985) noted that, during analysis by repeatedly comparing the interview data, the investigator can identify when categories are saturated and no new information is being identified. After the interview of the eighth participant, the researcher noted that no new information was emerging.

Presentation of phenomenological research data decrees that the "rich" data from the interview subjects be communicated in a way that the reader is able to identify with the description of the individual lived experience. Knafl and Howard (1984) stated: "Presenting and discussing specific results in the context of their theoretical relevance demonstrates how conceptual formulations are

grounded in the data" (p. 23). The researcher synthesized an integrated picture from the data by organizing aggregate formulated meanings into clusters of themes and linking these to a body of literature that yielded a construct useful to a professional audience (Ammon-Gaberson & Piantanida, 1988). The findings from this study will present an overall picture of the experience of an adolescent female who becomes pregnant.

Scientific Rigor in Qualitative Research

Four areas for measuring rigor in scientific inquiry, whether it is quantitative or qualitative, have been identified as: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality (Guba & Lincoln, 1981; Sandelowski, 1986). For quantitative research, truth value refers to internal validity, applicability to generalizability, consistency to reliability, and neutrality to objectivity (Guba & Lincoln, 1981). For qualitative research Guba and Lincoln, and Sandelowski have identified four specific factors: (a) credibility, (b) fittingness, (c) auditability, and (d) confirmability. These factors maintain an analogous position: credibility refers to truth value, fittingness to applicability, auditability to consistency, and confirmability to neutrality. The strategies used to achieve these four factors in this study are described.

Credibility

Credibility refers to the truth value of the study, that is the explication of subjects' perceptions of their experiences rather than the researcher's perceptions of them (Giorgi, 1985; Sandelowski, 1986). Credibility is established when participants or others who are experiencing the phenomenon immediately recognize descriptions and interpretations as capturing their experiences. The researcher asked the young women in the second interviews whether examples taken from the collected data and interpretations sounded like their own experiences. In general, the young women agreed that the description was similar to their experiences, and further explicated their feelings. One young woman described how reflecting on her future with her new baby was intertwined with ambivalence: "I'm just scared that this will not work out, that I will end up ruining his life and my life. That is my biggest worry, that I will some how not be able to do it, but that is why I wanted lots of support--emotional, financial--when I started out."

Knaack (1984) has noted that researchers need to make explicit their assumptions, preconceptions, and presuppositions about the research topic in writing to avoid misunderstanding the phenomenon as it exists for the individual--a process known as bracketing. Bracketing was accomplished when the researcher wrote notes on her thoughts about working with adolescents and

adolescent pregnancy, prior to beginning the interviews and afterwards. For example, the researcher did not think that all adolescents viewed their pregnancy as a negative experience, and thought that adolescents were sensitive to how others viewed them, and were, thus, wary of approaching health care professionals for help with their concerns. She believed that it was important to communicate interest in and acceptance of the teenagers' concerns. She recorded and bracketed her thoughts so that any indications of these perceptions reflected the adolescents' own lived experiences. For example, during the interviews the researcher wondered about the meaning of the young women's relationships with their older boyfriends--whether they were meeting different emotional needs. The researcher felt strongly that the young women had different emotional needs than their boyfriends; bracketing was used to allow the researcher to concentrate on what the young women were saying about their experiences, as opposed to the researcher's own concerns.

The researcher also recorded impressions during the interviews and data analysis. For example, the researcher noted that during the first interview she did not ask the young woman how old her boyfriend was. Because the researcher had prior experience working with young people who lived on the street, she was careful not to ask too many probing questions, which

have had the effect of increasing the youth's distrust and interfering with rapport.

A threat to the credibility of a study is "going native". Going native, refers to the researcher becoming so enmeshed with the participants that he/she has difficulty separating his/her own experience from that of his/her participants (Sandelowski, 1986). The researcher avoided going native by maintaining some distance from the participants and by carefully recording and reflecting on her feelings when conducting interviews and data analysis. For example, after completing several interviews the researcher noted that she was struck by the young women's resiliency, despite the difficulties they had experienced in their lives, and noted this in her field notes.

Fittingness

Fittingness refers to the degree to which findings from a study can fit into other persons' experiences outside of the context of the study situation (Guba & Lincoln, 1981). To achieve fittingness, the researcher needed to avoid two major threats identified by Sandelowski (1986): holistic fallacy, and elite bias. Holistic fallacy refers to conclusions that do not contain all the data, but report the data as if they did (Sandelowski, 1986). To avoid holistic fallacy, the researcher was careful to include typical and atypical data in the data analysis. The researcher also

avoided elite bias. Elite bias refers to overweighting the contributions of the most articulate, accessible, or high-status members of their group so that all the stories are not placed in the proper perspective (Sandelowski, 1986). The researcher avoided elite bias by giving all the adolescents' descriptions equal weight and by including quotes from all the young women who participated in the study. The findings presented in Chapter Four demonstrate the fit between the findings of the study and the data from which they were derived.

The five strategies identified by Sandelowski (1986) were used to manage threats to credibility and fittingness. The researcher checked the representativeness of the data as a whole, the coding categories, and the examples that were used to reduce and to present the data with the original transcripts. In addition, data sources (field notes and interviews) were triangulated to determine the congruency of the findings.

The researcher also included typical and atypical elements of the data in the descriptions, themes, and concepts; and deliberately tried to disprove a conclusion drawn from the data. To try and disprove a conclusion from the data, the theme of feeling overwhelmed was compared with the original transcript and also asked of the young women. The researcher discovered feeling overwhelmed was not supported by all of the original transcripts and received this response from one young woman:

"Not really overwhelmed. Just having problems and having someone else trying to help you out".

Finally, the researcher had the participants validate the information. During the second interviews, themes were validated with the young women. For example: "From talking with the young women I have interviewed, I got the impression that becoming pregnant helped them turn their lives around, that is, it gave them "new meaning" or a purpose to live for that they did not have before. Does this sound like your experience?" The young woman replied:

> "Me getting pregnant with her is the best thing that could have ever happened to me it gave me a second chance to make it better. There was a time before I found out I was pregnant that I was on the road to hell. Yeah it did I had never cared about myself at all and now I do."

Auditability

Auditability refers to the ease with which another researcher can follow the decision trail used by a researcher in a study. The second researcher is able to understand the logic of the data analysis by following the "decision trail" and identifying similar conclusions given the same data, perspective, and situation (Guba & Lincoln, 1981; Sandelowski, 1986). To achieve auditability, the researcher requested that experienced researchers--the thesis advisors--assist with data analysis and review the data analysis

for clarity. The way in which the data were organized was discussed in meetings with the advisors. The advisors verified the themes--ambivalence and adolescent pregnancy as a life change event.

Confirmability

Confirmability of the research findings occurs when adherence to credibility, fittingness, and auditability are accepted (Guba & Lincoln, 1981; Sandelowski, 1986). Confirmability "refers to the findings themselves, not to the subjective or objective stance of the researcher" (Sandelowski, 1986, p. 34). The researcher achieved confirmability by valuing the young women's perspective, and by focusing on the subjective meaning they gave to their experiences of pregnancy, rather than the researcher's objective professional perspective.

Throughout the data collection and analysis procedures the researcher sought the assistance of thesis committee advisors to provide guidance in the form of feedback during participant recruitment, data collection and analysis. By reviewing the trigger questions, an interview transcript, and the researcher's ongoing analysis of the data, the thesis advisors helped the researcher to develop questions to access further data important to the experience, and to reflect on and abstract the data to a

higher level of analysis. This guidance was invaluable in assisting the researcher to perform the phenomenological method.

Characteristics of Participants

In this section, the demographic characteristics of the study participants will be described. This information was collected using the guide in Appendix F. The eight young women ranged in age from 14 to 17, with a mean age of 15. The ethnic backgrounds of the adolescents included one North American Aboriginal and seven of mixed European descent. The young women were between 29 and 39 weeks gestation for the first interview. When the second interviews were conducted, they all had delivered their babies. The adolescents had acquired a grade eight to grade ten education. Five of the young women stated they had not attended school in the past year. They all had experienced problems in their family unit. Three young women cited a parent with a problem with alcohol. Six of the adolescents had run away from home and had lived on their own for several months in the past year. Six teenagers had parents who were separated. Two young women were wards of the court.

The socioeconomic status of the young women was measured by using their parents' occupations. One 16-year-old's parents were semi-professionals. Five of the young women came from households utilizing social assistance. The remaining two had

parents who were employed in skilled occupations. After becoming pregnant, two young women had moved back home with their parents. All participants were planning to keep and to raise their babies, except one who decided to give the baby up for adoption at two weeks post-partum.

Summary

Phenomenology was used to study the female adolescents' experience of pregnancy. Trigger questions were used to generate data. The researcher collected the data through audio-tape recorded interviews with the young women. A total of 13 interviews were conducted. The sample size (eight adolescents) yielded significant data. The ethics of consideration for human participants to participate in nursing research applied to this study. Despite the difficult and numerous decisions they were faced with at the time, all the young women willingly shared their experiences with the researcher.

The procedure for data analysis involved four steps. First, reading the entire description to get a general sense of the whole and then reading the description again to identify units of meaning in the experience. Secondly, eliminating redundancies in the units, and clarifying the meaning of the remaining units. Third, transforming the units from the language of the young women into scientific language. Fourthly, integrating and

synthesizing the units into a description of the female adolescent's experience of pregnancy to be communicated to other researchers (Giorgi, 1985). The major themes that emerged are intertwined and are explicated as ambivalence and a life change event in Chapter Four.

In Chapter Four, the themes, concepts, and subconcepts which have been validated in the adolescent's descriptions will be discussed in depth. The findings from this study will be linked to the literature.

CHAPTER FOUR

PRESENTATION OF FINDINGS

Introduction

Use of the phenomenological method, as discussed in Chapter Three, produced the findings presented here. These findings represent an interpretation of the young women's perceptions, their "story" of what it was like to be a teenager and pregnant, and experiencing two maturational events simultaneously. The use of open-ended questions elicited the "story" of each young woman's pregnancy from the point of suspecting she was pregnant to after the birth of the child. As part of that story, each young woman discussed her perceptions of factors related to getting pregnant, and her family's, peer's, and partner's responses to her pregnancy.

The young women in this study spoke with feelings of determination and hope. In their accounts, they discussed the factors that influenced their lives as they strove to achieve the developmental tasks of adolescence simultaneously with the developmental tasks of pregnancy.

Organization of this chapter reflects the themes that emerged during data analysis. The over-riding phenomenon of adolescent growth and development shaped the young women's experiences of pregnancy. The young women were experiencing

the developmental tasks of pregnancy layered over the developmental tasks of adolescence.

Two interrelated themes emerged from the data, ambivalence and adolescent pregnancy as a life change event. As the young women strove to achieve the simultaneous maturational events of adolescence and pregnancy, they experienced ambivalence. Ambivalence occurred throughout adolescent pregnancy as a life change event, which was characterized by what this researcher has chosen to call phases: (a) suspecting the pregnancy, (b) confirming the pregnancy, (c) making decisions about the pregnancy, (d) living the reality of the pregnancy, and (e) experiencing a changed life (see Figure 1).

Ambivalence and Pregnancy as a Life Change Event

Ambivalence, or feeling ambivalent, was characterized by the young women as experiencing conflicting thoughts and emotions. All the young women experienced ambivalence, which was associated with uncertainty and change at a challenging time in their lives. They described their ambivalent emotions as excitement interspersed with shock, worry, and fear. The young women experienced ambivalent feelings from the time they suspected they were pregnant until after their deliveries. They were ambivalent about the effects of pregnancy on their lives, their relationships, and their futures, because they were

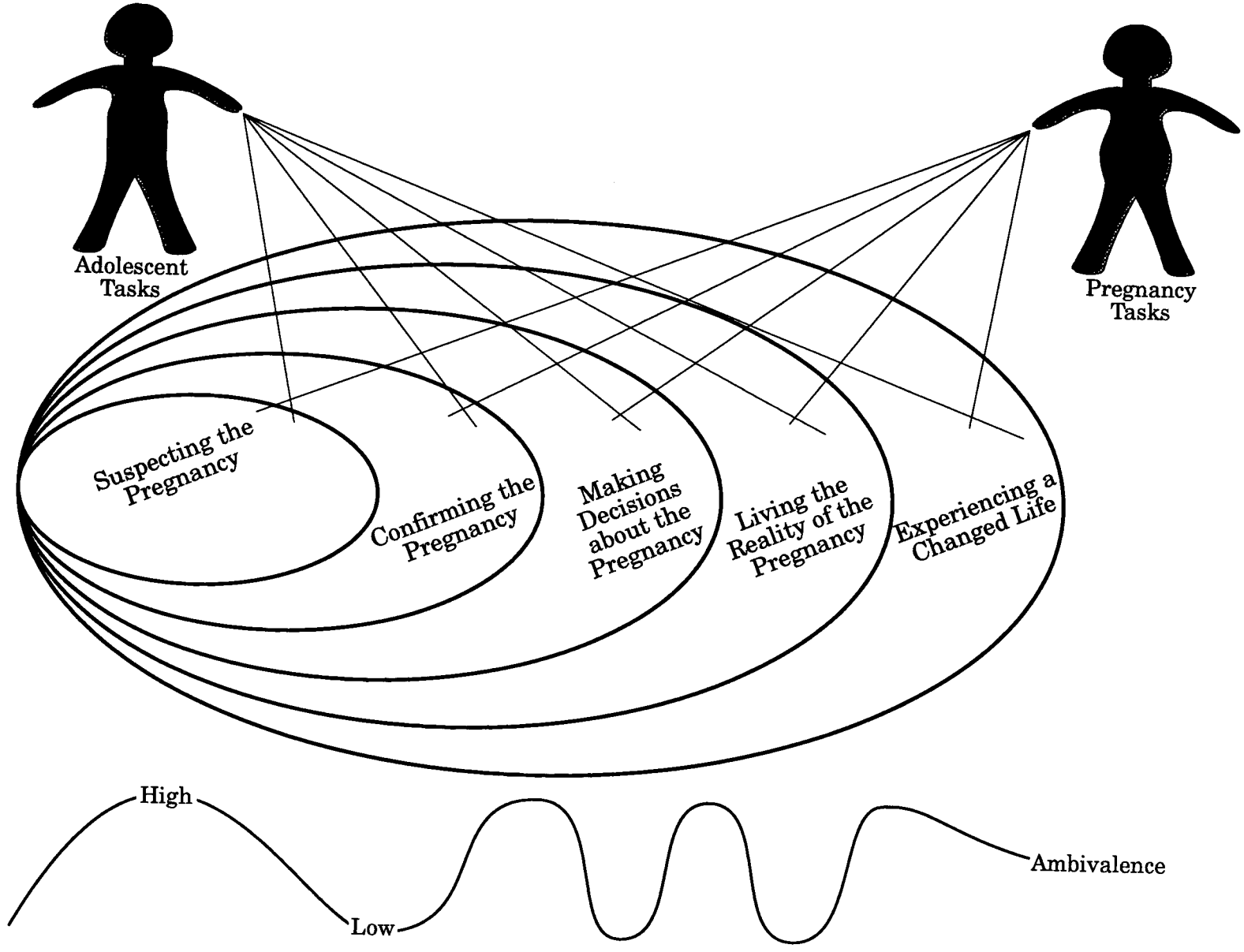

Figure 1: **Phases of Adolescent Pregnancy as a Life Change Event**

struggling with the developmental tasks of adolescence. Ambivalence took different forms, and varied in intensity.

Ambivalence explicated the emotional impact of experiencing adolescence and pregnancy simultaneously. The young women's progression through the phases of pregnancy as a life change event was influenced by their ambivalence. Their feelings increased with strains and conflicts, and then, slowed their movement through the process. Thus, the young women's ambivalent feelings were cyclic, with high and low ambivalence characterizing aspects of each of the phases (see Figure 1).

Flagler and Nicoll (1990) acknowledged that, when pregnancy is viewed as a hurdle to overcome, research has often been focused on a single variable such as ambivalence about pregnancy. As a result, it "denies the complexity of the pregnancy experience" (p. 268). In this study, both ambivalence and the multiple physiological, psychological, and social changes associated with pregnancy, influenced the coping behaviors the young women used to manage the developmental tasks of adolescence and pregnancy; thus reflecting the complexity of the experience.

Because pregnancy changed the lives of these adolescents, they were forced to make decisions about responsibilities that are usually ascribed to adults. The researcher believed the adolescent females' experience was different than adult women. The young women's stories in this study suggest that there was a

process through which they coped as they experienced the phases of their pregnancies.

The phases of pregnancy as a life change event can be compared to the ripples that result when tossing a stone into a pond, an ever widening circle--a progression toward becoming a mother. While the young women progressed through these phases in an orderly fashion, their processes were individual. Some subconcepts experienced were of greater importance to one teenager than another. Also, the young women varied in their completion time of each phase, depending on their struggles with the ambivalence created by the conflicts of the developmental tasks of adolescence and pregnancy. Each of the phases of adolescent pregnancy changed their lives. The concepts and subconcepts that influenced the young women's experience are presented in Table 1. The concepts will be described and supported by direct quotes from the interviews with the young women, and then compared and contrasted with relevant literature.

Phase One: Suspecting the Pregnancy

The following subconcepts were apparent in this phase: (a) not expecting the pregnancy to occur, and (b) initially denying the pregnancy.

Table 1

Subconcepts Influencing each Phase of Adolescent Pregnancy.

1. **Suspecting the Pregnancy.**
   - not expecting pregnancy to occur.
   - initially denying the pregnancy.

2. **Confirming the Pregnancy.**
   - seeking confirmation.
   - self-questioning.
   - telling others about the pregnancy.

3. **Making Decisions About the Pregnancy.**
   - prior life experiences influencing decisions.
   - reviewing the options.
   - discussing their decisions.

4. **Living the Reality of the Pregnancy.**
   - accepting the pregnancy.
   - living with the bodily changes.
   - forming a self-identity.
     - thinking about me as an adolescent.
     - fantasizing about being a mother.
   - thinking about parenting.
     - concern about ability to parent.
     - influence of their families.
     - influence on the rate of maturation.
   - dealing with supportive and nonsupportive relationships.
     - the supporting role of families.
     - coping with other's reactions.
   - dealing with social and environmental influences.

5. **Experiencing a Changed Life.**
   - changed thinking.
   - experiencing a sense of hope for the future.
   - caring for the infant.
   - caring for oneself.
     - influence of previous life experiences.
     - thinking about future roles.
     - thinking about contraception.
   - changing relationships.
     - family.
     - boyfriends.
   - coping with the maternal role.

Not Expecting the Pregnancy to Occur

When the young women in this study described their experiences, they indicated they had not made a conscious decision to get pregnant. They had participated in sexual activity without consciously realizing the impact it would have on their lives. The young women did not view their sexual activity as risk-taking behavior, or they maintained a false sense of security and believed pregnancy would not happen to them. For example, a 16-year-old stated:

> it was just that I never thought of that, because I thought hey that couldn't happen to me. I'm never going to get pregnant . . . . I was wrong . . . . It was something that never popped into my mind . . . this happened the first time we actually had sex, it was just a spur of the moment thing . . . . it was the first and only time . . . We broke up just after that. It was like we never really discussed that.

She could hardly admit her suspicion that she might be pregnant, because she had not perceived herself at risk for pregnancy. The notion of invulnerability has been identified in the literature as playing a role in adolescent sexual decision-making in regard to the need for contraception (Ringdahl, 1992; Urberg, 1982). Tauer (1983) has identified this sense of invulnerability as being a factor that enables the teenager to think it will happen to someone else, but not to them.

The following comments from a 17-year-old illustrate how past experience influenced one young woman's perception of her risk for pregnancy:

> Well for some reason I never figured it [pregnancy] would happen . . . After my last abortion I was hemorrhaging really badly. Something I believe went wrong with the operation . . . I'd have periods that were like two weeks long . . . . figured I couldn't get pregnant again . . . I figured they'd screwed up my body good enough, now I wasn't ever gonna get pregnant again.

Like the young woman above, a 16-year-old did not see herself at risk in the context of her relationship. She was provided with a false sense of security by her boyfriend.

> I wasn't planning to get pregnant again . . . I just didn't take any precautions [laugh]. Cause the father told me he was infertile, cause he doesn't like using condoms, so it kind of stuck us both in a spot.

These findings are supported by Pete and DeSantis (1990) who interviewed 14-year-olds about their initiation of sexual activity and their decisions to continue with the pregnancy that resulted. They also found that the young women did not feel vulnerable about becoming pregnant (Pete & DeSantis, 1990). Urberg (1982) has noted that if an adolescent female feels pregnancy will never happen to her, she will see little point in taking precautions to prevent pregnancy.

Initially Denying the Pregnancy

The young women resisted feeling physically different or they ignored their symptoms. The following comments from a 17-year-old indicated that only after she experienced several symptoms did she stop ignoring them:

> I didn't eat. I couldn't sleep. I was very depressed . . . . I had one period that came it was just discharge . . . . I was getting very lazy, I just wanted to stay at home and sleep, my jeans wouldn't fit anymore, like around the stomach . . . . Me and my girlfriend went out . . . . I couldn't get to sleep 'til two or three in the morning . . . . the next morning when I did wake up I felt very ill . . . I was just green. Just all these things getting me to think.

It took time to even consider the possibility of pregnancy, because denial was commonly used as a coping strategy. This strategy permitted the adolescents to deny their feelings and to deny their suspected pregnancies. Although it allowed them time before they had to acknowledge being pregnant, the young women's denial made them unable to acknowledge their suspicions and to act on them, and thus, interfered with seeking safe passage for themselves and their children during the pregnancy (Rubin, 1984).

The young women used denial until something or someone compelled them to investigate their physical symptoms. A 16-year-old was fairly certain she was pregnant but tried to hide it.

> After I missed my first period I kind of knew . . . . I tried to hide it as much as possible.

When at three months gestation, she was hospitalized with a kidney infection she could no longer deny her pregnancy.

A 14-year-old was so frightened that she denied her pregnancy for four months. Finally she told her aunt about her suspicions.

> . . . I thought I was pregnant because I didn't get my monthly [period]. But I didn't want to do anything about it. I was too scared to do something.

She used denial to help her cope with her fear of telling her family.

Denial permitted the young women to continue the adolescent lifestyle that they were living. It appeared to the researcher that, by denying they were pregnant, the young women did not have to deal with acting on their suspicions regarding the pregnancy. However, denial also increased the young women's ambivalence during this phase. Only in the next phase, confirming the pregnancy, were the young women able to articulate their ambivalent feelings about their pregnancies.

Phase Two: Confirming the Pregnancy

The following subconcepts were manifest when confirming the pregnancy: (a) seeking confirmation, (b) self-questioning, (c) and telling others about the pregnancy.

Seeking Confirmation

By acknowledging the possibility of pregnancy and seeking confirmation, the young women acknowledged their flood of ambivalent emotions. One young woman articulated the ambivalence she was experiencing when she confirmed her pregnancy particularly well in the following comments:

> Actually it was a shock to find out that I was pregnant. But it was kind of like at the time I was yes, no, I can't do this, yes, right on type of thing.

Although she mostly described excitement about being pregnant, she was also frightened, partly because she was worried about whether she could do what was required at this stage in her development.

Some young women sought immediate confirmation rather than denying their reality. They admitted they might be pregnant and proceeded to confirm it. They sought confirmation in a variety of ways. One 15-year-old suspected she was pregnant after she missed her period and sought medical assistance.

> . . . eight weeks when I found out . . . . I . . . thought . . . I was pregnant before I went in to get checked out . . .

Another young woman began to question why her periods had changed, and performed a home pregnancy test.

> I had one period that came it was just discharge . . . . I had a period the next month that was two days long the same thing and I said . . . there is something wrong here . . . can we go and get a pregnancy test . . . . So I went and did it [a home pregnancy test] and it started turning purple [positive], I was going no. And that is how I knew.

One young woman, who did not consciously realize that she was pregnant, could not ignore unusual bleeding. She went to the hospital to find out why she was bleeding.

> . . . the way that I found out that I was pregnant was um I went in for a threatening miscarriage to the hospital and I didn't know what it was or anything and they told me it was a threatening miscarriage. And I stayed in the hospital for a couple of days and they checked the baby and did an ultrasound and told me I was seven weeks.

The above descriptions illustrate that confirmation of a pregnancy is a personal process that varied among individuals. These findings are supported by Faber (1991) who also found that the process of confirming a pregnancy varied among adolescent females. Once they confirmed they were pregnant, the young women began a process of self-questioning.

Self-questioning

Ambivalence following confirmation of the pregnancy made the young women question themselves. A 15-year-old related her ambivalent feelings about what would happen to her now that she had confirmed her pregnancy:

> So I could say I was basically really excited that I was having a baby. Then I was worried, um, also because ok what is going to happen to me . . .

With the admission of pregnancy, the young women were uncertain about what to do and what being pregnant would entail.

> I was excited . . . . I was kind of scared I didn't know what to do, what going through pregnancy was like or anything.

Both of these young women were experiencing pregnancy for the first time. They were worried about their personal safety, and their thoughts were egocentric. While egocentricity is normal for adolescents, in these cases, it did not allow the young women to focus on their babies.

Sometimes their questioning was expressed as a roller coaster of excitement followed by uncertainty or doubt. For some, the feelings were associated with being pregnant outside the safety of a relationship and of feeling alone, but at the same time wanting to claim her child as her own. This included a 17-year-old, who had broken up with her boyfriend prior to realizing that she was pregnant.

> The father and I did want to have children together. And then before I found out I was pregnant he left . . . . it's been really weird since --- there will be days when you feel absolutely great and doing anything that you feel like. Then, is it even worth it [I] think I should just get rid of it now kind of thing . . . then you sit down and think to yourself for five or ten minutes, and then you think no, it's . . . worth it I should keep it---it's life; it's beautiful.

The end of her relationship was associated with a high level of ambivalence about whether she wanted to be pregnant or not. At the same time she was working on developing a personal value system.

A 14-year-old questioned whether she was ready to be a mother, and shared these feelings after confirming the reality of the pregnancy:

> . . . when I first found out I was pregnant I wanted to keep the baby, and after a couple of months I started thinking it's not fair to the baby maybe I shouldn't.

Her ambivalence about whether or not she should keep the baby reflected her ability to move beyond her egocentricity. Her awareness of the expectations to accept adult responsibilities associated with a pregnancy indicated that she questioned the effect of her development on raising a baby.

The young women expressed ambivalence in relation to accepting their pregnancies. They struggled with the reality of being pregnant and yet still wanting to do what they wanted. For example, a young woman who was 15, described her ambivalence this way:

> Like in some ways my mind doesn't want to accept it yet. Like it will probably accept it two seconds after the baby is born . . . I don't know my mind still wants to like, like I can still be a kid and everything right, but it is still my mind just doesn't want to. Like there are some times that I just want to totally forget that I am pregnant, and just go out and do things, then the other half of my mind [says] no you're pregnant you can't do that.

Her emotions shifted between accepting being pregnant and not wanting to be pregnant. The young women discussed how telling other people about the pregnancy also assisted their acknowledgement of the reality of pregnancy.

Telling Others About the Pregnancy

Telling others enabled each young woman to acknowledge her pregnancy and to confirm the existence of the baby. Telling others made the experience real. Consequently, they thought about how others would react. After the young women confirmed their pregnancies, they related numerous questions that ran through their minds such as: What will everyone think? What will my boyfriend say? Will he leave me? What am I going to tell my parents? How will I face them with the news?

They were thinking about the response of important others in their lives to the pregnancy; they wanted their acceptance. But the young women were not certain about how others would react, hence, they felt ambivalent. They were experiencing a conflict between the adolescent's need to be accepted, and their

fear of rejection because they were pregnant. A 15-year-old gave the following account of her concern about other's perceptions:

> . . . at first I was concerned about what people thought about me, and then I have never been one to worry about what people thought. [I thought] Oh, great, everyone is going to think I am a slut . . . Then I thought why would they think I'm a slut, there's so many people that are having sex it could happen to any of them . . . another thing that is really scary is telling my parents.

Some of the young women felt ambivalent about their sexual activity. Having sex was acceptable, but getting pregnant was not. Many felt that they had been labelled "slut" by their school mates and friends, even when others did not overtly give that message. Like the young woman who gave the above account, a 16-year-old avoided telling her friends, because she had anticipated they would label her as a "slut". By avoiding them she did not have to confront their reactions.

> I don't associate with any of my friends anymore. Um, not that they don't want to, it's me that doesn't want to. They're wanting to get involved all the time but I don't want to see them. It's kind of embarrassing . . . . Cause they all know I have been pregnant before and I'm afraid, not really afraid of them but I don't want them to see me [laugh] they all know. But I don't really want to associate with them . . .

The literature supports that there are two conflicting messages in the adolescent's peer group: one, is where they are considered stupid for getting pregnant, as in the above account,

and the other, is that it is acceptable not to use contraceptives and to get pregnant (Wilkerson, 1991b).

Although the young women wanted to tell others their news, they were ambivalent about how their families and boyfriends would react. Even though they felt compelled to share their news of pregnancy, they also hoped others would be accepting of them. The need to complete the maternal task of acceptance by significant others, overcame their fears and discomfort about pregnancy being out of synchronism with their developmental stage (Rubin, 1984). For example, a 15-year-old gave the following account of telling her father the "news":

> Well, my Dad, it's just like all my sisters in my family got pregnant at the age 15, 16, 17 . . . he was, you know, he kind of took it lighter than all the rest cause he knew that it is probably going to happen. He though it is going to happen. I never thought it would. I thought well I'm going to be a goody, goody, and not. But then he took it nicely. And he went along with me, with what my decisions were.

Even though she was uncertain about what her father's reaction would be to her news, she needed to tell him. When his reaction was supportive, she was relieved and her ambivalence decreased.

One young woman received mixed reactions when she told people. These mixed reactions had the effect of increasing her ambivalence. She recalled telling others about her pregnancy as being a scary experience. She was scared because she expected her family to reject her, which was in conflict with her hope that

her family would support her in her decision to continue with the pregnancy. She gave the following account:

> . . . another thing that is really scary is telling my parents . . . Actually my foster parents took it really good . . . my social workers took it pretty good, and my Mom um she didn't even want to talk to me or see me . . . my Dad was pretty understanding about it.

This young woman's feelings of high ambivalence were specifically related to her mother's reaction, one of rejection of her pregnancy. This interfered with the maternal task of seeking acceptance from significant others (Rubin, 1984).

In addition to being scared of their families' rejection of them, the young women were upset about their families' hurt and disappointment. For example, a 16-year-old, who had parents who were divorced, stated:

> . . . I didn't tell my mom 'til I was five and a half months, because I was scared of what she would say . . . . I cried . . . all I could think about was how I was going to tell my Mom . . . and what she'd say, I figured she would be really disappointed in me --- and that she just wouldn't want to be there anymore.

The young women revealed that all their mothers reacted with feelings of shock and disappointment when their daughters confided their pregnancies to them. For example, a 14-year-old gave the following account of telling her mother of her pregnancy:

> . . . it's just as soon as I got pregnant all hopes were shattered type of thing. My mother was a teenage mother and said I was gonna end up in her same situation.

Another 14-year-old was upset by her mother's reaction to her pregnancy, she shared the following feelings:

> My . . . Mom was hurt, cause she didn't expect it from me . . . . I felt bad because I hurt her.

Having their mothers react with disappointment to news of their pregnancy, particularly increased the young women's feelings of ambivalence. Their mothers were very significant people in their lives. This finding is consistent with Smith's (1975) description of the initial reaction of the mother to her adolescent daughter's pregnancy as being one of shock, anger, self-questioning (what did I do wrong?), and sadness that her daughter was losing her adolescent years of freedom.

A 14-year-old was so concerned about her families' response that she was scared to confirm her pregnancy.

> My family, I didn't know . . . [whether] my family would disown me or something, so I didn't want to do anything.

The young women indicated acceptance of them by their families was important, because it allowed them to confirm the reality of their pregnancies, and to feel valued as individual persons. They were particularly afraid that family members would desert them and they would be without support.

Another young woman talked about how her boyfriend's acceptance of the pregnancy influenced her own feelings.

> But he didn't leave me so that makes me feel better [laugh]. He's excited about it [the pregnancy] now.

Her boyfriend's acceptance was interpreted, by this young woman, not only as acceptance of her pregnancy, but also as acceptance of her as a person. Consequently, sharing her news made her feel good about herself and confirmed her pregnancy in a positive way. The link between seeking acceptance of significant others, and positive feelings about self is consistent with the adolescent developmental task of self-identity formation (Mercer, 1979a). Acceptance increased the young women's self-esteem when they had been doubting themselves. In the next section the young women's decision-making about their pregnancies will be described.

Phase Three: Making Decisions About the Pregnancy

The following subconcepts comprised making decisions about the pregnancy: (a) prior life experiences influencing decisions, (b) reviewing the options, and (c) discussing their decisions.

Many of the young women were faced with numerous decisions, beginning with what they should do about being pregnant. One 15-year-old, discussed how she considered her decisions for pregnancy resolution in the following excerpt:

> . . . there is so many decisions and things that you have to think about . . . like keeping it or not . . . or the first issue should I have an abortion . . . or facing the future and having those kind of heavy decisions laid on you. It makes you really think.

The above description indicated that the young women suddenly had many things to consider all at once, including both immediate and long-term consequences of their decision. Once the pregnancy was confirmed they realized that this was happening to them and not someone else, and that they needed to make decisions.

Their decision-making was influenced by prior life experiences, the options available to them, and discussions with their families and boyfriends. Their responses also influenced the young women's feelings of ambivalence.

Prior Life Experiences Influencing Decisions

Prior life experiences influenced the young women's decisions about continuing with their pregnancies. For example, a 15-year-old shared the following comments about a prior abortion:

> I knew I didn't want to go through that [abortion] again . . . the other one still bothers me.

When asked how having a prior abortion influenced her decision about having the baby and keeping it, a 17-year-old replied:

> . . . it was like I don't need this now, kind of thing, right, then I thought about it and I've had two abortions already . . . and to me that is not a form of birth control. You know, I believe to each his own opinion but it is still not a form of birth control . . . and with this one I figured I was ready.

The logic this young woman used showed an inability to project consequences; she was operating from an orientation in the

present rather than the future. However, this young woman was struggling with developing a personal value system and expressing a belief in her ability to cope with this pregnancy.

Even though she denied trying to get pregnant this time, a 14-year-old's feelings were influenced by a previous pregnancy that had ended in miscarriage. Her positive feelings were indicative of her acceptance of the pregnancy because she was ready to change her life.

> The first time I got pregnant I really didn't want a baby, to be pregnant. I was young I still wanted to go out and party and not be tied down with a little baby. And when I lost the baby I thought, you know, that if I had cared about the baby more I wouldn't have --- lost it . . . . but with this one I was happy . . .

Some of young women reflected on the current effect of their families' input during past decisions. A 17-year-old reflected on her lack of input into the previous decision to have an abortion:

> For one thing I didn't have the choice before . . . I did not have a choice as far as [being] 14 [years-old]. I was under my mother's roof and law. [She said] 'Sorry you have to get rid of it.' And I didn't want to but . . . in a way it did influence my decision [this time] . . .

This young woman was trying to establish her own identity and independence, and part of doing that was refusing to consider abortion as an option again.

There are differing opinions in the research literature as to the consequences of abortion among adolescents. Most studies examine the effects of abortion on psychological outcome or subsequent fertility (Zabin et al., 1989). No research articles were found that explored the influence of previous abortions on future decisions to carry subsequent pregnancies to term. The literature does indicate that prior life experiences influence adolescents' decisions for continuing on with their pregnancies (Hayes, 1987). In this study, experience with a prior abortion was identified as a strong influencing factor for making a specific decision about pregnancy resolution--to keep this baby. The influence of a traumatic former life event on decision-making should not be overlooked and may merit further study.

Reviewing the Options

In addition to reflecting on past experience while making decisions about the pregnancy, the young women reviewed their available options. Some of the young women had never thought seriously about their attitudes toward abortion, adoption, or keeping the baby. Their attitudes were not well formulated, and consequently, their decisions were difficult. A 14-year-old shared these feelings about her decision-making for pregnancy resolution:

> I decided . . . that I wanted to keep the baby and if I didn't want to I would have had an abortion . . . because I was ready to be pregnant . . . yeah it was a hard decision to make.

A 15-year-old had considered the pros and cons in relation to her options. She had obviously been tempted to have an early abortion so that she would not have to be public about her pregnancy, but reconsidered because of worrying about her guilt over an abortion.

> . . . but I am against abortion in some ways . . . . A lot of hard times. A lot of tears. Just too much, felt like your head was going to explode . . . . with adoption I was thinking, like um, well at least give somebody who can't have a child a chance. Then with abortion I was thinking nobody would have to know but then I would probably feel bad and so I decided against that. Like I never thought about it seriously.

Some of the young women felt abortion was morally or ethically wrong and rejected it as an option in their decision-making. For example, one young woman shared the following thoughts:

> I chose to have the baby instead of having an abortion . . . . to me it is another life inside of me . . . some people don't think it is, [but] to me it is life, and it [abortion] is murder. And I won't do it.

A 15-year-old felt frightened by taking the responsibility to end a life and described an element of retribution for making mistakes.

> some people did tell me that, oh, the baby's heart is already beating and it is already developing. And then when I started reading things about abortion and it just scared me, you know. I am taking life and killing it . . . . it just scared me . . . I decided not to . . . . I went and got pregnant myself, right, I did it myself. So I should be the one to suffer instead of the baby.

Ambivalent feelings were also evident in making decisions about keeping the baby. One young woman thought about what it would be like to have a baby. She openly discussed her feelings in the following comments:

> Well I am still kind of confused about whether to keep it or not. I want to.

Further comments demonstrate that she had clearly considered a number of factors and was uncertain about the best course to take.

> Ok, for giving it up I keep thinking about it not having a father and I'm so young I'm like [not] totally emotionally stable. And I think in some ways the baby would have a better chance with more mature parents. But then I want to keep it because I love it so much already, I mean it is just like it is a part of me, it's there. And at first I wanted it to go away but now if it just went away I would be really upset because I've formed a bond with it, and so that is why I'm confused.

She showed insight into long term decision-making as well:

> you have ten days after you have the baby where you, before you are allowed to sign anything. I think in those ten days I'll really make my decision with the child. Cause I am planning on keeping it with me during that time. That is probably when my real decision will get made no matter what I say now.

Her comments illustrated her realization that she would not appreciate what carrying on with the pregnancy would mean in terms of child-rearing and how challenging the maternal role would be until after the baby was born. This young woman demonstrated insight by her ability to project what her future would be like. These are qualities not expected of someone of her chronological age.

None of the young women initially chose to adopt out their babies. The literature suggests adoption as a choice for pregnancy resolution by adolescents is a rare event (Herr, 1989; Nichols, 1991).

The decisions were difficult for all the young women. Many of the young women described it as a painful time when they had shed many tears. For example, a 15-year-old, described her emotional turmoil when confronted with options she had never experienced:

> Yeah I did. It took me quite awhile because I read the adoption book. And . . . the day before I was supposed to go for the abortion I said no. I started crying . . . and I cried a lot, it wasn't the thing to do, it wasn't that easy . . . it took me a while to make my decision up [sic].

A 15-year-old, who had looked after her sister's baby tried to take her baby's interests into account during her decision-making. She gave the following account:

> I was going to give it up for adoption, then I decided to keep it . . . . I just thought no. It is going to be hard for the baby too. And I decided I could give it a good life, and I think I can.

Discussing Their Decisions

During the making decisions phase, the young women used discussion with their friends, or family members, for example, a mother, an aunt, or a sister to consider their options. A 15-year-old talked to her sisters who had been pregnant as adolescents themselves, and she had this to say about the discussions:

> . . . nobody [sic] else made my decision I made it myself . . . they are the ones that told me I should give it up for adoption or I should have an abortion and I didn't feel right . . . I didn't go.

Even though the young women wanted input from others, and talked over their decisions with them, they still made the decisions themselves. Family members affected the young women's levels of ambivalence. The young women's ambivalence decreased if family members were accepting and offered support, their ambivalence increased if family members rejected their decisions.

Some of the young women used supportive boyfriends to discuss their decisions. For example, a 15-year-old described her discussions with her boyfriend:

> . . . and then for a while we talked about adoption and that, I'm against abortion in some ways . . . I thought that because I am healthy enough to have it at least then if I can't look after it, give it to somebody else who can't have a child a chance.

Not everyone had a supportive boyfriend. Another young woman related quite a different experience:

> . . . he . . . said you gotta get an abortion or give up the child, cause I don't want anything to do with it and [laugh] I don't want my parents to find out.

Consequently, this young woman experienced feelings of high ambivalence related to rejection by her boyfriend. His rejection negatively affected her coping and made her feel uncertain about the pregnancy.

Faber's (1991) research with Caucasian and African-American adolescents revealed that family members were an important influence in the young women's decision-making related to pregnancy resolution. This is consistent with the findings in this study.

During decision-making the young women had to consider a number of factors such as, previous experience with abortion, the young women's desire to become a mother, a belief in the sanctity of life, acceptance of the consequences of their actions, and what they perceived to be the best interests of their babies. The importance of these factors varied amongst the young women. By discussing their decisions with others they clarified their thinking and made their decisions.

Reedy (1991) suggested that young adolescents do not have the cognitive skills to cope with the maturational event of pregnancy. Negative sociocultural factors can increase the conflict the young woman is experiencing between her tasks of adolescence and tasks of pregnancy, particularly around issues of independence (Reedy, 1991). There is some evidence in this study that negative sociocultural factors had increased the young women's maturity in relation to decision-making, before and during their pregnancy experiences. Rich (1990) reported similar findings when studying homeless pregnant adolescents.

The young women in this study all stated that making this decision was a difficult process for them. Unlike adult women who can draw on their life experiences for making decisions, the young women had limited life experiences, and also had yet to achieve abstract thinking. Despite this some of the young women demonstrated remarkable insight as they described their perspectives, and how they made their decisions for pregnancy resolution. As they moved from the making decisions phase to the living the reality of the pregnancy phase, the young women's emerging sense of self-identity became evident. Pregnancy produced multiple effects in their lives.

Phase Four: Living the Reality of the Pregnancy

In the living the reality of the pregnancy phase, the young women thought about what motherhood and it's attendant responsibilities would mean to them. These adolescents had not previously carried a pregnancy to term and parented. It was difficult for the young women to anticipate what it would be like to become a mother. This was compounded by their immature cognitive and value systems development and a need for independence and self-identity. In living the reality of the pregnancy the following subconcepts were evident: (a) accepting the pregnancy, (b) living with the bodily changes, (c) forming a self-identity, (d) thinking about parenting, (e) dealing with supportive and nonsupportive relationships, and (f) dealing with social and environmental influences.

Accepting the Pregnancy

Although the young women had confirmed their pregnancies and considered their options, they still had to accept the reality of living the role, and that the pregnancy would end with the birth of a baby. Even though living the reality of the pregnancy was difficult, they saw the pregnancy and mothering as an opportunity to make their lives right, because they expected that their pregnancy experiences would end with the birth of a healthy baby. One 17-year-old reflected on the desired outcomes:

> My expectations of the pregnancy are pretty well just to have a healthy child. And do the best I can after it is here.

Some days it seemed like an easier task than others, as evidenced by the following excerpt, in response to a question on having doubts about her decision to continue with the pregnancy:

> . . . I think everybody does at one time or another. You know, you look at what is going on in your life time --- and you think, this moment if I had a choice. Like, I have days when . . . I wish I could take it out put it into an incubator and leave it for the day. Or often I used to do drugs and alcohol . . . I'll be the first to admit that, but there are days when you just want to, when you wake up in the morning and you're feeling great, and you're like, I'm going out to get pissed tonight. Um, you walk out of the house going yeah, right. Yeah, you know, just a glass of Pepsi please, sort of thing . . . . you know, some days you want it to hurry up and be over with, other days you wish you hadn't even started it.

Because the reality of their lives contrasted with the expected outcome, the ambivalence the young women felt about their pregnancies was high. Their risk-taking behaviors and adolescent developmental tasks of defining their self-identities were in conflict with the maternal tasks of binding-in to the unborn child, and seeking safe passage for themselves and their children (Rubin, 1984).

Living with the Bodily Changes

The adolescent is often self conscious and preoccupied with the changes her body is undergoing during normal growth and development. Pregnancy brings more changes in the form of

breast enlargement, skin changes, abdominal enlargement, weight gain, and discomforts like backache, and leg cramps. Everyone discussed the changes in their bodies, in particular, the change in the shape of their bodies.

Some young women were aware of what the changes would be and others were surprised by the body changes they experienced. For example, a 15-year-old described her body changes as:

> It is really weird because changes started happening that I didn't expect . . . and I just started freaking . . . Like my breasts got different, like totally different shapes and that was something that I was not expecting. And I was like why is this happening all that is supposed to happen is my stomach is supposed to get bigger . . . and I was supposed to miss my period, that is all that is supposed to happen.

Her lack of knowledge of the bodily changes associated with pregnancy and lack of previous experience did not provide her with realistic expectations, made her fearful, and increased her ambivalence.

A 16-year-old was concerned with different body changes, and stated:

> . . . I'm always hot . . . you have more blood in your body and it doesn't travel around as fast, therefore it doesn't cool down as fast. And your body is like one degree in temperature higher . . . . All 380 pounds [gross exaggeration] of it [laugh] that is what it feels like, it does, it feels like I am just a giant . . . I know I have only gained 15 pounds, but still it is like it is 40 or 50 . . . because I am not used to carrying it around, that extra weight.

The bodily changes were often undesirable, particularly weight gain, and could place the young women in direct conflict with seeking safe passage for their babies if they tried to stay slim (Rubin, 1984).

Several of the young women commented on how uncomfortable they were when they tried to sleep. For example:

> I try to find a position . . . then I have to change it and find another position . . . . It is mainly my back [that is uncomfortable] it's my stomach that is in the way, right.

Another young woman had this to say about the discomforts she was experiencing with her pregnancy:

> . . . I like being pregnant, of course, I don't like the backaches and leg cramps, but I like knowing the baby is there, and feeling it inside of me . . .

As the young women grew more tolerant of the discomforts of pregnancy, their pleasure about being pregnant increased.

The bodily changes experienced by the young women made the pregnancy more "real" to them, and heightened their awareness of the growing fetus. Consequently, these feelings helped them accept the bodily changes as part of pregnancy. They expressed excitement about the changes they were experiencing as the pregnancy progressed and the fetus grew. This enabled them to identify the baby as a distinct individual, a developmental task of pregnancy. For example:

> . . . there is something alive inside of me . . . just thrills me, I love it, like every time the baby kicks it amazes me. The other morning when I was having a shower I felt pressure on my stomach and I could see a little hand.

Forming a Self-Identity

Forming a sense of self-identity, a major task of adolescence, refers to an individual's concept of who they are as a person. The young women's pregnancies influenced their emerging self-identities. Forming their self-identities is the third area of living the reality of pregnancy. The following factors influenced their self-identity formation: thinking about me as an adolescent, and fantasizing about being a mother.

Thinking about me as an adolescent. Prior to the pregnancy they were already experiencing role confusion. They spoke of experiencing a struggle between being concerned with what they appeared to be in the eyes of others as compared to their own view of themselves. The literature suggests that some adolescents in role confusion, cling to an intimate relationship to assist them with integrating their identities (Holt & Johnson, 1991).

Part of the way these young women defined their identities was by exploring intimate relationships with older men as boyfriends. At times, these relationships appeared to develop without conscious planning but they became important to the young women's self-identities.

> . . . I was on [one of] my running away little trips and I just found him, and he was another person to live with. I didn't think I was going to be staying there. But he was really good looking. [laugh] So I . . . ended up staying and got feelings for him and he got feelings for me. But he thought I was 18-years-old, I did a lot of lying to him.

This young woman's description highlights her struggle with her independence from her parents because she had run away from home to achieve this, and her struggles with development of a self-identity. She had to lie and misrepresent herself to stay with her boyfriend. This represented a difficult situation when she started to care for him.

Once pregnancy occurred, the formation of a self-identity was also tied to future plans. A 15-year-old shared the following thoughts about her plans for the future:

> I have kind of decided what I want to be, but it could change. I know I am not going to go through years of university or something. I am just planning on going to nursing school, to do something that won't take up too much time [laugh] . . . . I'm not going to be able to work, I want to get a job so bad . . . . It is a lot easier living here [at home] . . . I want to live here until I finish my high school. It will be another three years.

Self-identities were confused during these experiences. Although considering the future and working towards career or vocational development while anticipating motherhood increased the young women's ambivalence, this young woman also suggested that making plans for her future made her feel in control of her life and decreased her ambivalence. This was a complex situation.

Another young woman could not predict how the pregnancy would change her life in the future, or impinge on her developmental tasks, consequently she felt a high level of ambivalence.

> I've though a lot about that and it could change in a lot of different ways, but the only way I'll really know is when I see it. When the baby is there and, you know, we have had a few years together.

Because this young woman's age (14 years) and stage of cognitive development made her unable to visualize her future life, she experienced a high degree of ambivalence.

Fantasizing about being a mother. Some of the young women fantasized about what their lives would be like with a baby.

> I am always thinking what it is going to be like . . . . all I can really say is I want to give this baby a good life. Um I want to finish my schooling, like I am going to do that, like I understand that I am giving up my whole life for this baby, and I feel . . . great, you know. I am really looking forward to it.

Fantasizing allowed the young women to begin to prepare themselves for the birth of their children and the realities of the maternal role (Lederman, 1984). In their fantasies, the young women saw the baby as promising excitement and challenge. They viewed "making a baby of my own" as an experience that would bring excitement into their own lives, but it was initially difficult for them to think of the baby as a separate individual. The young women's expectations were consistent with Brown and

Urback's (1989) report that adolescents describe unrealistic expectations and fantasize that life with a baby is wonderful and that parenting is easy. For example, the following comments from a 15-year-old:

> Yeah it's, it's the weirdest experience that somebody could go through, I don't know how to say. It's like having something on the inside, that's alive, and you can feel it kicking, and like your stomach starts getting bigger, and bigger, and bigger. I don't look very big, but believe me in another month I'll be out to here [laugh] [gesturing with hands] But it's weird because you're thinking wow this is a new life. This is actually going to be mine and no one can take it away from me.

Another 14-year-old enjoyed other people's excitement about her pregnancy:

> Everybody is excited about it, every time your belly gets a little bigger and the day comes a little closer . . . and when you go clothes shopping they say do you want a boy or a girl, it's nice . . . I don't know, the baby is positive and I think people realize that even if I am young . . . . the baby is something they can be excited about . . . . it's good, right now the baby in my eyes is perfect . . . . it just feels right.

This adolescent viewed the expected baby as being perfect. This may be in contrast to an adult woman's view that encompasses how much care a newborn requires, and how dependent they are on their mothers for their needs. This view might create high levels of ambivalence when the experience does not meet the adolescent's expectations.

On the other hand, the excitement the young women felt made them feel positive about the pregnancy. This decreased

some of the ambivalence they were feeling during the pregnancy and made them feel good about themselves, because they were creating something.

An adolescent forms her self-identity by interacting with others and the peer group is an important source of validation for what is normal and acceptable. Peers became less important as the individual teenager fantasized about her identity as a mother. To a large extent, that shift probably reflected the new realities that pregnancy had created in the young women's lives, which made their issues very different from others in their age group.

One young woman talked about how her pregnancy had helped her to appreciate herself as a person.

> I've had to do a lot of growing up myself and a lot of learning [about] myself, and a lot of nurturing to myself and this child before I can, you know. As they say, you have to be able to love yourself before you can love somebody else. Well, I have never really loved myself . . . and I have in the last nine months become [sic] to love myself. So I want to . . . continue that before I go on to sharing it with anybody else.

In learning to appreciate herself as a person she was defining her self-identity as a person and a mother.

Because they had grown to love themselves, and had started to understand themselves better, the young women felt better about who they were. A 17-year-old who had run away from home at nine years of age, and lived in a series of group homes shared the following response:

> Yeah, very much so, I love myself more today than I have in the past seven years of my life.

Because she felt like she had a purpose in life, something to live for, pregnancy had increased her self-esteem.

Another young woman did not believe that becoming pregnant had helped her to understand herself better:

> I liked myself before I was pregnant . . . and I still don't understand myself, I don't think people ever totally understand themselves.

Perhaps for those young women who had a strong identity pregnancy did not increase their self-esteem. But, this young woman did acknowledge that becoming pregnant had given her life a purpose and "settled" her down.

> It gives you a reason to live for . . . . It has mellowed me out . . . . I used to do wild things, that's the main thing it got me to settle down.

None of the young women in this study viewed pregnancy as a way to keep their boyfriends. Their exploration of the maternal role did not necessarily include the fathers of their babies. As a matter of fact, one young woman stated she turned down her boyfriend's offer of marriage. She gave the following reasons for her decision:

> He [her boyfriend] wanted to get married before it was born but I said no. I didn't want to get married just for this reason. Plus, I don't know if he is the right person.

Steane and Heald (1987) suggested that many teenagers who become pregnant have a poor self-image and self-esteem and view

having a baby as a way to improve their lives by having someone who loves them. The young women in this study did not talk of their pregnancy as giving them someone who would love them, but rather as experiencing something positive that could help them to love themselves.

Holt and Johnson (1991) reported that teenagers, who see motherhood as one of the only options available to them, hope to find direction through their pregnancies and babies. The young women in this study did talk about how their pregnancies had helped them to change the course of their lives to a more positive direction. They hoped that motherhood would enable them to continue their lives in this positive direction.

Thinking about Parenting

A fourth area that comprised living the reality of the pregnancy was thinking about parenting. The young women expressed concerns regarding: (a) their ability to parent, (b) the influence of their families, and (c) how thinking about parenting influenced their rate of maturation.

Concern regarding their ability to parent. One concern the young women expressed repeatedly was, whether they would be good mothers. This was part of establishing a maternal identity through comparing themselves--their actual self, to their image of an ideal mother--their ideal self (Rubin, 1984). They expressed

concern as to whether or not they would be able to manage the role. In response to a question about feeling apprehensive in regards to her pregnancy, that is, things that she felt scared or unsure about, a 14-year-old shared the following comments:

> Um, just how I am going to be a good mother or a bad one.

She stated she was unsure if she was going to consciously decide how she would mother. Her comments reflect her uncertainty about her coping abilities for being a mother. It is difficult for teenagers to think about and plan for motherhood, because they probably have not had the life experiences to help them imagine what the maternal role involves. In addition, they may have experienced inadequate parenting and want to do better than their parents. This is also a developmental task of pregnancy that adult women struggle with--how to define themselves as a mother (Flagler & Nicoll, 1990).

Increased knowledge assisted the young women to anticipate the responsibilities of the parenting role. The young women also used their previous experiences to help them reflect about parenting. For example, a 17-year-old provided the following description:

> I've always had that motherly instinct. I've practically raised my two brothers, or at least when I was younger I did. Um, I've lived with a girlfriend who didn't take care of her kids so I did.

Some of the young women were very clear about their readiness to be a mother. They wanted the baby, liked children, believed they had the necessary skills, and were looking forward to becoming a mother. For example, a 15-year-old had thought about becoming a mother and shared these thoughts:

> . . . I have always liked young kids . . . . I used to look after my sister when she was a little baby . . . . I was feeding her and changing her diaper . . . . it is like I have always had like, I guess you could say motherly instinct cause I have always been around little kids . . .

However, it was difficult for some of the young women to envision just how much their lives would be changed by becoming a mother. A 15-year-old, who had spent time thinking about how her life would be changed by having a baby, shared the following thoughts:

> Like well first of all I won't be able to, well I could go to a normal school, like regular high school, but then I would have to pay all the money for a baby sitter and whatever else. It is just really weird, like it is something that you think would happen to someone else.

Although she was beginning to acknowledge the limitations of having a baby, she was still having trouble relating them to herself.

Some young women carried their wondering about whether they would be able to fulfill the parenting role further and worried about whether they had made the right decision to carry on with their pregnancies. For example, a 15-year-old stated:

> Will I be a good enough mother for the baby? . . . will it grow up in an alright . . . environment? Will it have proper nutrition? I think about all that stuff . . . . what is going to happen afterwards . . . that's basically what I worry about . . . just am I gonna' be alright, and how I'm going to be living with a new addition to the family type of thing . . .

Some of the young women who talked about wanting to be "good" mothers had a vision about what that would entail. A 16-year-old shared the following thoughts:

> Spending lots of time with them . . . and loving them as much as you can, making your life better for them, I haven't decided how I am going to discipline her yet . . . . I don't want to spank her or hit her, maybe a slap on the hand sometimes . . . . My parents never hit me or my sisters and other than me they have turned out fine (laugh).

Her comments reflect some feelings of lack of self-esteem. She defined being a good mother as spending time with the baby and providing lots of love. She felt being a good mother and discipline were linked, but was unsure how. She also felt her own parents were good role models.

Other young women were very certain that they wanted to mother, but worried about their timing:

> . . . it's great like in some ways I was always scared that I wouldn't be able to have children for some reason, like I don't know why I was just scared that I wouldn't be [able]. And now I know I can, and I have always wanted a family, right, just not so early.

Her ambivalent feelings about the pregnancy are evident in her comments. Although pregnancy was an indicator of her fertility, she recognized conflict with her current stage of development and

readiness for pregnancy. The above narratives indicate that each young woman thought about different variables in relation to her pregnancy and parenting. What was important to one young woman was not necessarily accorded the same importance by another.

Influence of their families. A part of thinking about parenting was acknowledging the influence of their families. Some of the young women considered their behavior in comparison to their parents, specifically in relation to teenage pregnancy. Parents' attitudes had an effect on the young women's attitudes. Two young women spoke of the cycle of teenage pregnancy being repeated. For example, a 14-year-old shared these thoughts on her situation:

> . . . My mother was a teenage mother and said I was gonna' end up in her same situation . . . . I figure we are two different people and we have lived our lives two different ways so far . . . . And if I end up in the same place it's not because I got pregnant it's because of other choices I made and not because I got pregnant.

Either she did not have the life experience to enable her to judge what her life in the future would be like, or she may have been denying reality in an attempt to establish her independence, believing that she would continue to have choices.

A 15-year-old described her boyfriend's parents' experience in the following excerpt:

> They were young when [boyfriend] was born . . . . And so it is really like I guess you could say it is a cycle, because his dad was 17 when he was born, well when he was conceived, and 18 when he was born. [boyfriend] was 17 when the baby was conceived, and he'll be 18 when it is born . . . . Like they went through all the same things we did . . .

By doing this comparison she was able to normalize her own situation. She was also perhaps trying to place some responsibility for the outcome on the parents' behaviors.

Adolescent parenthood repeating in families is a phenomenon that has been studied in recent years. Newcomer and Udry's (1984) study suggested a strong link between being a teenage parent and coming from a family in which the mother was sexually active at a young age herself. This is in contrast to studies done by Horwitz, Klerman, Kuo, and Jekel (1991) and Furstenberg, Levine and Brooks-Gunn (1990) which specifically investigated a relationship between the offspring of teenage mothers becoming adolescent parents themselves, and found that only a minority of adolescents repeat the pattern of adolescent parenthood of their parents. More importantly, Furstenberg et al. found that maternal experience with social assistance increased the likelihood of the daughters bearing children as adolescents. The reason for this link remains unclear. They raised questions about whether the link was related to family socialization, limited family resources, living in neighborhoods with high rates of early childbearing, or a combination of these three (Furstenberg et al., 1990). It would

appear that some of the young women in this study did repeat the pattern of teenage parenthood like their parents and step-parents. One young woman's mother had been a teenage parent on social assistance.

Influence on the rate of maturation. The third part of thinking about parenting was reflecting about how pregnancy and parenting had influenced their rate of maturation. Maturation was affected by their cognitive growth and their past life experiences. Living the reality of the pregnancy required the young women to grow towards adulthood. Some young women already saw themselves as mature and no longer a teenager. Others saw themselves as teenagers who were taking on the responsible role of adult parents.

A 16-year-old who had run away from home on several occasions in the past two years described how her perspective of her parents had changed:

> I think I have matured a lot more . . . Well when I look at my sisters and how they act. I know I am a lot more mature than my older sister. They're terrible the way that they talk to my parents. I guess I'm understanding what it is like to have kids [laugh]. And what my parents have gone through. Especially after . . . trying to live on my own.

Her feelings about adolescents' appropriate behavior had changed. She was able to place herself in her parents' position because she was contemplating her own parenting. Her values about

appropriate behavior used by adolescents for communicating with parents had changed, because she had changed her perspective.

A 16-year-old who believed that becoming pregnant had made her more mature, shared the following analysis:

> Well I think I am more mature than I used to be. I have to say that because there is so many decisions and things that you have to think about . . .

For her being more mature meant having to be more responsible for making decisions and thinking about the future. Speraw (1987) also reported that young women perceive pregnancy as increasing their level of maturity. Some of the young women viewed pregnancy as a way to grow up, to become an adult. Viewing pregnancy as a way to become mature may make pregnancy appear a viable alternative for taking on an adult status thereby making their lives more positive. Walker (1991) noted that pregnancy is not a negative event for all adolescents, some view pregnancy as providing them with social and personal benefits.

Some young women denied becoming more mature during pregnancy. A 14-year-old stated:

> I don't think so . . . No for me it didn't make me grow up faster but it made me feel more insecure about every little thing I was thinking . . . I felt, I don't know, more of a demand on what I was looking at while I was shopping . . . it just wasn't the same. But I don't think it [pregnancy] makes you mature . . . if anything I'd say you still have to grow and still be growing when your child is growing.

This young woman saw maturity as an outcome of adulthood, and acknowledged that although she was not an adult she was growing. The next narrative indicates how another young woman viewed maturity differently. A 14-year-old thought she needed to maintain her freedom to be an adolescent.

> Um not really, because I'm not going to grow up fast. I'm not going to let myself grow up really fast. When the baby comes I am still going to go out and do everything I have to.

This young woman's normal adolescent behaviors were in conflict with her pregnancy tasks. Although she wanted to act like a teenager, that is, "hang out" with her friends, she realized that having a baby involved responsibility and would reduce her freedom.

> Yeah . . . . [in what ways] The baby needs someone and I'm always going to have to be there. That means that I am going to have to get it for the baby.

To a further question about how she felt about the increased responsibility, she replied:

> Um --- I don't mind but then again I sort of do because I don't think I am going to be able to get it everything when it needs something.

Her comments indicate the ambivalence she was feeling because of the conflict between her adolescent task of forming an adult identity, and the developmental task of pregnancy of learning to give of herself to her child. She was able to identify some of her responsibilities as a parent. She also recognized that she might

not be able to obtain all the resources her child needed. Thus she was uncertain as to how she would cope and whether she could accomplish the adult responsibilities of parenting.

Another young woman linked maturity to the responsibility of parenting. She anticipated maturity developing as she became responsible for parenting, but she also anticipated being able to still enjoy children's pleasures.

> If anything I'd say you still have to grow and still be growing when your child is growing. I've lived with a lady, who I was living with before the one I am now, who had her first baby at 13 and her second baby at 14, and she said even with her second baby she wasn't mature. I mean she was mature to know the responsibilities of the baby, she was good to the baby. But she still went down and she played on the swings with her children, and she went to and enjoyed the amusement parks as much as her children did. And I don't think there is any reason why to have to go out and mature like that just because you get pregnant. Just the responsibility part but I understood that before I was pregnant.

Even though this young woman realized the role of mother and parent involved a lot of responsibility, she felt that enjoying childlike behaviors was not incongruent with being responsible. Another 15-year-old shared the following analysis of her situation:

> I can't really say I've gotten more mature since I have gotten pregnant, because I haven't, it is just like I have always . . . liked young kids. Right, and I always babysat . . . . I have always been around little kids and always looked after them and that. So I haven't matured any. Like I am sure I will once the baby is born, like I will realize how much worst [more work] it is. Like I know a lot, like how much you have to do [but] . . . . when you sit there and you watch somebody do it doesn't seem like a lot of work, but it really is.

Even though she had not been a mother before, this young woman compared the maternal role to an experience she knew, babysitting. By doing this comparison she was able to envision the maternal role as being "a lot of work". She was also able to project and acknowledge that it would be different. She seemed to be operating at a cognitive level somewhat beyond her chronological age.

The young women were anticipating what the new role of mother and parent would be like in relation to their maturity. Mercer (1979b) observed that adolescents who assume parenting (a mature role) experience a break in the continuity of their development; they move from a dependent role of receiving care to an independent role of giving care. This results in a conflict between the adolescent developmental task of achieving independence, and the pregnancy task of learning to give of oneself. The experiences of the young women in this study are consistent with this observation.

Dealing with Supportive and Nonsupportive Relationships

As part of living the reality of pregnancy, the young women discussed their perceptions of their need for support in the maternal role. During their pregnancies the young women described how their relationships with others affected them; they identified supportive and nonsupportive relationships.

Talking things over with other pregnant teenagers, program group leaders, family, boyfriends, and friends was viewed as supportive. This was a coping behavior that assisted in finding solutions to problems, relieving stress and frustrations, and receiving information. The young women felt that talking things over had a positive effect on their mental health. One young woman described how she used talking things over:

> And we [she and her boyfriend] thought [and talked] about if I was to keep it [the baby], like how we would end up getting the money and stuff. And like how we would support it, and like if we would be able to look after it.

This young woman was fortunate because she had a supportive boyfriend who would talk about her decisions and plans with her.

The supporting role of families. Some of the pregnant teenagers identified their families as sources of emotional support and guidance for them. Parents were often more supportive than the teenagers thought they would be. For example, in response to a question about her parents' reaction to her pregnancy, a 16-year-old shared the following thoughts:

> Actually she [my mother] was really understanding . . . I wasn't expecting her to be, like I was expecting her to freak out . . . but she has just been understanding and she has helped me and supported me.

Not all the young women identified the same need for support. But, they consistently wanted their families involved in their lives. This was a theme that occurred in all the interviews. As the young women anticipated the new role they were taking on, some very much wanted their mothers for emotional support and guidance for labor, and child-rearing activities. A 17-year-old provided the following comments:

> I didn't expect anything from my family I haven't for the last couple of years but it amazed me that they were there for me . . . . Yeah my Mom was the most support that I had there [labor].

Despite this young woman's past experiences with an unsupportive family, she found that her mother was more accepting of her pregnancy as the birth neared. Her mother was her main support person during a long, difficult labor. Consequently she felt closer to her mother, and less ambivalent. She did not have contact with her natural father, and she had been physically abused by her stepfather so she did not want any contact with him.

Poole, Smith, and Hoffman (1982) studied mothers of adolescent mothers and found that the addition of a baby to the family may enhance the mother-daughter relationship, as was the case for the young woman in the previous narrative. Smith (1975) identified the mother of the adolescent as being a significant

figure for role modeling and emotional support; she found that "the support a mother gives her daughter at this crucial time, her caring and empathy can increase the younger woman's confidence in herself and her ability to become a mother" (p. 282). The young women in this study were more confident of their ability to become mothers as a result of their mothers' support.

Support from their fathers or step-parents was also needed. The young women were looking for approval and support from both of their parents.

> Yeah my mom and my step-dad they really supported me a lot. [How] Well for one they both seemed really interested . . . and excited about it like my step-dad he just [laugh] he acted like a little kid . . . like every time I'd come home for a weekend he'd say let's see how big you have gotten . . . . he'd see it kicking all of a sudden you'd see his hand would go over, and that showed me they weren't mad . . . . And my mother was the same way . . . she cried with me when I felt like crying and she was just there once I told her.

This young woman was ensuring acceptance of herself and her baby by significant family members, a developmental task of pregnancy.

The reaction of siblings was also of importance to some of the young women, because they provided emotional support and acceptance. The following comments from a 16-year-old illustrated that although her brother's reaction was somewhat negative, she viewed him as caring and supportive, because she saw his behavior as being protective of her.

> He [her brother] was really upset with the father. I mean really upset. I mean he threatened to go out and kill him a couple of times . . . . that is just the way my brother is with me. I'm his little sister and he takes care of me . . . . he is scared for me, he doesn't want me to have any pain . . . . My brother has actually been very understanding about it [the pregnancy] . . .

Communication problems with parents increased the young women's feelings of ambivalence about their pregnancies and their self-esteem.

> a lot of parents think . . . well you shouldn't do this I screwed up, you know, a lot of people want to learn by their own mistakes, not from somebody telling them . . . I did this and look at what happened . . . . And my Mom was always like yeah, look it I did this and look at what happened, and I wanted to find out for myself. But she was really strict about everything.

This young woman related that she did not want her mother's experience imposed on her life. Although her decisions placed her in major jeopardy, she wanted to make her own mistakes and deal with the consequences herself. She demonstrated the adolescent developmental task of achieving independence from parent(s). This young woman's experience is confirmed by Cohen (1983) who suggested that sexual activity may be a form of acting out used by some teens to achieve independence in relationships with parents.

Acknowledging the support of their families was only part of the experience of pregnancy for the young women. Others' reactions to their pregnancies were also of concern.

Coping with other's reactions. Under the second area of coping with supportive and nonsupportive relationships the adolescents described others' reactions to their pregnancies. A young woman admitted that she talked to people, but did not always follow their advice.

> Um if . . . I didn't like what they had to say I just ignored it. And mostly I just took it as advice, like I took everything. If somebody said something that was supportive that made sense, that was the kind of thing that I wanted to hear. Even if it didn't make sense, [if] it was still supportive I still wanted to hear, [it] just didn't necessarily mean I listened.

This young woman's comments indicated that when she was talking things over she was only prepared to listen to certain comments that she viewed as supportive. Although that decreased her ambivalent feelings at the time, it also prevented her from listening to suggestions that might have interfered with her autonomy.

The adolescent female who becomes pregnant often feels she has done something wrong. There is an implicit social code that conveys the message that pregnancy is not a socially acceptable behavior for teenagers. However, many of these teenagers believed it would be acceptable to be pregnant, and could not understand what they had done wrong. A 15-year-old gave the following account:

This young woman was thinking ahead about how her life would unfold as a mother indicating development toward formal operational thinking.

Experiencing a Sense of Hope for the Future

The second aspect of experiencing a changed life was experiencing changes that gave life meaning and a sense of hope for the future. The young women reflected on how their pregnancies had changed their lives after they had given birth. Because, by the second interview, the young women had recently given birth, their discussions vacillated between pregnancy and their current lives as new mothers. They believed becoming pregnant had given their lives hope, and "new meaning" or a purpose that they did not have before.

The young women reflected on how becoming pregnant had forced them to change their risk-taking behaviors. As a 17-year-old stated:

> Yes it has changed my life a lot, I used to go out and party with my friends all the time but I can't do that anymore . . . . I had very mixed feelings at the time [when I found out]. Well at the time life wasn't going so good, so it was kind of like um it gave me new meaning to life.

After the baby's arrival she was relieved, and not disappointed that her life had changed.

> I don't care, it might have been a shock, but I'm glad I kept her. I'm glad I got pregnant.

> I feel uncomfortable at times . . . I don't know, it is hard to explain how it feels . . . . I feel like I have done something wrong and --- it's just my fault --- but I also realize that it isn't. And when some people will look at you strange when they find out that you are a teenager and you're pregnant. And that makes me feel more insecure and scared to tell people.

Feeling they were wrong and at fault created insecurity and fear, and increased the amount of ambivalence the young women felt. This may have been related in part to feeling different from peers, and identifying difficulties in finding acceptance from their peers that they were normal.

Teenagers' friends were also an important source of support. A 15-year-old described feelings of low ambivalence. This was related to feeling others cared about her. She acknowledged that her friends supported her in her pregnancy experience, their support helped to offset her feelings of being out of step developmentally. Having their support enabled her to feel part of her peer group, rather than rejected by her peers.

> . . . I still have contact with my friends. All my friends really support me . . . and they care a lot. It is like every time someone looks at me I have someone to phone because they are all are waiting on me.

She viewed the support of her friends as vital to her self-image, because she felt normal and part of the group. This would fit with the middle adolescent task of trying to define their self-identity by comparing themselves to their friends to see if they are normal. Support included affirmation from others, including peers, that they were normal. The following young

woman was worried about being judged as abnormal by not living up to the expectations of her parents (and peers) and was relieved to be supported instead:

> I'd have to say that one thing that was really important that was helpful was . . . my friends just listening no one really judging, they'd listen and . . . everything would be ok to them. And that is what helped me because if people had been judging me I would have been really hurt.

While the young women saw themselves as different than their peers they neither viewed themselves as abnormal nor did they want to be viewed that way.

Speraw (1987) conducted an exploratory study to determine adolescents' perceptions of pregnancy and found that perception of pregnancy was influenced by: sources of emotional support, anticipating pregnancy and motherhood. Similarly, the young women in this study also identified their families, boyfriends, and friends as sources of emotional support. As well, they identified their positive anticipation of parenthood as influencing their experiences of pregnancy.

The young women viewed pregnancy as a way to improve their lives and therefore, felt positive about their pregnancies. This decreased some of their ambivalence and enabled them to make decisions about coping with the pregnancy. In addition to talking things over and looking to their families for support, and dealing with others' reactions to their pregnancies, the young

women acknowledged that a variety of social and environmental variables influenced their thinking.

Dealing with Social and Environmental Influences

Lastly, the young women discussed social and environmental variables that were also influencing the reality of their pregnancies such as: using social assistance, smoking cigarettes and marijuana, and drinking alcohol, having a dysfunctional family, experiencing abusive relationships, and experiencing homelessness.

A young woman who had a mother who had been on social assistance shared the following perspective about how her experience with social assistance influenced her thinking:

> I will do everything in my power to not to have my child on Welfare . . . My mother was on Welfare when we were really young, and it didn't bother me but it bothered my mother a lot. --- it was hard on her, so I figure I would never put myself in that position and mostly I want to be able to give my child, to be able to afford little hockey lessons if it's a boy, or dance lessons if it is a girl. You can't do that if you are on Welfare . . . your child won't get a lot of those things that other children would and I don't think it is fair --- Or to have to wear second hand clothes and feel embarrassed. I never had to do that but a lot of kids do . . . . you lose a lot of self respect . . . I mean you're having somebody else support you, you are not you know, you figure if you're on your own you otta make it on your own and not have other people support you.

This young woman viewed social assistance as a negative influence on self respect for herself and her child. It is an important

perspective to acknowledge, because it may influence the way adolescents access health services in the prenatal and postnatal periods of their lives. In addition, their perspectives may offer insight into how they feel about the bureaucracy of social services and collaborating with those professionals.

Smoking cigarettes or marijuana, and drinking alcohol were seen as coping behaviors the young women used. Quantity of use was not explored. Alcohol and drug use appeared relevant to the social activities in which they participated.

Smoking and use of street drugs have been associated with earlier sexual activity and risk for pregnancy (Zabin, Hardy, Smith, & Hirsh, 1986). Zabin et al. used a self-administered questionnaire to study the relationship between substance use and sexual knowledge, attitudes, and behaviors; and found that teens who experienced early onset of sexual activity participated in other problem behaviors such as smoking, and use of street drugs (Zabin et al., 1986). These findings are consistent with the young women's behaviors in this study.

Additional variables the young women identified were abusive relationships that had led to running away from home and related life experiences that placed them in more challenging situations than their peers, but that may have led to their pregnancies. A 16-year-old reflected on why she had run away from home and lived in group homes. She described how she felt

betrayed by her mother when she suffered physical and emotional abuse. As a result she continued to feel her mother would be unsupportive during her pregnancy.

> I was a mummy's little girl and then all of a sudden she got together with a man who would beat her and beat my brother and beat me . . . . and that is when things really started going wrong . . . . I was becoming more independent wanting to do things on my own because my mother wasn't there for me anymore, I needed her.

She did not indicate that she consciously became pregnant, but she did acknowledge that the pregnancy had given her a chance to make her life right. In the subsequent section on changed life, the way pregnancy and childbirth changed the young women's lives is explored in more depth.

There is a paucity of literature that addresses the homeless, pregnant and parenting adolescent (Rich, 1991). The literature acknowledges that the reasons for running away are multiple, including: parents who are physically abusive, parents with drug or alcohol abuse problems, physical and sexual abuse by their mother's partner, foster care situations, and dysfunctional relationships with both parents. In describing Capable Adolescent Mothers (CAM), a program in New Jersey for homeless pregnant and parenting adolescents, Rich (1991) noted that although the young women were homeless they were not totally cut off from their families. However, Rich (1991) also noted that the family as a whole may have been dysfunctional to some degree prior to the

adolescent's pregnancy, which may further exacerbate family dysfunction. This observation supports the experience of some of the young women in this study. Although they did not live with their families of origin, they still had contact with their mothers and/or fathers, and their siblings.

A unique characteristic of this sample was the number of young women with a history of running away from home and/or living on the street in the year prior to their pregnancies. Rich (1991) noted that homeless adolescents developed a coping mode of "running" to deal with their incredibly difficult life circumstances. Because of their experiences of running away from home and living on the street, the young women in this study may have had different emotional needs and attitudes than their peers who lived at home under less stressful situations. These factors may have influenced their coping behaviors and explained why they viewed their pregnancies as a positive change in their lives.

Because some of these young women had been exposed to family dysfunction, stress, and abusive situations, they felt they had sought out relationships and experiences that were beyond their chronological ages. Their social and environmental life experiences may have also influenced their maturation and how they viewed their pregnancies. A 17-year-old, provided the following analysis of her life, which she described as different from her peers:

> I've done quite a bit of growing up in my lifetime and I, you know, it is only because of my background that I have, it has almost forced me to become older than what I am. You know, sure I wish I had that perfect, you know, life going to school and going out with the 16-year-old boyfriend. No I've gone out with 20-year-olds or older, up to 30-year-olds, and you know, sorry but I never had that so I've never, can't relate to that. But this you know, in a way I have been forced into an adult world kind of thing and for me I want to give my child more than what I had, right.

She recognized that her family situation and life experiences differed from that of peers who lived in a two parent home where they felt loved and secure. She came from a broken home, had been physically abused by her stepfather, and had spent time living in foster homes and on the street.

Protinsky, Sporakowski, and Atkins (1982) found that pregnant teenagers were significantly more untrusting of others than nonpregnant peers. Although a substantial number of the pregnant teenagers were from broken homes, they did not relate this to the teenagers' lack of trust in others. Other authors like, Hartman, Burgess and McCormack (1987) have related runaways' lack of trust to their life experiences:

> In general, the longer runaways have been away from home, the more self-demoralizing experiences they have had. Such experiences impinge on their ability to trust, to be calm, and to feel connected and committed to both people and places (p. 298).

Although the young women in this study did not specifically talk about trust, they did talk about not feeling connected and committed to people. A 17-year-old who had run away from home, and lived in foster homes shared the following comments:

> I had nothing to come home to like . . . it's the same way with the abused child, who goes home and gets beaten everyday, why are they gonna go home? They are not going to go home there is nothing there . . . . if they go home and they have a good loving family. Well they are going to be home everyday right after school.

Her comments indicated that she did not feel connected to her family. This may have implications for how she copes in the future in the maternal role.

The young women in this study indicated that their life experiences influenced their rate of maturation, their ability to trust, and how they viewed their pregnancies. This researcher perceived a difference in the way the young women viewed pregnancy depending on their chronological age. Social and environmental influences also had a major impact on their perceptions. The perception of Experiencing a Changed Life is phase five of pregnancy as a life change event.

Phase Five: Experiencing a Changed Life

In this section, the young women's descriptions of their changed lives as a consequence of the experience of adolescent pregnancy will be presented. Particularly, their reflections of

pregnancy, and the births of their children will be discussed in relation to the life change event. This phase is composed of the following subconcepts: (a) changed thinking, (b) experiencing a sense of hope for the future; (c) caring for the infant, (d) caring for oneself, (e) changing relationships with families and boyfriends, and (f) coping with the maternal role.

Changed Thinking

In the first interviews, some young women said that they would not let being pregnant change their lives. In the interviews after the births of their babies, they indicated that their lives had changed.

A 14-year-old stated in her first interview, that she would not allow having a baby to make a difference in her life.

> When the baby comes I am still going to go out and do everything I have to.

In a follow-up interview, after the birth of her baby she stated that she had to get someone else to look after the baby when she went out with her friends, and had realized how much responsibility motherhood entailed. In addition, she acknowledged that she spent a lot of her time caring for her baby. The conflict she felt between wanting to remain an adolescent and taking on responsibility had decreased. She was able to respond to how the baby had changed her life and to the responsibilities of

parenting. Consequently, she was able to think about plans for her future that included envisioning how different decisions would influence her future life, for example, making plans to continue living with her parents, and to attend a school with a program for adolescent mothers.

Other young women also recognized that their thinking had undergone change over time. For example, in a follow-up interview after the birth of her baby, a 16-year-old was excited about being a mother and did not want to be like a teenager anymore. She shared the following thoughts:

> I don't, I don't see myself as a teenager . . . I don't think I feel or think like a teenager . . . . [that period of life is over]. I can't really do the teenage things, I don't want to jump in the cars with the boys, or go get drunk, it doesn't appeal to me anymore at all . . . . It makes you grow up a lot when you have kids [laugh] I don't want to be a teenager I want to be an adult so far.

She was striving to achieve an adult identity--a developmental task of adolescence. Having a baby increased her responsibilities and was causing her to think beyond her adolescent role to an adult mothering role.

One young woman demonstrated a change from self-centered thinking to concern for the infant.

> But you have to experience it to, um, really know how it feels, because, like there are things you have to plan for thinking of the baby.

Others described having a baby as motivating them to change their behavior. For example, a 16-year-old stated:

> Um you try and be better for her, better yourself for the baby . . . You want to make everything better, --- to give her the best there is, and I want her to have so much [opportunities to experience different sports, youth activities].

Some of the young women reflected about how they started to change to be a better role model for their children during their pregnancies.

> . . . right after I found out I was pregnant with her. I tried to mold myself to Um be what I want, to be a better person . . . . Me getting pregnant with her is the best thing that could have happened to me. It gave me a second chance to make it better. There was a time before I found out I was pregnant that I was on the road to hell . . . . Yeah it did I had never cared about myself at all and now I do.

The above comments conveyed a sense of hope and optimism. The young women believed their lives would be better because they were making opportunities for their babies. Their thinking moved from destructive egocentricity toward a more healthy caring for oneself. Rich (1990) suggested that homeless adolescent mothers need help in balancing their own needs with those of their infants because "enduring love, altruistic self-denial, and empathy . . . are maternal qualities that come in conflict with the adolescent's egocentric pursuits" (p. 208). These maternal qualities are also difficult to maintain during child-rearing. As the young women in

this study were just becoming mothers they were just beginning to experience these conflicts.

Pregnancy also increased their self-esteem. Many of the young women acknowledged that because their lives had changed, they felt better about who they were. They saw a way to change their self-destructive behaviors and they wanted those changes. However, their changes could be influenced by barriers in their social environments, which had a negative influence on their coping behaviors.

Caring for the Infant

A third aspect of experiencing a changed life was caring for their infants. In addition to the young women discussing their concerns about whether they could care for the baby and go to school or work, they also talked about how their previous life experiences influenced their physical caring and their emotional caring.

A 14-year-old described how she was adjusting to caring for her infant.

> Every night I am up with him . . . I'm . . . here to feed him, to change him, ... I enjoy being with him.

She also compared her present experience, of caring for her infant, to that of her former experience as a baby-sitter.

> it is a little different with your own [compared to babysitting], I guess you are really tired and he is crying, but it is usually for a reason and you are pulling out your hair, so at least you love the kid. If you didn't love the kid you'd have problems.

As part of caring for their infants the young women discussed how important their babies were to them. The theme of "making a baby of my own" was part of claiming the infant (a pregnancy task) and provided feelings of accomplishment. For example, in response to a question regarding why having the baby was exciting, a 17-year-old gave the following reply:

> . . . that she was born healthy, that I made her, I love her, you have to feel it to know . . . exactly how it feels . . . . I created her . . . I am proud of her.

Some of the young women feared that their babies might be abnormal. This was a maternal task, they sought safe passage for their infants, and worried about whether their babies would be normal (Rubin, 1984). One young woman expressed her fears in the following comment:

> . . . wondering if she was going to be ok . . . I always had a fear that something bad was going to happen to her.

This fear was resolved once a healthy baby was born. It made the experience seem even more positive, and gave them a sense of achievement; perhaps one of the first achievements they had accomplished.

The 16-year-old who had contemplated adoption, made her decision to place her baby after the birth. In response to a

question about what she had found helpful in making her decision, she shared the following comments:

> I found it really hard to keep up with everything she needed. And that showed me that I wasn't really ready yet, and just thinking about everything that I would never be able to give her and what they [the adoptive parents] could, really helped.

Being able to care for the baby after the birth helped her to understand what the mothering role involved. Consequently she decided that she was not ready to be a mother yet. She had plans for her future. She wanted to go on to college and get her business degree. Because of her young age, few resources, and limited life experiences, she felt it would be difficult to accomplish maternal tasks as well as developing a vocation or career. Her ideal image of what a mother should be and her ability to be a mother did not fit together. Her caring was expressed in giving the baby up.

Caring for Oneself

A fourth aspect of experiencing a changed life was caring for oneself. Although the young women were thinking about their infants' needs they were also thinking about their own needs. All the young women considered schooling important, either they had plans to return to school, or were continuing with their schooling at the time. Many had even considered child-care arrangements while they were in school. They were using formal operational

reasoning in making plans for the future. They discussed: (a) the influence of previous life experiences, (b) thinking about future roles, and (c) contraception.

Influence of previous life experiences. The young women who had run away from home had not experienced their teen years in a way that is presented in textbooks on adolescent growth and development. Their former lives were very difficult and these experiences influenced their plans for parenting. For example, a 15-year-old gave the following account of her life:

> A lot of bad things have happened to me in my past. Like in my family and just being on the streets . . . like my family is mostly alcoholics. So I had a lot of trouble with that during my life. I think that is why I started drinking and everything . . . . I started drinking when I was eight . . . but I never really used to drink a lot when I was eight, but I started drinking more and more . . . . I started smoking when I was five . . . . I have quit that . . . . I have seen so many kids get abused like I got abused when I was little . . . . I was always the odd one when I was little . . . . I wouldn't want to see any child go through that, what I went through.

Her comments illustrated the multiple problems she dealt with as a child, and her desire that her child not have the same experiences. As stated previously developing a self-identity was difficult for these adolescents because of their young age and limited life experiences, but the adolescents who have experienced abuse in their families of origin, found development of a self-identity and a maternal identity even more complicated.

Sander (1991) interviewed four black women who were adolescent mothers. The women described the social, economic, and psychological struggles they faced as adolescent mothers. Their poverty, loss of their fathers, difficult relationships with their mothers, and battered sense of self-esteem affected their ability to achieve the maternal role. From the personal testimonies of the women, Sander (1991) concluded that it takes tremendous resilience and personal resourcefulness for adolescent mothers to turn their lives around. Similarly, the young women in this study required personal resourcefulness and resilience to deal with the difficulties they experienced as pregnant teenagers who were becoming mothers.

The young women who had experienced homelessness talked about their need for assistance and support with the mothering role.

> I'm just scared that this will not work out, that I will end up ruining his life and my life. That is my biggest worry, that I will some how not be able to do it, but that is why I wanted lots of support, emotional [and] financial when I started out.

This 14-year-old was making a transition to behaviors in the context of an experience of inadequate parenting. Her ability to think about how her life had changed, and about the many challenges that she still had to face, is more typical of late adolescence or early adulthood than a middle adolescent. By

voicing her doubts, she demonstrated her realistic appraisal of her coping abilities, and identified her needs for support.

Oz, Tari, and Fine (1992b) studied the psychological characteristics of teenage mothers who had experienced traumatic childhoods and found that while teenager mothers feel good about themselves and want to be good mothers, they recognize that they are inexperienced with the role. They proposed that the teenagers' lack of education and job skills required them to remain dependent on social assistance, even though they were assuming an adult role, causing them to feel powerless about changing their lives.

Many of the young women, in this study, who had run away from home, associated their pregnancies with a chance to change the pattern of their lives. Their life experiences had made some of these young women more mature than their years. This is supported in the literature by Oz, Tari, and Fine (1992a) who compared the psychological characteristics of a group of teenage mothers to a group of nonmothers and found that the teenage mothers had more mature ego development. Traumatic experiences, such as growing up in a broken home, living in a foster home, and being sexually abused exerted an influence upon the maturational processes of young women (Oz et al., 1992a). They suggested that many adolescent females from foster care and abusive environments, who become mothers handle the conflicts

between life as it should be and life as it is by tolerating ambiguity and appreciating life's complexity (Oz et al., 1992a). In this study, tolerance assisted the young women to cope with the developmental tasks of adolescence, the developmental tasks of pregnancy, and the maternal role. This observation is consistent with the descriptions provided by the young women in this study.

Thinking about future roles. The young women wanted to finish their schooling so they could get jobs and support themselves and their babies. This was a change from their past experiences. A 16-year-old had this to say:

> I want to finish my schooling and get a career so I can support myself comfortably . . . . before I was not caring about school, now I know I have to go back.

The following excerpt from a 14-year-old illustrated how the pregnancy and birth had changed her life and provided her with an opportunity to finish her schooling:

> If I hadn't had it [the baby] I probably would have been somewhere else. I would have just gotten drunk if I hadn't gotten pregnant. At least with him I can finish my schooling or I am going to finish my schooling . . . It is like a different chance . . . I wouldn't say it [having a baby this young] is unfair, having a baby is not unfair it is sort of a gift . . . It gives you a reason to live for . . . . Before I had him the biggest thing was going out and partying being with my friends. And school wasn't one of those things, and not being responsible. And now that I have him I can get my education at least I can do it, it's just with him it will take longer.

This young woman acknowledged that pregnancy and birth had provided her with a reason to live her life differently. She had moved from living her life from day to day for pleasure to planning ahead to finish school and to make career or job plans for her future. She was learning to give of herself to her child--a maternal task (Rubin, 1984). At the same time she was developing a personal value system, formulating her self-identity, and choosing a vocation or a career--tasks of adolescence.

Thinking about contraception. With their lives changing as a consequence of pregnancy and giving birth, came the realization of what the maternal role entailed. As a result some of the young women mentioned that they did not want to get pregnant again for a long while. They wanted to wait until they had had a chance to accomplish some of the other things that they wanted to do with their lives. For example, a 14-year-old provided the following assessment of her situation:

> . . . after this baby --- no babies for a long time so --- one more reason I don't need a relationship with the baby's father . . . . the only sure way abstinence [laugh]. What I should have done in the beginning so that way you don't have to worry about getting anything, which I was always paranoid about before.

This young woman planned for abstinence as a coping behavior to avoid another pregnancy. Her young age may have contributed to her not considering other viable options.

A 16-year-old communicated that she would give serious thought to her actions in the future:

> . . . I am never going to let this happen again, we're talking two condoms, and the pill, and everything else you can think of. Cause I'm scared, I don't want it to happen again, I will be on the pill for sure next time. [If] I do have a boyfriend that this may happen again with, it is like I will be prepared [laugh]. (5.1)

The reality of having a baby forced these young women to develop coping behaviors (some more realistic than others) and to think about their needs for contraception. In this study, the young women assumed the responsibilities for their pregnancies and future needs for contraception. These findings are supported by Meyer (1991) who reviewed the literature on adolescent pregnancy and found that men did not take responsibility for contraception and pregnancy.

Changing Relationships

A fifth aspect of experiencing a changed life encompassed living arrangements and relationships with families and boyfriends, which had changed. For some of the young women who had lived on the street or in group homes, becoming pregnant had enabled them to be in a stable home environment for the first time, but living arrangements changed over the course of the pregnancy. Their relationships with families and boyfriends also changed after their infants' arrivals.

Families. Many of the young women were assisted by their families. Family support allowed them to learn mothering skills, and enabled them to feel that they could cope with the mothering role. Family support was expressed in various ways consistent with the literature.

Smith (1983) studied the developmental tasks that must be successfully negotiated in the family life cycle when an adolescent daughter becomes pregnant. She used grounded theory to analyze the specific developmental tasks and process involved when a family incorporates a young mother and her child into the household. Three patterns of incorporating the young mother and her infant into the household were identified: role sharing, role blocking, and role binding. She defined role sharing as "the shared performance of acts that in their sum represent the performance of the maternal role" (Smith, 1983, p. 51). The role sharing pattern provides the young mother with opportunities to learn mothering skills, whereas in role blocking--the adolescent's own mother assumes many of the "mothering" responsibilities and in role binding--the adolescent assumes all responsibilities for mothering herself.

One 16-year-old appreciated her family's support.

> they are always taking her from me and letting me go take naps and so on. Even my Dad has come to help, when she was first here, like at three o'clock in the morning he was rocking her to sleep for me . . . . They have been really helpful.

Because this young woman lived at home, her family was able to assist her in meeting the 24-hour responsibilities of child care, consistent with Smith's (1983) definition of role sharing.

Having their mothers' praise and approval for doing a good job was important to several of the young women. For example, a 16-year-old provided the following account:

> My mom is still mothering of course she still tries to take over, but I just tell her, but she says I am doing a good job.

A 14-year-old identified the following reasons why her mother's encouragement was important to her:

> I've got my mother mostly for emotional support when I am ready to pull my hair out or have a question, she will answer the question or just say that she thinks I am doing fine . . . with the baby , which is a big help. For financial support I have social services, if I need to take a shower or just need to sit down for a minute I've got my foster mother . . . I have actually got a lot of support . . . it is nice to have . . . . the little things like having someone say yeah you're doing good makes a big difference.

Both her mother and foster mother offered her advice and assistance with child care. She especially valued the emotional support her mother provided to her.

Flaherty, Facteau, and Garver (1987) in a study of 19 African-American grandmothers (adolescents' mothers) who had engaged in the care of their adolescent daughters' infants, identified seven grandmother functions: managing, nurturing, caretaking, coaching, assessing, assigning, and patrolling. These

functions are also applicable to grandmothers from other cultural groups. In this study, the researcher found the young women valued the role their mothers played in nurturing them during the later half of their pregnancies, coaching and supporting them during labor, and in providing information related to caretaking and assessing their infant's needs. Mercer (1980) also found that adolescents identified their mothers as a source of support for taking on the mothering role.

Living with families could create difficulties with siblings. A 16-year-old who was experiencing difficulty with her little sister's acceptance of her in the maternal role shared the following comments:

> My little sister is having a hard time trying to accept it . . . like watching me go through everything I've gone through so she is kind of mad at me. So I guess she is taking it out by calling me names and stuff, or saying she doesn't care about the baby, but then she will turn around and say oh can I hold her she's so cute and things.

This young woman's description of her relationship with her sister is consistent with the literature. Rich (1991) suggested that the relationship between adolescent mothers and their siblings is characterized by tension, and feelings of competiveness, which consequently increase rivalry feelings and behaviors.

Boyfriends. Three of the young women had partners who were their age or two to three years older. This presents its own set of problems. Hardy and Duggan (1988) stated:

> Many of the studies of young fathers have shown that they, like teenage mothers, tend to be from among the poorer and less educated groups in society, and that they may face serious and long-term social and economic disadvantages, when compared with young men who postpone parenting until a later date (p. 159).

None of the partners of the young women in this study were interviewed, so data on their backgrounds is incomplete. One young man chose to offer emotional support to a young woman, but the other young men were no longer involved in relationships with the young women.

Four of the young women had "older" boyfriends that they had left as their pregnancies progressed or shortly after the birth of their babies. Some of the young women had different needs than their boyfriends as evidenced by the following statement:

> He's got his job and his house, he's got everything set up and for him it's a good time to start [a family], and for me it's just a little early.

The "older" father and the young women were both trying to meet their emotional needs for being special and having a caring intimate relationship with another person, but their needs were not always compatible.

A 14-year-old who did not want a permanent relationship with the 24-year-old father of her child shared the following perception of their relationship:

> I don't want to put myself in a position where . . . if I were to live with him he'd have custody of me until I was 18. You don't have . . . a spouse or a partner having custody of you [and your child] . . . If there are any problems that puts you in a bad situation . . . . I don't want to put myself in the position where the baby can be stuck in a bad relationship when people are young they usually don't --- we are more like good friends too, more like good friends than actual --- mummy and daddy figures.

Her thinking shows concerns for independence and autonomy that is more typical of an adult than a middle adolescent.

Even though the young women viewed their pregnancies as positive, they expressed ambivalence about maintaining relationships with their infants' fathers, and the impact of their relationships on their infants. For example:

> I don't want any contact with him for myself but for the baby I would like for him to know who his father was. If he wants to be a father and see him, he can but I'm not going to make it easier for him.

A 14-year-old was no longer interested in a relationship with her "older" boyfriend. She provided the following comments:

> I'm not so much worried or if I am at all interested in a relationship with him for myself, but for the baby I'd like for him to be involved. He wants custody and I'm not going to let him have custody. I don't think he'll go to court for it, I'm hoping he won't. --- just visiting I'd like that actually.

These quotes indicated the conflicts the young women were experiencing about their relationships. They wanted their boyfriends' involvement with their babies, but they wanted autonomy for themselves. They also did not want to lose custody of their children.

Some of these young women were in vulnerable positions for abuse and with the birth of their babies they recognized they needed to monitor their own and their infants' safety needs. For example, a 16-year-old related the following account:

> He hit me when I was pregnant. When I was seven months pregnant, and I did a stupid thing staying with him. He went through the birth and everything with me but now he's talking about wanting full custody and stuff. I won't go over to his house alone. Because I am scared of what he might do. When I did before he grabbed her from me and wouldn't let me back in the house to see her and stuff. And I tried to get up to go and phone the police but he wouldn't let me go. So I told him if he wants to see her he has to come here [her parents home]. But now . . . he doesn't want to see her at all, until I finish breast-feeding. So he doesn't have to see me.

Similar to the experience of the young woman in the previous narrative, Parker and McFarlane (1991) acknowledged that pregnant teens reported that their abuse began or increased once their partners were informed about their pregnancies. Parker and McFarlane also noted that pregnant adolescents report battering more frequently than pregnant adult women.

Ending a relationship was complicated by the men's threats to pursue custody of their children. It was not explored in this study, but some of the young women discussed that they did not want to leave their babies in day-care facilities. This may have been related to threats by the fathers to apply for custody of their children. The two young women who stated they did not want to have their children looked after in day-care centers were both no longer in relationships with their babies' fathers. Mercer and Flick (1991) have also expressed concern about the emotional upset young women experience when the fathers of their children threaten to sue for custody.

Only in recent years has the literature discussed the differences in age of the fathers and the adolescents who become pregnant by them. Five of the eight young women that were interviewed had partners who were 6 to 12 years older than themselves. Hardy and Zabin (1991) raised an important issue concerning the male role in adolescent pregnancy, whether there is sexual abuse or coercion of the young women to have intercourse with older men. Reedy (1991) also suggested that it is unlikely that young female adolescents are sexually active for sex itself. "She may be sexually active as a result of abuse/incest by the older male object of her adolescent crush, or, if the home situation is unstable, she may be trading sex for food and/or lodging" (Reedy, 1991, p. 222).

Two of the young women in this study started living with their "boyfriends" because they offered a place to live, prior to beginning their relationships. The issue of sexual abuse was not addressed in this study, but it raised questions for the researcher as to the nature of the young women's relationships particularly when the fathers of their children were much older than themselves. A young to middle adolescent is concerned with different developmental tasks than a young adult. For example, in response to a question about her boyfriend knowing her age, a young woman who was 14, had this to say about her 24-year-old boyfriend:

> Um --- I didn't lie or tell him otherwise but he never asked not until I was living with him and he asked me and I told him and he kind of backed away for a bit, and then I figured it didn't matter. When I first got pregnant it scared him he was wondering if he could be charged or you know anything like that. And when he found out he was safe he just kind of, he was ok with it again . . .

She needed to maintain a place to stay, her boyfriend's acceptance of her meant she would continue to have lodging. It also sounded as though her boyfriend was seeking an intimate relationship.

Coping with the Maternal Role

The sixth aspect of experiencing a changed life was coping with the maternal role. These young women were interviewed in the immediate postpartum period, and the maternal role was very

new to them. Even though some of the young women had experience with babysitting and caring for siblings, they did not have experience with the 24-hour responsibilities of mothering. Consequently they found it was hard. They were still pleased, however, that the pregnancy had provided them with a chance to change their lives. A 15-year-old stated:

> I have thought about it [the baby] a lot . . . . but I still think, you know, that there are lots of things I can do. And, it is not taking my whole life away, it will still bring more joys to it . . . . I am glad actually because it took me away from the drugs and alcohol and . . . a lot of those things, bad things that I used to do.

Even though pregnancy and the birth had changed the young women's lives, they still had to deal with issues from their past. One young woman discussed how taking responsibility for stress and anger came down to some very specific coping behaviors:

> You see if I am stressed out then she is stressed --- by findings ways to vent my anger, to vent my frustration. Other than in the same room as her, I don't do it anymore. As I've said I have yelled three times around her. That was enough to worry me . . . Just because anger can lead to other things . . . And that is why I started feeling I was on the road then to being a danger to my own daughter. And I couldn't allow that, and so for me trying to be a better mother [involves] going and talking, I am trying to get . . . referred to a counsellor so I can spend an hour with somebody talking over my problems . . . . problems from the past that I haven't solved.

These young women acknowledged their coping behaviors were limited and that their past had put them at risk for hurting their children. Some were able to acknowledge their difficulties and seek help to deal with their concerns.

It is unclear if adolescents abuse or neglect their children because of their young maternal age, the environment of social disadvantage in which adolescent pregnancy often occurs, or a combination of these factors (Hardy & Zabin, 1991). Hardy and Zabin found that parenting education was effective in preventing accidents and child abuse/neglect of children born to adolescents. The literature indicates that adolescents who have social support available for developing mothering behaviors are more likely to feel competent in the mother role (vonWindeguth & Urbano, 1989).

As the young women began to project ahead, they saw parenting as a responsible role. They realized being a single parent would not be easy:

> . . . I want her to have a dad. I thought I wanted to raise her on my own but I don't want to do that now. But I think It would be too hard and I think she needs a guy around . . . . so I could have some help with decisions and stuff about her. Cause I may not be right all the time [laugh]. But it would be nice to have some input from somebody else about what is right for her.

They were also concerned about finding a partner.

> I am really worried about finding a husband [laugh] . . . I think it will happen.

Worrying about supplying a father figure and concerns about being a single parent complicated the numerous responsibilities involved with mothering. Some of the young women also thought about how a baby would affect establishing relationships with young men. For example:

> . . . finding a guy that will accept me and my child and not be put off by the fact that I have one. Because there is a lot of guys . . . that would be scared away by that.

The young women were projecting their needs for intimacy and support but, because of their young ages, they were assuming that males in their peer group would not want to deal with an infant.

After their children were born, the young women considered all the challenges they were facing and acknowledged the reality of years of work and responsibility that was ahead.

> but yet now that I have her and know the responsibilities . . . . once you have the baby out in your arms it is a hell of a lot of hard work it is.

The difference between carrying the baby during pregnancy and caring for a separate individual echoed their earlier comments. Even for adult women it is often difficult to understand how much their lives will be changed by the birth of a baby.

The findings of the study were explored in the context of the current literature from nursing, medicine, social work, psychology, and sociology. By examining their stories, this

chapter has explored how the young women perceived and managed their pregnancies. In Chapter Five, a summary of the study findings and conclusions that arise from the study are presented, as well as implications for nursing practice, education, research, and social policy.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND IMPLICATIONS FOR NURSING

Introduction

This chapter presents a summary of the findings and important conclusions arising from the study. In addition, implications are proposed for nursing practice, education, research, and public policy.

Summary of Findings

The study explored and described the female adolescent's perspective of what it was like to be pregnant. Chapter Four presented the young women's stories which were elicited during the interviews. These accounts were candid and rich in detail. Because the perceptions and experiences of the young women were highly individual and related to both their personal and social environments, their management of their pregnancies was also individual. The phenomenological analysis resulted in a description of this unique group of female adolescents' experiences of pregnancy.

The maturational event of pregnancy was superimposed on the young women's developmental tasks of adolescence. The theme of ambivalence was interwoven with the theme of adolescent pregnancy as a life change event. The ambivalence the young

women experienced took many forms and varied in intensity. They were ambivalent about changes in their lives, their relationships, and their futures.

The description that emerged from the data analysis process has been characterized, by this researcher, as phases of adolescent pregnancy as a life change event. These phases were entitled: (a) suspecting the pregnancy, (b) confirming the pregnancy, (c) making decisions about the pregnancy, (d) living the reality of the pregnancy, and (e) experiencing a changed life. Concepts and subconcepts that influenced how the young women managed their pregnancies were identified under each phase.

During the data analysis, it became evident that a number of factors influenced the adolescent females' experiences of pregnancy and their coping behaviors. Throughout the narratives, the young women talked of the role others played while they struggled to cope with the simultaneous developmental tasks of adolescence and pregnancy. In particular, mothers' acceptance was important and mothers were identified as valuable sources of support. The social environment in which the young women lived, and interactions with their significant others, also acted as factors which influenced their coping behaviors and consequently their experiences of pregnancy.

While coping with pregnancy, the young women continued to learn about themselves. Data from this study suggested that

these adolescents perceived their pregnancies as a positive life changing event.

Conclusions

Qualitative research findings "are important in and of themselves since it is the richness and detail of the data that give[s] the reader an understanding of the . . . [participant's] social world" (Knafl & Howard, 1984, p. 18). The findings of this study cannot be generalized to all pregnant female adolescents. These findings are descriptive of an unique group of middle adolescents who have had a history of unstable family and living arrangements. Many had run away from home. Some had lived on the street from time to time. Some were living with foster families or boyfriends. None were attending school when the interviews were conducted. All the young women were vulnerable because they were uncertain about the level of family commitment to themselves, and later to their infants. The findings of this study provide nurses, who work with pregnant adolescents, with insight about adolescents' pregnancy experiences. Such perspectives can enable nurses to respond to pregnant female adolescents' health care needs in a manner that supports and enhances adolescents' coping abilities.

The following are the major conclusions from this study:

1. The experience of pregnancy, and the expected child provided the young women with meaning, purpose and a sense of hope for their lives. This meaning and purpose provided them with motivation to change their previous self-destructive behaviors. The hope and optimism they felt about their pregnancies, and later their healthy babies, provided them with a sense of achievement and increased their self-esteem.

2. All of these young women were vulnerable. Some of them were escaping from abusive situations and seeking shelter elsewhere, and as a result, they were at increased risk for pregnancy. Also, they had a poor understanding about the risks of pregnancy associated with sexual activity, or falsely believed they were not at risk. The lower the chronological age and stage of cognitive development the less developed were the young women's abilities to use realistic future thinking and to examine possible outcomes of their actions.

3. Because they were unsure about their abilities to provide a safe environment during their pregnancies and following their births, they wanted assistance from their families and various social programs. At the same time they were uncomfortable with being dependent on social assistance or their families.

4. Ambivalence characterized the young women's responses to pregnancy. Initial ambivalence caused the young women to deny their pregnancies and prevented them from seeking early

prenatal care. Denial was associated with ambivalence and enabled the young women to cope when they first suspected they were pregnant. However, denial also permitted them to continue risk-taking behaviors at the most critical time in their pregnancies. Some young women denied their pregnancies at first because they were ambivalent about their parents' or other's reactions. These actions also prevented them from seeking early prenatal care.

5. When the young women did tell others about their pregnancies and were rejected, their ambivalence increased. Rejection by families decreased adolescents' feelings of trust and reduced their receptiveness to help from others including health care professionals. The findings in this study indicated how important even dysfunctional families were to adolescents' views of their pregnancies and feelings of self-worth.

6. Higher feelings of ambivalence were associated with feeling unsure about themselves and had a negative impact on their self-esteem. High ambivalence prevented them from feeling in control of their lives and from achieving their pregnancy tasks. Also, the more limited their life experiences, the more ambivalent the young women felt about pregnancy and parenting.

7. The young women identified their mothers as important sources of support during their pregnancies, labors, and after the births. Although the young women wanted to be in control of

their lives, they also wanted their mothers to be emotionally supportive and available for guidance.

8. These young women did not consider abortion a feasible option for pregnancy resolution. Previous experience with abortions reduced some of the young women's willingness to use that form of pregnancy resolution again during this pregnancy experience. This was especially true, when the young women's parents had controlled previous decisions about abortion. In addition, some held beliefs that abortion was not acceptable.

9. The young women's thinking and decision-making became more mature during their pregnancies. They thought more about how their pregnancies would affect their future lives. However, the previous life experiences of the young women had also increased their maturity in relation to decision-making.

10. The young women's relationships with families and partners were often dysfunctional and put some of them at risk for abuse. Five of the eight young women had older partners and their perceptions of their male partners changed as their pregnancies progressed. Some young women wanted less involvement with their partners and choose to bear and raise their children on their own. However, some of the young women's partners threatened to apply for custody of their children when their relationships ended. The climate of fear and coercion

created by their relationships made the young women fearful about their own and their infants' safety.

11. The young women's abilities to accept help were dependent on their perceptions of being supported. They indicated that when they talked to others about their pregnancies they were only prepared to listen to comments that were supportive. Thus, they valued persons who were seen as empathic and supportive. While this decreased their ambivalence, because they blocked out comments that would interfere with their autonomy, their resistance to necessary positive changes may have been increased.

12. Peer relationships were affected by the pregnancy. The young women had different experiences than their peers. Some young women were not interested in relationships with their peers because they felt they no longer had things in common. Others indicated that their friends' support continued to be important to them, because they did not see their pregnancies as abnormal.

13. The young women made associations among social assistance and negative influences on their self-image; their children's self-image; and their loss of independence.

14. This was the first time for the young women to carry a pregnancy to term. They had difficulty anticipating what the mothering role entailed, however, they expressed a strong desire

to be good mothers and wanted recognition for their abilities with the role.

15. The young women stated that they were not overwhelmed by the information they were given throughout their pregnancies. They may have found it difficult to acknowledge that they were overwhelmed, or perhaps, they found the information decreased their ambivalence and made them feel they could cope with the pregnancy.

16. The young women became more interested in education and career or vocational planning following confirmation of their pregnancies. However, some of them wished to maintain teen behaviors.

17. All the young women were participating in support programs for pregnant and parenting adolescents, which they indicated helped them to adjust to their pregnancies, prepare for labor, and care for their babies after the delivery.

18. In the early postpartum period, the young women stated that they wanted to postpone future pregnancies until they had finished their schooling and career plans. Consequently, they discussed their readiness to practice contraception. However, their history of dysfunctional relationships influenced their abilities to be assertive about their own needs.

These conclusions provide implications for nursing practice, education, research, and public policy.

Implications for Nursing

Practice

Nursing interventions that are derived from an understanding of the female adolescent's perceptions of pregnancy are likely to be more effective than those derived only from professionals' speculations of what is important to these young women. The data from this study provide direction for nursing interventions aimed at assisting pregnant adolescents to cope with their pregnancies.

The five descriptive phases of adolescent pregnancy identified in this study can provide a framework for nurses to use in exploring young women's experiences of pregnancy. The framework would assist nurses to focus simultaneously on adolescents' developmental tasks and the tasks associated with each phase of pregnancy as a life change event. The framework provides the nurse with direction to assess a young woman's experiences and expectations related to her pregnancy, and to identify her ambivalent feelings.

The young women in this study felt that their experiences of pregnancy and their expected babies provided them with meaning, purpose and a sense of hope for their lives. The hope and optimism they felt about their pregnancies, and later their healthy babies, increased their self-esteem and provided them with

a sense of achievement. These positive feelings should be supported and enhanced by nurses so that the young women's ambivalence would be decreased and their motivation to change to healthier behaviors would be facilitated. Recognizing the young women's strengths would enhance their coping skills for pregnancy and parenting.

A striking characteristic of all the young women in this study was their vulnerability. Many of them came from families of low socioeconomic status. Their mothers were single parents, or they identified problems in their family unit. They were not attending school during their pregnancies, and did not have major support groups like churches or youth groups in their lives prior to their pregnancies. The young women talked about wanting to change their lives for the better, and reducing self-destructive behaviors.

Nurses, who are designing programs for high risk youth, need to be aware of young women's vulnerability in relation to pregnancy risk and inadequate living situations during pregnancy. Interventions need to address the social factors that are present in young women's lives prior to as well as during their pregnancies. Nurses need to refer pregnant adolescents to suitable housing and programs that provide financial and emotional support to young women. This could lessen their vulnerability and assist them to become more effective mothers. These

programs must be designed to move them towards increasing independence in order to build self-esteem and address concerns about dependency on social assistance.

Since the young women's living situations and false beliefs or poor understanding of risks for pregnancy contributed to their vulnerability, nurses in practice settings such as youth clinics or schools must assist young women to realistically assess their risks for pregnancy. As well, nurses should help young women to assess their safety concerns when they are in abusive relationships. Nurses could address these concerns in individual counseling sessions or small group discussions.

The young women wanted help to provide safe environments for their babies. They asked for assistance from their families and social programs. Nurses should make referrals for teenagers to adolescent pregnancy programs. Nurses should also work with social workers to ensure that young women's and their children's needs for safe living situations are addressed, this may include safety in their own homes.

High levels of ambivalence when suspecting pregnancy and subsequent denial challenges nurses to acknowledge young women who deny their pregnancies. This finding is supported by Harvey and Faber (1993) who found that a significant barrier to obtaining prenatal care was a woman's ambivalent feelings about her pregnancy. Nurses need to assist young women to confirm their

pregnancies by acknowledging their symptoms and by encouraging them to access prenatal programs and services.

Since the young women's ambivalence increased when they felt rejected, nurses also need to provide young women with assistance to tell their families, boyfriends, or friends that they are pregnant. It would be helpful for nurses to review strategies for telling others with pregnant teenagers, perhaps through role-playing. Nurses should also help pregnant adolescents to gain skills for decision-making for pregnancy resolution.

Because the young women identified families and especially their own mothers as important sources of emotional support, nurses need to look at ways these relationships can be supported and enhanced. Lederman (1991) has suggested that group therapy that includes both adolescent females and their mothers is effective in preventing unplanned pregnancies. Family counseling or support groups could also be used to offer support to families so that optimal family relationships could be facilitated. The support to the families should address concerns of individual members and the family as a unit, as well as effective communication patterns.

Smith (1991) suggested clinical interventions that impose a different model for mothering than adolescents' families' beliefs may undermine the resources and skills of adolescents' families for supporting their daughters in the role of mother. Nurses need to

collect data about the family's perceptions about mothering, and validate their impressions with families. Clinical interventions that are consistent with the family's beliefs are more likely to be seen as supportive and accepted. As well, Wilkerson (1991b) noted that adolescents learn patterns of communication for meeting their needs in their families of origin. These patterns of communication can either assist or hinder the adolescent in meeting her needs. Nurses could be involved in sensitively offering interventions that build on the current communication skills of adolescents' and/or families' to make them more effective.

Some of the young women in this study mentioned that their decisions to carry the pregnancy to term were influenced by their beliefs that abortion was not an option, or by a prior abortion. Some of their families had made decisions for them to have an abortion during a previous pregnancy. Nurses must recognize that, if adolescents are not allowed to make decisions for pregnancy resolution (i. e., a parent tells them what to do), a subsequent pregnancy resolution experience will not be addressed with the necessary decision-making skills. As well, subsequent experiences may be influenced by unresolved feelings, or negative perceptions from a previous experience.

Nurses can assist young women in developing decision-making skills by working with them and their parents. The parents' concerns for the best interests of their daughters

needs to be recognized. But, parents must also understand the importance of their daughters being allowed to participate in the decision so that they gain decision-making skills and take responsibility for decisions for contraception and pregnancy resolution.

Some of the young women in this study felt that the pregnancy experience had allowed their thinking and decision-making to mature. Viewing the pregnancy experience as a way to become mature may make pregnancy appear a viable alternative for changing a young woman's life to a more positive course. This concept is important for nurses who work with adolescents at risk for pregnancy and pregnant adolescents. Nurses often assume this is a negative experience, and these findings provide direction as to how these young women can be supported. Where an adolescent expresses a desire to change, interventions need to work specifically toward achieving developmental tasks that will prepare her to develop skills for parenting. Interventions that are aimed at helping young women who are pregnant develop as adolescents, will simultaneously support their abilities and confidence to take on the maternal role.

Some young women also indicated that their pregnancies did not make them adults; they still wanted to engage in adolescent behaviors, for example, hanging out with their friends. An important consideration for nurses working with adolescents is

identification of conflict between their desire to maintain adolescent behaviors and accepting adult parenting responsibilities. Acknowledging their conflicts might assist young women to deal with their ambivalence.

Because of their dysfunctional families and having spent time living on the street or with their boyfriends, these young women were living in less than ideal situations. Consequently their choices were affected. The challenge for nurses is to empower these young women to develop healthy behaviors in the context of their own living situations. These young women required ongoing support during their pregnancies and parenting. Support over a long period of time with consistent caregivers can enhance young women's abilities to be effective, confident mothers.

Stevens and Hall (1992) pointed out that people living in "health damaging" conditions (unsafe physical surroundings, economic impoverishment, and oppressive social arrangements) may identify different priorities than community health nurses. "It is not nurses' responsibility to think for others or to mandate their actions. We must let go of 'ideal' notions of health that are not relevant to people's everyday lives" (Stevens & Hall, 1992, p. 5). Young women should be involved in identifying their own needs. This would reinforce the nurses' respect for young women and consequently encourage them to be more open to care and advice. In such an environment of care-giving, nurses would be more

likely to note what the young women's interests were and when they were ready to learn.

The findings indicated that the young women valued interactions with others who were caring, and who offered encouragement and support. Some of the young women indicated that they wanted to hear advice that was supportive, but if others offered advice that was not supportive they would ignore it. The young women viewed their pregnancies as a positive influence in their lives, and were optimistic about their futures. In order to help these adolescents, nurses can gain their trust. Hardy and Zabin (1991) noted that staff who offered services to teens needed to build relationships of caring, confidence, and trust so they could help young people gain the skills they need for their futures.

It is important that health professionals respect a young woman's beliefs and values and avoid imposing their own values if interventions are to be successful. These young women had engaged in many risk-taking behaviors (e. g., use of street drugs and alcohol, and unprotected sexual intercourse). Practitioners who examine their own beliefs and values, especially when working with adolescents living in disadvantaged situations, will be more effective. Mercer (1991) noted that health professionals must respect a young woman's and her family's values if interventions are to be successful, but at the same time nurses need to offer

support and facilitate healthy behaviors. This may create some ethical dilemmas for nurses.

The young women who were interviewed initially wanted their boyfriends involved in their pregnancy experiences. They wanted them to attend their prenatal classes, and to support them during labor. There is a need to involve the male partner more in the pregnancy experience. Involving men in the prenatal care of their partners would enable them to gain skills for supporting their partners and preparation for parenting. Support of this idea is found in the literature by Wilkerson (1991a) who states: "Nurses should assess the nature of the pregnant adolescent's relationship with the father of her infant. Attempts should be made to incorporate his support into her plan of care whenever appropriate" (p. 127).

Many young women in this study had partners who were much older than themselves; they chose not to remain in their relationships, but to bear and raise their children alone. Hardy et al. (1989) found that men who father children of young adolescents are in poor financial situations themselves, and could not provide a stable, independent home, even if they wanted to. Nurses must acknowledge the possibility of sexual abuse being associated with older partners. Butler and Burton (1990) conducted an exploratory study with young rural mothers who had been pregnant as teenagers and found that childhood sexual abuse

was linked to some adolescent pregnancies. Childhood sexual abuse was not explored with the young women in this study, but nurses need to be cognizant that childhood sexual abuse may be a factor in some adolescents' pregnancies.

Although none of the young women mentioned sexual abuse in their relationships, one young woman did mention that she was physically abused by her boyfriend as the pregnancy progressed. Nurses need to be aware of the potential for abuse with this vulnerable population and refer to agencies for battered women. Nurses can also assist young women in evaluating the positive and negative aspects of their relationships. Parker and McFarlane (1991) suggested that nurses should assist women to gain problem-solving and decision-making skills so that they can leave a relationship, or to recognize imminent danger to their own or their child's safety.

The young women in this study wanted to be respected for their knowledge and skills, and to be able to find out things for themselves. The phases of adolescent pregnancy as a life change event indicated that the young women's ambivalence decreased when they felt supported, thus, enabling them to learn new things about pregnancy and parenting. Consequently, nurses who demonstrate respect and support for adolescent's existing knowledge and skills will offer opportunities to learn based on the young women's individual learning needs. Positive parenting

behaviors can be modeled by nurses. Contact with a consistent caregiver would allow the young woman to develop a relationship where she would feel comfortable asking for advice, and the nurse would be able to observe changes in behavior, consistent with positive parenting, over time.

Many of these young women had spent time living on the street, nurses need to offer services in clinics that are accessible and in locations frequented by adolescents. Storefront clinics that offer contraception, sexually transmitted disease treatment, and prenatal care have advantages because they are accessible to adolescents whether or not they attend school.

Nurses can recognize that adolescents' interactions with their peers may change during their pregnancies. Although their peers' approval was important to the young women in this study prior to their pregnancies, as their pregnancies progressed the young women only maintained contact if they felt their friends were supportive. After the birth of their babies, they placed less emphasis on their peers' approval. By recognizing how responses to peers could change, nurses could assist adolescents to build supportive networks. This information assists nurses to use peer interaction judiciously to assist young women to meet their needs for approval and belonging.

Nurses need to recognize that if young women associate social assistance with a negative influence in their lives, they may

not be willing to use social assistance until they have explored other options. This negative perception of social assistance may cause young women to delay seeking health care services.

It was difficult for the young women to imagine what it would be like to become a mother and what responsibilities each phase of adolescent pregnancy entailed. The framework of adolescent pregnancy as a life change event provides the nurse with direction to collect data in relation to a young woman's home environment, relationships, life experiences, and their cognitive abilities. As well, it provides some anticipatory guidance about the phases of the process and coping strategies.

The young women expressed desires to be good mothers, and wanted help as they took on the mothering role. Acknowledging the young women's strong desires to be good mothers and their prior experience with child care would provide the young women with recognition and increased self-worth while decreasing their ambivalence. In addition, young women might be more receptive to specific information about pregnancy and mothering.

The young women in this study did not think they were overwhelmed by the information that was given to them about pregnancy. They may have been unwilling to admit they were overwhelmed, or the information that was given to them may have decreased their ambivalence. This has implications for designing

programs that capture the interest of pregnant adolescents and that can decrease their ambivalence and support them as knowledgeable capable parents.

These young women indicated a greater interest in pursuing education following confirmation of their pregnancies. Programs that enable young women to finish their schooling even though they become pregnant can increase their self-esteem and allow them to achieve vocational training or a career. Both factors are important for decreasing pregnant and parenting adolescent's risks for poverty and dependence on social assistance.

The young women in this study were participating in programs for pregnant teenagers. They found the programs helped them adjust to their bodily changes, prepare for labor, and to care for their babies after their deliveries.

Programs that begin in pregnancy and continue after the birth can incorporate role modeling that would assist young women to meet both their adolescent and maternal developmental tasks. At the same time, these programs can offer adolescents a supportive environment for dealing with their conflicts between adolescent and pregnancy developmental tasks. Fleming, Munton, Clarke, and Strauss (1993) noted that by recognizing adolescent mothers' needs for respect and recognition of their positive parenting behaviors, nurses can foster parental and child development.

Emphasis needs to be given to working collaboratively with other health care professionals and social agencies in the community to support pregnant adolescents in their changed lifestyles. Reedy (1991) acknowledged that social workers can assist with home evaluations and investigations of abuse, as well as connecting young women with community agencies. Mercer (1991) taking a broader view of adolescent pregnancy in the community, proposed that a multidisciplinary team approach, supportive networks in the community, and funding are necessary if changes are to be effected. Nurses can make referrals to programs that address adolescents' learning needs for pregnancy and parenting. As well, there are numerous settings in which nurses can participate as members of multidisciplinary teams offering services to adolescents.

The young women in this study mentioned they did not want to get pregnant again for a long time. They wanted to achieve some of their other developmental tasks such as education and career or vocational goals. They planned to use contraception or abstinence. Abstinence may be an unrealistic method to prevent a future pregnancy if a young woman is still in a relationship or under pressure to resume one. Early in the postpartum period would be a prime time to explore the use of contraceptive methods with young women, because of their receptive attitudes. The nurse could offer information about several methods, and

encourage the young women to verbalize their own feelings about the different methods. Discussing contraceptive options would provide young women with an opportunity to clarify their values. It is important to recognize that young teens often need support in using a method, whether it be review of how to use the method, or possibly an offer to try something different. By following up at regular intervals, the nurse is able to answer questions and offer emotional support.

This study also found that the young women assumed responsibility for contraception in their relationships. Nurses need to acknowledge that reality when they counsel young women. The counseling should include how to talk with, and involve partners in the responsibility for preventing pregnancy. This is particularly challenging area for nurses to facilitate young women's assertive behaviors, because recent research indicates that young men who have been responsible for a previous pregnancy report it enhanced their male self-esteem, and were less likely to use effective contraception (Marsiglio, 1993). Furthermore, vulnerable young women are often not assertive when discussing contraception with their boyfriends.

The findings of this study add to the research based knowledge for planning nursing care of pregnant adolescents. Implications for nursing education follow from this discussion.

Education

Nursing educators teaching about adolescent pregnancy are directed to use an eclectic model that integrates knowledge from a variety of fields. The findings indicated numerous sociocultural and familial factors influenced the young women's risks for pregnancy and their decisions to keep and raise their children. These factors included: the reactions of their families to their pregnancies, living in single parent families, prior life experiences such as having been abused or running away from home and living on the street, problems with street drugs and alcohol, having older men for boyfriends, and the support or lack of support they received for coping with pregnancy and parenting.

Nursing educators and their students need to be aware that some young women have dysfunctional families, and these young women view their pregnancies as a positive life changing event that gives them a sense of hope and optimism. Hope and optimism are usually conspicuously absent from discussions about adolescent pregnancy.

Ambivalence is a concept that is not often discussed in relation to adolescent pregnancy and parenting. Ambivalence influenced the young women's coping strategies by delaying their seeking of prenatal care, allowing continued risk-taking behaviors in the early prenatal period, and preventing them informing others. In addition, levels of ambivalence increased when

rejection from family, boyfriends, or friends occurred. Ambivalence was linked to decreases in self-esteem and these relationships should be explored with students. The relationship between limited life experiences and increased ambivalence about pregnancy and parenting must be appreciated by educators and their students. Particularly, this relationship must be explored in light of strong desires to be good mothers and to value interactions with others who were caring and supportive. Students can be made aware of adolescents' needs to remain a teenager and to maintain their teen behaviors with peers. In addition, there is a possibility that relationships with peers may vary and some young women may not want contact with peers who are not supportive of their pregnancy, or parenting after the birth. These concepts provide educators and students with a more complete understanding of adolescent pregnancy.

Some young women can have older men for partners, which can make them vulnerable to abuse. Students can relate young women leaving their partners and deciding to gestate and raise their children alone, to their needs for safety. They are also, however, at risk for living in poverty. Case studies would be an effective educational tool, as they would allow students to gain an understanding of the multiple factors that influence a young woman's experience of pregnancy.

Also of importance to educators is preparing nurses at advanced levels who understand public policy so that they are able to work with community leaders to develop services and programs for pregnant and parenting teens. Norr (1991) urged nurse educators to prepare nurses who understand the importance of community-based nursing and know how to work with community leaders to develop programs that address the needs of pregnant adolescents.

Agencies that employ nurses to work with adolescents could offer specific orientation programs. Such programs could address topics such as adolescent decision-making, counseling skills for working with adolescents and their parents, and services to which referrals can be made for adolescents who need support during pregnancy and parenting, or who have experienced abuse. As well, staff nurses could be encouraged to attend workshops and inservice programs to up-date their knowledge base, including information reflective of the findings of this study. This idea is supported in the literature by O'Sullivan (1991) who recommended that nurses who work with pregnant and parenting adolescents should attend conferences to keep themselves professionally up to date and abreast of new developments.

Since nurses that practice community health are in key positions to advocate for community support and the development of programs for adolescents during pregnancy and parenting,

attention needs to be given to these nurses' preparation. Considering, that this study found the young women's social environments influenced both their risks for and experiences of pregnancy, it behooves nurses to understand how the environment influences adolescents' decisions affecting sexuality and pregnancy. Morgan and Barden (1985) suggested that community health nurses delivering care to adolescents need an orientation that provides information on: adolescent growth and development, antepartal and postpartal care, environmental influences on health, and community referral sources for problems that are beyond the nurses' immediate scope.

Nurses in educational settings are in key positions to carry out research on adolescent pregnancy and to influence nurses who work directly with adolescents. The next section discusses implications for nursing research.

Research

The phenomenological method has been useful for developing knowledge about the perspective of pregnant teens from dysfunctional families. It is important to realize the difficulties for researchers working with this group. Mercer (1991) noted that attrition of subjects is a problem when studying adolescent pregnancy: "we need to develop more critical ways of capturing those incidents and situations that contribute to attrition" (p.

273). In this study, the researcher found the young women were difficult to access due to their age and problems with obtaining consent, and they moved frequently during the study.

By coincidence, several of the young women had run away from home and spent time living on the streets. Further qualitative research with young women who have lived in unsafe environments needs to be done to expand understanding of their experiences. What are their needs? How do they access services? How can their needs be met?

It would appear from this study's findings that disadvantaged adolescents view themselves differently from same age teenagers because of their life experiences. As well, further longitudinal research should be done with adolescents from dysfunctional families or unsafe living conditions who are mothers. Does their hope and optimism continue? If so, how does it enable them to be capable parents? What other factors are necessary?

The young women talked about how their relationships with their mothers changed as their pregnancies progressed. This was a relationship that they valued, because it provided them with emotional support, decreased their ambivalence, and increased their self-esteem. Further research needs to examine how the mother-daughter relationship can be supported and enhanced. How do pregnant adolescents and their mothers perceive their

relationships? What interactions are effective in helping them to meet their needs? How can these interactions be enhanced?

The young women valued the support significant others offered to them during their pregnancies and in the immediate postpartum period. How are supportive relationships within the family, such as with fathers, foster parents, siblings, and extended family members like grandparents and aunts used by the young women? Anderson (1991) and Smith (1991) also called for further research on family relationships. Anderson (1991) suggested that more research is needed in order to understand the role of the family in adolescent pregnancy, because the family may contribute to both the problem and the solution. Smith (1991) suggested that health professionals who lack an understanding of the supportive relationships within the family sometimes devalue the caring practices of the family; practices which could support the adolescent taking on the role of mother.

The young women's perceptions of their relationships with boyfriends changed as their pregnancies progressed. Further research with young women could assist nurses to identify pregnant adolescents who will require support with maintaining or terminating these relationships. What are pregnant adolescents' perceptions of relationships that end during pregnancy? What types of relationships do parenting adolescents seek?

This study identified some of the young women's partners as older men. More research is needed to understand this population. What are the characteristics of this population? What are their attitudes towards adolescent pregnancy? This research will require innovative approaches as Hardy et al. (1989) noted that this is a difficult group to access.

Although the concept of intimacy was not explored in-depth in this study, it is an area that needs to be studied to identify if the young women and their partners were seeking intimacy for the same reasons. Some of the young women in this study became involved in relationships with older men when they ran away from home and the men offered them a place to live. Oz and Fine (1988) made a similar observation: "The family problems of the teen mothers, apparently having lead to school problems and association with troubled males, may have allowed the emergence of a lifestyle facilitating more frequent sexual encounters" (p. 259). How do disadvantaged young women meet their needs for intimacy? Do these intimacy needs get incorporated under needs for safety and shelter?

Research also needs to explore intimacy in young women's relationships with parents, and the association of intimacy with risk for pregnancy. Some of the young women indicated that they felt a lack of caring in their relationships with their parents. Oz et al. (1992b) suggest that pregnant female adolescents who are

trying to work on the developmental tasks of autonomy and independence in relationships with males of their own age, rather than parents, may have difficulty developing healthy intimate relationships. Therefore exploration of intimacy between young women and young men is important. How do young women and young men define their needs for intimacy? Are their needs the same? If different, how are they different? This information could be used to assist both young women and men in decisions regarding sexual activity, contraception, and pregnancy resolution.

Perceptions of intimacy, also have implications for identifying young women who are at risk for sexual coercion or abuse. Boyer and Fine (1992) found that physical maltreatment and sexual victimization influence the adolescent's developmental processes, and consequently their decision-making for contraception and pregnancy. They suggest that many young women who become sexually active and pregnant before their peers, despite the options for contraception available to them, have not been adequately understood (Boyer & Fine, 1992). Further research with vulnerable adolescents in relation to achieving their needs for intimacy could lead to a better understanding of their risks for pregnancy.

The young women's discussions in this study suggested that their cognitive thinking and decision-making progressed during their pregnancies. Middle adolescents develop cognitively and

physically at different rates whether they are pregnant or not. Orr et al. (1988) suggested that assessing cognitive development within the context of physical maturation may be misleading, as cognitive and physical maturation occur at different rates. Further research is needed to identify how cognitive development influences decision-making for pregnancy resolution and how young women's cognitive development is influenced by their need to make decisions about pregnancy. Also, how cognitive development influences future decision-making re: sexual activity, contraception, and pregnancy resolution. How does cognitive development influence future decision-making? How does the need to make decisions about pregnancy influence cognitive development? Miller and Paikoff (1992) suggested that research is needed to link adolescent social and cognitive growth to adolescents' social and sexual development. The young women in this study indicated that their social environments influenced their development and their perceptions of their pregnancy experiences. What is the relationship between pregnant adolescents' social environment and cognitive development?

While the issue of child care and fathers applying for custody was not explored in this study, it is an area that needs to be examined more closely. Is there a link between young women not wanting to place their children in day-care facilities and fathers threatening to apply for custody? Because some of

the fathers of their children were older than themselves, the possibility of exploitation needs to be examined. What are the attitudes of young women toward day-care centers or other child care facilities? There may be a link between their unwillingness to place their children in day-care and fear that their partners will exploit or harm their children.

While the findings from this study add to nursing's understanding of adolescent pregnancy, they have also raised new questions for research. The next section further expands on the findings of this study, by presenting implications for public policy.

Public Policy

Topics in this section are included under the separate heading of public policy because they are political activities in which nurses must become involved in as the health care system evolves in the 1990s. Anderson and McFarlane (1988) described public policy as a planned course of action taken to address issues that involves four stages: "the recognition and definition of a problem, the development of programs and allocation of resources to address the problem, implementation of the programs, and evaluation of the impact of the programs" (p. 102).

Findings from this study indicated the young women viewed their pregnancies and the expected babies with hope and optimism.

It behooves nurses to educate other health care professionals to acknowledge young women's hope and optimism, and find ways to assist adolescents with their pregnancy experiences; after all, the consequences for unmet needs are great for both the adolescents and their infants.

Many of the young women in this study had spent time living on the street. This has implications for where nurses offer their services. Street front clinics or roving vans staffed with health professionals willing to understand the multiple problems these young women face in their lives must be funded. Such clinics are accessible to youth and provide contact with familiar caregivers, which is important for building trusting relationships. This approach would enable teenagers to access information on sexuality, contraception, and other health concerns in a nonthreatening environment. It would also provide a place to access counseling and teaching during pregnancy, and possibly encourage early prenatal care.

Nurses need to advocate for programs that assist disadvantaged adolescents who are pregnant and parenting. In order for young women to pursue their "new life course" they need support and services for themselves and their children, which promote normal growth and development, and encourage positive parenting behaviors. Anderson and McFarlane (1988) defined advocacy as presenting the case of another, based on

awareness, knowledge, and sensitivity to the unique needs of the individual or community. Several authors have acknowledged the role of nurses as an advocate for teens in their communities to lobby for programs (Mercer, 1991; Oz et al., 1992b; Rothenberg & Sedhom, 1991; Swenson, Oakley, Swanson, & Marcy, 1991). "Nursing intervention at the community level includes: working with community leaders as an advocate for youth to discuss the problem [of adolescent pregnancy] . . . and lobbying political leaders to make necessary policies and appropriations of funds" (Mercer, 1991, p. 272). Swenson et al. (1991) noted that community health nurses as primary care providers of reproductive health services for adolescents, are in key positions to act as advocates for services for pregnant and parenting adolescents.

Nurses need to be aware of these young women's increased needs for food, shelter, emotional support, and sometimes legal aid. Poverty must be reduced if programs are to ameliorate the negative consequences of adolescent pregnancy. Nurses can work with community leaders to plan for and obtain funding to meet the initial needs of adolescent mothers.

Nurses need to advocate for programs that improve the child-rearing skills and confidence of adolescents during their pregnancies and the years following. Fleming et al. (1993) found that nurses were more effective in promoting parental and child

development when they praised positive parenting behaviors, thus enabling the adolescents to feel a sense of accomplishment.

Nurses also need to advocate for programs that support young women living in disadvantaged situations in their roles as mothers, by allowing them to finish their schooling. Being unable to complete their schooling, is linked to living in poverty and a need for social assistance by the young women and their children.

During the interviews the young women talked about a negative perception of being on social assistance. This perception has implications for how adolescents access services, and needs to be recognized when health care professionals develop and offer programs and services to adolescents and their families. Programs and services that offer support and allow for gradual independence could make social assistance more acceptable for both pregnant adolescents and policy makers.

Nurses also need to advocate to increase the public's awareness of the incidence of abuse in this population. Support groups and counseling services for young women who have been physically or sexually abused must be made accessible. Raines (1991) also acknowledged that nurses need to advocate to increase the public's awareness of the need for services for adolescents who are victims of abuse.

There is a great need to develop programs in the community that offer support to families that have problems within their

family unit. Although some of these young women had run away from home, they also went back to their families when they experienced a crisis. Nurses, who have knowledge of growth and development, family, and maternal-child health, need to advocate for services that support these families in their coping on a day-to-day basis.

In addition, nurses need to collect evaluation data on programs and services that are effective in helping adolescents to meet their needs during their pregnancy and parenting experiences. This information would enable the health care system to more effectively meet the needs of pregnant and parenting adolescents. Without data indicating effectiveness there will be no funding for these programs. As well this information could assist communities to help adolescents channel their energy, hope, and optimism into becoming knowledgeable capable parents.

In conclusion, this study described the female adolescent's experience of pregnancy, which involved experiencing simultaneously the developmental tasks of adolescence and pregnancy. Ambivalence was a dominant theme which occurred throughout the pregnancy experience. Pregnancy was seen as a life changing event that occurred in five distinct phases: (a) suspecting the pregnancy, (b) confirming the pregnancy, (c) making decisions about the pregnancy, (d) living the reality of pregnancy, and (e) experiencing a changed life. The description

validated previous research, which acknowledged that growth and development are factors in adolescent's decision-making regarding sexual activity and resolution of pregnancy. Adolescents' pregnancy experiences were influenced by personal, social, and environmental factors. Pregnancy and the expected child provided these disadvantaged adolescents with hope and optimism, which created a sense of achievement and increased their self-esteem. Findings from this study add to the profession's knowledge about female adolescents from unstable family situations who become pregnant. This study has provided direction for nursing practice, education, research, and public policy.

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Appendix A

Letter to Agency

Dear

My name is Kathryn Banks. I am a graduate student in the Master of Science in Nursing program at the University of British Columbia School of Nursing. I would like your cooperation in identifying potential subjects, for a study I am conducting entitled, The Adolescent Female's Experience of Pregnancy, as a partial requirement of my graduate education.

The purpose of this study is to examine the experience of adolescent females who are pregnant. This study is not concerned with evaluating care, but with determining the client's perceptions of their pregnancy experience.

Understanding how the adolescent female describes her pregnancy can be beneficial for the following reasons: (a) provide current information regarding the pregnancy experience for a group of adolescents in Vancouver in 1991, (b) increase understanding of why adolescents do or do not access services, and (c) provide information from which prenatal programs can be designed to address the identified concerns of the pregnant adolescent.

In order to determine the female adolescent's perception of the pregnancy experience, information will be obtained through interviews. Eight to twelve adolescents will be selected for interviewing based on the following criteria: (a) in their third trimester (i. e., 33 to 40 weeks gestation), (b) able to speak and read English, (c) 13 to 16 years of age, (d) unmarried, and (e) currently planning to keep the baby.

The researcher will use an interview format designed to discover the adolescent's perceptions of her pregnancy experience. Each participant will be interviewed two to three times. The interview will last approximately 45 minutes, and will be tape recorded. The participants will be informed that their participation is voluntary, refusal to participate or a decision to withdraw from the study, or refusing to answer any question will not jeopardize their care. The true identity of the participants will be coded, so that their true identity will be known only by the researcher.

If you have any questions regarding the study, please contact me, or my faculty supervisor, Anna Marie Hughes. Thank-you for your cooperation.

Yours sincerely,

Kathryn Banks RN BN Telephone 222 - 8194

Anna Marie Hughes RN Ed.D. Telephone 822 - 7437
Assistant Professor
UBC School of Nursing

Appendix B
Letter to Attending Physician

Dear Dr. _____

My name is Kathryn Banks. I am a graduate student in the Master of Science in Nursing program at the University of British Columbia School of Nursing. I am conducting a study of the female adolescent's experience of pregnancy as a partial requirement of my graduate education.

_____, a patient under your care has agreed to participate in a nursing research project, The Adolescent Female's Experience of Pregnancy.

The purpose of this study is to examine the experience of adolescent females who are pregnant. This study is not concerned with evaluating care, but with determining the client's perceptions of their pregnancy experience.

Understanding how the adolescent female describes her pregnancy can be beneficial for the following reasons: (a) provide current information regarding the pregnancy experience for a group of adolescents in Vancouver in 1991, (b) increase understanding of why adolescents do or do not access services, and (c) provide information from which prenatal programs can be designed to address the identified concerns of the pregnant adolescent.

In order to determine the female adolescent's perception of the pregnancy experience, information will be obtained through interviews. Eight to twelve adolescents will be selected for interviewing based on the following criteria: (a) in their third trimester (i. e., 33 to 40 weeks gestation), (b) able to speak and read English, (c) 13 to 16 years of age, (d) unmarried, and (e) currently planning to keep the baby.

The researcher will use an interview format designed to discover the adolescent's perceptions of her pregnancy experience. Each participant will be interviewed two to three times. The interview will last approximately 45 minutes, and will be tape recorded. The participants will be informed that their participation is voluntary, refusal to participate or a decision to withdraw from the study, or refusing to answer any question will not jeopardize their care. The true identity of the participants will be coded, so that their true identity will be known only by the researcher.

If you have any questions regarding the study, please contact me, or my faculty supervisor, Dr. Anna Marie Hughes.

Yours sincerely,

Kathryn Banks RN BN Telephone 222 - 8194

Anna Marie Hughes RN Ed.D. Telephone 822 - 7437
Assistant Professor
UBC School of Nursing

APPENDIX C

Letter to Participant

Dear

My name is Kathryn Banks. I am a graduate student in the Master of Science in Nursing program at the University of British Columbia School of Nursing. I would like your help in a study entitled, The Adolescent Female's Experience of Pregnancy.

I want to know about the concerns of adolescent females who are pregnant. I am not intending to evaluate the care you receive, but I want to know how you view your experience of being pregnant.

Understanding how you view your pregnancy will be beneficial to health professionals for the following reasons: (a) developing an idea of how adolescents who are pregnant feel, (b) assisting in identification of the reasons young women do or do not access services, and (c) influencing prenatal programs that are being designed to address the identified concerns of young women.

To meet these aims I need to interview you. If you are: (a) in your third trimester (i. e., 33 to 40 weeks gestation), (b) able to speak and read English, (c) 13 to 16 years of age, (d) not married, and (e) currently planning to keep the baby, I would be very interested in hearing about your experience.

Each interview will last approximately 45 minutes, will be tape recorded, and you will be interviewed two to three times. Your participation is voluntary, you can refuse to participate, or decide to withdraw from the study, or refuse to answer any question without any risk to your care. Your true identity will be protected by coding, so that your true identity will be known only by this investigator. A summary of the information will be reported in a thesis, and possibly published in professional journals.

If you would like to talk to me about your pregnancy, please call me at the number below, or leave your name and number with the clinic nurse.
Thank-you for your cooperation.

Yours sincerely,

Kathryn Banks RN BN Telephone 222 - 8194

Anna Marie Hughes RN Ed.D. Telephone 822 - 7437
Assistant Professor, Faculty Advisor
UBC School of Nursing

Appendix D

Client Consent Form

I understand that the purpose of the study, The Adolescent Female's Experience of Pregnancy, is to identify my concerns, and how I feel about being a teenager and pregnant.

I understand that this study will involve the following:
1. The researcher will interview me about my experience for approximately 45 minutes, on two or three occasions.
2. Our conversation will be tape recorded.

I understand that my name and any identifying information will not be used in the study or revealed. Confidentiality will be ensured by the researcher using a code to identify my name. She will be the only person who knows my true identity. If the information is published, my identity will not be revealed and all information will be reported as group, not individual information.

I understand that my participation in this study is voluntary. I may refuse to participate without risk to my care. I may decide to withdraw from the study or refuse to answer any question at any time without any effect on my future care.

I understand that if I have further questions regarding the study, I can contact the researcher or her faculty advisor.

I acknowledge that I received a copy of this consent form.

Date:.....

Signature of Subject:.....

Kathryn Banks RN BN Telephone 222 - 8194
Researcher

Anna Marie Hughes RN Ed.D. Telephone 822 - 7437
Faculty Advisor
Assistant Professor, UBC School of Nursing

Appendix E
Parental Consent Form

I understand that the purpose of the study, The Adolescent Female's Experience of Pregnancy, is to identify _____'s concerns, and how she feels about being a teenager and pregnant.

I understand that _____ will be asked to participate in the following ways:

1. be interviewed about her experience for approximately 45 minutes on two or three occasions.
2. such interviews will be tape recorded.

I understand that _____'s name and any identifying information will not be used in the study or revealed. Confidentiality will be ensured by the researcher using a code to identify _____'s name, and she will be the only person who knows her true identity. If the information is published, _____'s identity will not be revealed and all information will be reported as group, not individual information.

I understand that parents are not present during the interview.

I understand that _____'s participation in this study is voluntary. She may refuse to participate without risk to her care. She may decide to withdraw from the study or refuse to answer any question at any time without any effect on future care.

I understand that if we have further questions regarding the study, we can contact the researcher or her faculty advisor.

I consent / I do not consent to my teenager's participation in this study.

I acknowledge that I received a copy of this consent form.

Date:.....

Signature of Parent:.....

Kathryn Banks RN BN Telephone 222 - 8194
Researcher

Anna Marie Hughes RN Ed.D. Telephone 822 - 7437
Faculty Advisor,
Assistant Professor, UBC School of Nursing

Appendix F

Demographic Information

Participant's Initials

Age

Ethnic Group

Gestation

Level of Education

Living at home?

Parent's occupation?

Appendix G

Trigger Questions

1. What is it like for you to be pregnant?
2. What are your expectations about your pregnancy?
3. How has being pregnant changed your life?
4. About what aspects of your pregnancy do you feel happy?
5. What are the major difficulties that being pregnant has caused for you?
6. Have you experienced any losses from your pregnancy?
7. Have you experienced any gains from your pregnancy?
8. What do you feel apprehensive about in regards to your pregnancy?
9. How has your pregnancy affected you physically?
10. How has your pregnancy affected you mentally?
11. How do you think this will affect your life in the future?