

ADOLESCENT PERSPECTIVES ON PRENATAL EDUCATION

A QUALITATIVE STUDY

By

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## ABSTRACT

The rate of adolescent pregnancy is on the rise in British Columbia. As health care professionals encounter adolescents in a variety of settings, they are increasingly likely to be providing prenatal care and education for the adolescent population. Research studies have documented numerous physical and psychological risks with early childbearing. In addition, research findings support that a woman's ability to adapt to pregnancy depends on the individual's beliefs past life experiences and ways of perceiving the pregnancy experience. However, Kleinman's conceptual framework of explanatory models (1978) advocates that the beliefs, expectations and desires of the adolescent client during the prenatal period may be quite different from those perceived by health providers. Because the knowledge of adolescent pregnancy almost exclusively reflects the perspectives of the health care provider, this study attempts to identify and explore the adolescents' perspective about pregnancy and prenatal education from teens themselves.

With the assistance of the Vancouver Health Department and Maywood Pregnancy Outreach Program, nineteen, pregnant and single teenagers were recruited to attend one of three focus group discussions. The adolescents chose to describe their emotional response to pregnancy, previous experiences with prenatal education and their vision for adolescent prenatal education.

Direction for data examination was taken from Giorgi's (1975) and Knafli and Webster's (1988) guidelines for data management and analysis. Data analysis

revealed pregnant adolescents experience a transition of emotional responses throughout pregnancy including: denial, shock and disbelief, ignorance, hopelessness, abandonment and isolation, dependency, powerlessness and anticipation and pride. In addition, adolescents perceive societal attitudes towards pregnant teens as "negative", "judgemental" and "all-knowing".

Study participants described and defined their own learning needs for prenatal education. Adolescent learning needs addressed structure, content and teaching strategy for prenatal programs. The explanatory model operating in the adolescents' mind about prenatal education differed from that of health professionals in terms of: the definition of who provides education and care, preparation and readiness for pregnancy and parenthood, program format and duration and choice and delivery methods of prenatal care and education.

The findings from this study have implications for all health disciplines regarding practice issues and direction for future research.

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## CHAPTER ONE

### Introduction

The rate of adolescent pregnancy is rising in British Columbia. In 1993, mothers 19 years of age or younger accounted for 5.8% of all live births, or 58 per 1000 births, whereas in 1981, they accounted for only 2.8% of all live births (Vital Statistics of the Province of British Columbia, 1981, 1993).

Health care professionals are concerned about the increasing number of adolescent pregnancies because childbearing in the adolescent period is often associated with unfavourable obstetrical, neonatal, physical and psychosocial risks (Hardy, 1991; Hendee, 1991; McAnarney, Adams, & Roghman, 1978). Multiple research studies have shown that a pregnancy outcome may be influenced by how an adolescent perceives her pregnancy and the health behaviours she exhibits during the antepartum period. Anderson, Elfert & Lai (1989) acknowledge that a woman's ability to adapt to pregnancy depends on the meaning that she attaches to the situation based on her values, beliefs, and past life experiences.

While nurses recognize that pregnant adolescents present unique social and health care needs, they continue to plan and organize prenatal education as if the adolescent were an adult. This inconsistency between nurses' recognition and their actions is further reflected in the lack of comprehensive information identifying the need for prenatal education from the adolescents' perspective (Freda, Anderson, Damus & Mekatz, 1993). Few studies have attempted to identify and describe the adolescents' desires for prenatal care and education.

### **Background to the Problem**

Adolescents are neither children nor adults, but are transitional with respect to their bodies, minds and social development (Mercer, 1979). The adolescent experience constitutes a maturational crisis marked by complex emotional and physical growth (Auvenshine & Enriquex, 1990). Further, the maturational process is influenced by cultural and ethnic beliefs, geographical location, familial organization and economic status. The complexity of adolescent development is exaggerated by the addition of a pregnancy. The adolescents' focus must expand to include both mastery of the basic developmental requirements of adolescence and the changes and stresses of pregnancy (Turner, Grindstaff & Phillips, 1990).

In 1981, the Social Planning and Review Council of British Columbia (SPARC) released a report identifying that the health care needs of adolescents were being neglected within the Province. The task force proposed that key issues such as adolescent sexuality, development, pregnancy and parenting, required attention and investigation by health care professionals.

In response to the proposal from the SPARC task force, nurses in community agencies and individual health units have attempted to offer specialized prenatal education for teens. However, nurses are having difficulty setting-up and maintaining programs because neither needs assessments nor guidelines exist for program development. For the most part, nurses have modified the standardized "adult prenatal content" or have designed their own

programs through trial and error. The concern, then, is how do we as nurses know whether the modified adult oriented classes address the concerns of pregnant adolescents?

### **Problem Statement**

There is very little known about the kind of information and approaches adolescents perceive they want as they prepare to give birth and become parents. Nurses need to acquire knowledge about adolescents' perceptions of prenatal education in order to apply that knowledge in practice.

### **Purpose**

The purpose of this study is to identify and to explore concerns about prenatal education from the adolescents' perspective. The insight and understanding gained from the adolescents' perspective will provide information on how nurses can best intervene to provide support, education and nurturing for adolescent clients during pregnancy.

### **Research Questions**

The following research questions will assist the researcher to identify and to explore the concerns about prenatal education from the adolescents' perspective:

1. What are the learning needs of pregnant adolescents from their perspective?
2. What concerns do adolescents have about existing prenatal education programs?

### Definition of Terms

For the purpose of this study, the terms listed below will be defined as follows:

**Adolescence**: the process of evolving from childhood to adulthood, typically interpreted as occurring from 12 to 19 years of age.

**Pregnant Adolescent**: a single female, ages 12 - 19 inclusive, who is experiencing the growth and development of a new individual within her, from conception through the embryonic and fetal periods to birth.

**Prenatal Education**: programs that assist pregnant individuals in the process of making the transition from the role of expectant parent to the role of parent. Prenatal education includes topics associated with the care of a woman during pregnancy, the growth and development of the fetus, preparation for labour and birth and the transition to the role of parent.

**Concern**: something of interest or importance that is individually defined.

### Conceptual Framework

The framework of explanatory models used by Kleinman (1978) will provide the basis for this study of the concerns about prenatal education from the adolescents' perspective. Kleinman (1978) asserts that most health care systems contain three structural arenas within which health care is experienced: the professional arena (nursing, medical and other professions); the popular arena (individual, family, social network, community); and the folk arena (nonprofessional healers). Each arena is viewed as a sociocultural system with its

own beliefs, values and norms, and its own explanatory model of health and illness. "How one perceives and experiences health is based on individual explanations specific to the social positions occupied and the meanings employed" (Kleinman, 1978, p. 86). Kleinman's framework makes it apparent that the concept of health will be culturally shaped and individually defined within the context of each structural arena. Furthermore, the explanatory models operating within each arena will present differing perspectives of lived experiences, such as health and illness.

According to Kleinman, when there is no common basis or mutual understanding between those holding different explanatory models, communication problems and conflict often result. The knowledge gaps existing between those holding different explanatory models must be resolved to allow effective interaction and negotiation of mutually acceptable health care options. Because knowledge about adolescent pregnancy almost exclusively reflects the professional explanatory model, health care professionals have little understanding of the explanatory model of the pregnancy experience from adolescents' perspectives. In order to address the deficit in the theoretical literature, the researcher will attempt to generate knowledge about the concerns of prenatal education from the perspective of adolescents themselves. A naturalistic approach, using focus group discussions, will be used to generate a description of common elements in the pregnancy experience of adolescents.

### **Significance of the Study**

Since nurses play a major role in the delivery of health care and education to pregnant adolescents, they have a direct influence on the quality of patient care. While nurses apparently recognize that pregnant adolescents have a unique set of health needs, there is little evidence they have a sufficient understanding of these needs. Without a clear understanding of adolescents' concerns and needs, health care professionals have no basis for planning or designing learner-oriented prenatal programs. Therefore, this study is important because it will generate knowledge essential for understanding and relating to this unique population. It is also hoped this knowledge will provide a focus for assessing, planning and implementing prenatal programs for adolescents. Because adolescent pregnancy is increasing in prevalence, nurses require a better understanding of the pregnant adolescent population's needs and concerns.

### **Organization of Thesis**

This thesis is comprised of five chapters. In Chapter One, the background to the problem, problem statement, purpose, research questions, conceptual framework and significance of the research have been presented. In Chapter Two, a review of literature pertinent to the identified research problem will be presented. In Chapter Three the researcher will address the methodology used for the study including a description of research design, the data collection procedure, selection of participants, data analysis and protection of human rights. In Chapter Four, a description of the study findings will be presented. The

summary, implications, suggestions for future research and conclusions will be presented in Chapter Five.

## **CHAPTER TWO: REVIEW OF THE LITERATURE**

### **Introduction**

A lack of theory about adolescents' perspectives on prenatal education exists in the nursing literature. However, the literature does include a significant body of theory that may contribute to the understanding of various aspects of the adolescents' pregnancy experience. For example, the body of literature on the theoretical perspectives of adolescence and adolescent development orients us to the stages and maturational tasks that must be accomplished in order to reach adulthood. In addition, there is a body of knowledge pertaining to the physiological and psychosocial risks associated with adolescent pregnancy which helps to explain how pregnancy can complicate the maturational stage of adolescence. Finally, the literature contains anecdotal descriptions of a range of comprehensive prenatal programs for adolescents. Thus, the purpose of this chapter is to present an analysis of these bodies of literature to provide a foundation for understanding the adolescent pregnancy experience.

### **Theoretical Perspectives on Adolescent Development**

The literature includes significant theories on adolescent development from biosocial, psychoanalytical, sociological, anthropological and social learning perspectives. Prior to the 1900's, no theorist dealt exclusively with adolescence, but writings based on individual experience, historical accounts, philosophical and religious thinking about the nature of man give us impressions of how young people were viewed and treated throughout history (Thornburg, 1982).

Hall (1904), founder of the biosocial perspective, made the first significant theoretical distinction between childhood and adulthood and focused on the relationship between biological process and social experience during the adolescent period (Atwater, 1983; Conger & Peterson, 1984; Schneiders, 1965; Thornburg, 1982). Hall's biosocial perspective views adolescent development primarily as a sequential, biologically programmed process of maturation.

In his summary of adolescent development theories, Muuss (1962) states the following about Hall's biosocial theory: "development is brought about by physiological factors [such as increased sex hormones and changes in body structure and function], which are genetically determined. Internal maturational forces predominantly control and direct development, growth and behaviour" (p. 21). In addition, Hall (1904) describes adolescence as a period of inevitable conflict and contradiction. Further to the rapidly changing physical demands of adolescent development, the individual must learn to adapt and fit in with society. Adaptation may be difficult for an adolescent, physically mature, yet immature in cognitive and psychosocial abilities.

While Hall's (1904) theoretical perspective on adolescent development is viewed as somewhat simplistic, his premise that biological mechanisms and social experiences are instrumental in thrusting the adolescent towards maturity, is a basic postulate with which few theorists disagree.

Psychoanalytic theories of adolescent development developed by Freud (1935), Sullivan (1953), Blos (1962, 1967) and Erickson (1964, 1968), incorporate

Hall's biological conceptualization of human development with concepts and insights into the workings of the human mind.

Psychoanalysts, Sigmund Freud (1935) and Anna Freud's (1948) perspectives on adolescent development focused on the psychosexual stages of adolescence. They believed that development from adolescence through to adulthood had its roots in the successful or unsuccessful resolution of childhood developmental stages of sexuality (oral, anal, phallic, latent and genital) with each developmental stage viewed as a pre-requisite for the next.

In contrast to Freud, Erickson (1963) moved away from focusing on sexual struggle to examine the personality aspects of growth and development. Erickson divided the lifespan into eight developmental stages, each with its own social crisis that "involves a dialectical struggle between two opposing tendencies" (p.207). Erickson postulated that the developmental stage of adolescence presents a dilemma of identity versus role confusion.

During adolescent development, the individual is challenged to adapt to the conflict of physical, cognitive and social changes around her, while simultaneously defining who she is and what her role is to be within society. Muuss's (1962) analysis of Erickson's theory is summarized as follows:

If the conflict is worked out in a constructive, satisfactory manner, the positive quality becomes part of the ego and further healthy development is enhanced. However, if the conflict persists or is

resolved unsatisfactorily, the negative quality is incorporated into the personality structure (p. 53).

According to Erickson, developmental periods are universal to all mankind, sequential in order and interdependent with each other.

Havighurst (1972), Mercer (1979) and Johnson (1986) describe psychosocial models similar to Erickson's proposing that, throughout the life span, individuals are required to master age-specific tasks as a prerequisite for maturation and self-fulfilment. While researchers differ in their identification of the number of developmental tasks to be achieved in the adolescent period, the following concepts encompass the majority of perspectives: accepting the changes associated with physical maturation; identifying and incorporating a sexual identity; choosing a personal belief system or set of ethics to live by; establishing and forming relationships with members of both sexes; developing skills and abilities in order to function and participate within society; and finally, gaining economic independence from parents (Havighurst, 1972; Johnson, 1986; Mercer, 1979). Thus, in the literature on theoretical perspectives of adolescent development, the tasks associated with adolescent development represent the skills, knowledge, functions and attitudes an individual must develop or acquire in order to reach adulthood.

As highlighted by Havighurst (1972), developmental tasks are achieved sequentially – like building blocks – and rely on the successful completion of previous tasks. If, for some reason, a particular task is delayed or not completed,

the adolescent may find it difficult to accomplish it at a later time or to move on to the next task.

The more traditional anthropological work of Mead (1950) and Benedict (1934) negate the concept of sequentially accomplished tasks and developed traits. Instead, their anthropological perspective emphasizes the influence of culture, environment, norms, and rituals on adolescent development. The adolescent learns to adapt and to behave in a certain manner, not because of biological processes, but as a result of socialization (Mead, 1950). Socialization introduces expectations and boundaries for acceptable and unacceptable behavioral patterns within a culture. The adolescent, therefore, is exposed to and taught to incorporate the language, rituals, mannerisms and basic attitudes, beliefs and values of a particular culture into activities of daily living.

The goals of adolescent socialization are not universal as "the patterns by which the individual reaches adulthood and independence vary from one culture to another" (Muuss, 1962, p.143). Diverse conditions such as civil war, poverty, religious revolution and even technological advancement may have dramatically different effects on adolescent socialization. Children, for example, in third world countries are socialized to gradually develop adult responsibilities through early involvement in family duties. Work-related responsibility and diversity increase as the child gets older (Benedict, 1934). Children are expected to work in the fields, assist with the preparation of meals and care for other siblings. By contrast, in North American culture, the transition from childhood to adulthood is not a

gradual, continuous growth process. The transition is discontinuous with multiple shifts in expectations and roles (Mead, 1950). Muuss (1962) describes how modern North America views the role of the adolescent in terms of productivity as:

In modern society, a child rarely makes labour contributions to the subsistence of the family and is protected by law from employment outside of the family. But when young men and women graduate from high school or college, they must compete – sometimes for the first time – on an equal basis with older adults and suddenly assume different roles. (p. 145)

According to Benedict (1934), the adolescent may experience tension, anxiety and conflict with any sudden role transition, thus interrupting or altering his/her pattern of social, emotional and cognitive development. Herbert (1987) states that, while the adolescent may be physically mature, he or she may not have the emotional or cognitive skills and abilities to handle such a sudden transition to adulthood.

While social and anthropological perspectives reinforce the influence of socialization and culture on adolescent development, social learning theorists emphasize how previous experience and current circumstances are relevant to adolescent development. Specifically, social learning theorists focus on how the adolescent is socialized within a culture.

Adolescent behaviour is learned through observation and conditioning according to the social learning theory of Bandura and Walters (1959) and Bandura (1969, 1977). Imitation and identification assist the adolescent to acquire skills for problem solving, decision-making, communication, social and sexual behaviour and perceptual motor skills. However, problems may arise during adolescence if the individual chooses to imitate the behaviour of peers who may be no more knowledgeable, intelligent or mature than the individual (Brittain, 1963). Role models may display positive or negative patterns of behaviour which may be beneficial or destructive for the developing adolescent. Examples of negative patterns learned include: drug abuse; violence; crime; or dropping out of school. Examples of learned positive patterns include: promoting independence from the family; acquisition of interpersonal skills; building strategies to cope with change and conflict; learning to achieve intimacy and strengthening one's personal identity (Atwater, 1983, Herbert, 1987 & Thornburg, 1982). Thus, experience and circumstance provide opportunities for the developing adolescent to observe, imitate and acquire a variety of behaviours that will provide a foundation, positive or negative, for the transition from childhood to adulthood.

A review of several theoretical perspectives on adolescent development indicates similarities between theories, expansions of ideas among the theories and differences of opinion between the theories. Each perspective, however, holds different weight in terms of validation and acceptance by the academic community. Social learning theory is presented within the literature as credible

research, "based on experimental results" (Kimmel & Weiner, 1985, p. 35).

Alternative perspectives such as psychoanalytic, biosocial, social and anthropological views, present "observable, abstract and intuitive concepts" which are more difficult to validate (Kimmel & Weiner, 1985, p. 36).

Regardless of the variation in theories of adolescent development, adolescence can be summarized as the period in the life cycle that extends from childhood to adulthood at which time independent adult roles are assumed (Hardy, 1991). Adolescence represents a period of transition and adaptation to constant change in physiological, psychological, social and emotional aspects of the individual. This phase of the human lifespan is distinguished from adulthood by unique characteristics and styles of interacting with others and the environment.

### **Adolescence and Pregnancy**

While the theoretical perspectives of adolescence orient us to the stages and maturational tasks needed in order to reach adulthood, the body of knowledge on adolescent pregnancy helps to explain how complex adolescence may be with the addition of a pregnancy.

Pregnancy is presented in the literature as a maturational event in a woman's life that is characterized by both physical and psychological change and requires substantial alteration in life roles and identity formation (Mahomed, Ismail & Masona, 1989; Mercer, 1979). Therefore, it is not surprising that the majority of researchers view adolescent pregnancy as a situational crisis added to

the existing developmental crisis of adolescence. The pregnant adolescent is faced with the simultaneous challenge of engaging in the developmental tasks of adolescence and those associated with the acceptance of her new maternal role (Banks, 1993). Rubin (1975) describes the tasks of the maternal role: accepting the pregnancy; establishing a relationship with the unborn child; adjusting to changes in self and the couple relationship; and preparing for birth and early parenthood. Research, however, has shown that adolescent pregnancy increases the demands upon an individual who may not have the capacity to meet basic challenges of adolescence (Brooks-Gunn, & Chase-Lansdale, 1991; Stark, 1986). General consensus exists in the literature that adolescent pregnancy adds another level of complexity to an already complex period of development.

Prenatal care is documented as a positive influence on the outcome of the pregnancy for mother and infant (Institute of Medicine, 1985; Morris, 1991). However, "despite substantial evidence linking improved pregnancy outcomes with receipt of prenatal care and recent improvements in prenatal care utilization, specific sub-populations continue to delay or avoid prenatal care" (McDonald & Coburn, 1988, p. 167). In particular, the literature identifies the adolescent population as one such group. McDonald & Coburns' (1988) survey examining predictors of prenatal care utilization was intended to evaluate the adequacy of and potential barriers to prenatal care in the state of Maine. Data were obtained from a stratified random sample (3769 participants) using birth certificates and mailed questionnaires. The study findings showed four conditions likely to reduce

early entry into prenatal care. These conditions include: younger age; lower educational level; lower socioeconomic status; and an increased distance for commuting to and from the care facility (McDonald & Coburn, 1988). Thus, based on McDonald & Coburn's study findings, the pregnant adolescent may be at higher risk for prenatal care non-utilization because she may experience all four conditions.

Similar research, conducted by Young, Bowman, McMahon and Thompson (1989), is more applicable to this thesis topic because their study focuses specifically on the adolescent population. Eighty-seven adolescents, starting prenatal care in their final trimester, were interviewed about what would help them to get prenatal care earlier (Young et al., 1989). The findings revealed that participants were (a) afraid of disclosing the pregnancy to family and friends and (b) unmotivated to book or to show up for their appointments (Young et al., 1989). Additional barriers such as: "inadequate health insurance; transportation costs; a lack of knowledge about the importance of prenatal care; fear of doctors and medical procedures" were also identified as relevant findings in the study (Young et al., 1989, p. 393).

While the majority of research on adolescent pregnancy emphasizes the challenge adolescents face when accomplishing the basic tasks of growth and development, few studies reveal what impact this may have on the adolescents' perspective of the pregnancy experience and the prenatal preparation received. However, the literature on the psychological and physiological risks associated

with adolescent pregnancy may provide a more comprehensive understanding of the challenges adolescents face during this maturational crisis.

### **Psychosocial Risk Factors**

Numerous attempts have been made to describe or to define the "type" of adolescent who becomes pregnant. However, there is general consensus in the literature that the increased rate of adolescent pregnancy is due to a multitude of factors rather than a sole factor. Psychosocial factors that affect the adolescents' risk for pregnancy include: low socio-economic status; family environment; the cultural perspective on early childbearing; and peer influence.

In studies by Freeman and Rickels (1993), Furstenberg (1976) and Sacks, Macdonald and Lambert (1982), findings suggest that the following situations increase the risk of adolescent pregnancy: (a) unemployment within the family, or low socioeconomic status; (b) separation from a parent either through divorce, marital conflict, death or jail; and (c) low educational background within a family where neither education nor advancement are supported.

Similar research studies address the influence of peers, family or role models on teenage pregnancy. Morris (1991) found that adolescent girls, who have friends or siblings with babies, tend to view pregnancy as glamorous and desirable. Likewise, Combs and Rusch (1990) suggest adolescents may view pregnancy as a way to obtain family approval, show grown-up status to parents or relatives, get attention from family and friends, ensure commitment from a partner or to fill the void of love missed in childhood.

Unlike the negative connotation suggested by Morris (1991) and Combs and Rusch (1990) about adolescent pregnancy, Sugar (1991) presents a positive image of teen pregnancy. He describes how some societies, cultures or groups view pregnancy as "a sign of adulthood, maturity or being in charge of one's own fertility" (p. 175). Furthermore, Zabin (1990) considers views like Morris, and Combs and Rusch to be biased as they promote Westernized ways of thinking. Zabin (1990) presents adolescent pregnancy in a positive context:

In earlier times, and in cultural settings that have not developed the Western pattern of late marriage, unions are formed at ages much closer to puberty; in that context, sexual activity soon after maturation is seen as normal and the setting in which it occurs is neither unusual nor necessarily problematic (p. 581).

Zabin's perspective addresses the idea that social change will always have an affect on the incidence and prevalence of teenage pregnancy. Social changes have occurred in the "normative age of marriage, the age of economic independence for adolescence and in the duration of their educational incubation" (Zabin, 1990, p.581). Furthermore, Zabin notes that the average age of menarche has decreased over the past decade resulting in "an increased number of years during which young people are exposed to the risk of conception" (p. 581). Zabin challenges current researchers to address the question, "is adolescent pregnancy perceived as a problem solely because it offends long-standing moral traditions or because it leads to documented consequences for individuals and/or society?" (p. 582). There

exists limited research evidence of a balanced study of the moral issues related to adolescent pregnancy.

Further to the discussion of psychological risks and adolescent pregnancy, the literature reflects substantial research on the consequences associated with early childbearing. The Baltimore Study (Furstenberg, 1976), for example, was initiated in the 1960's to follow-up the progress of teen mothers and evaluate how their offspring dealt with the period of adolescence. The Baltimore study was unique because it started as "an evaluation of a program for expectant teenagers, but developed into a longitudinal study of 350 pregnant families" (Brooks-Gunn & Chase-Lansdale, 1991, p. 470).

Similar findings to Furstenberg's study of the psychological consequences of adolescent pregnancy are reported in the literature. The research reflects that the pregnant adolescent is more likely to: (a) have additional children while still an adolescent (Moore, Hofferth & Wertheimer, 1979), (b) experience difficulty in pursuing or completing education (Brooks-Gunn & Chase-Lansdale, 1991), (c) require income assistance, take on low paying jobs, experience less job satisfaction and demonstrate increased dependence on others for help, (Card & Wise, 1978; Moore et al., 1979), (d) be a single parent (Hechtman, 1989) and if married, (e) be at increased risk for divorce, ending up as a single parent. Thus, pregnancy in adolescence cannot be viewed as an isolated problem, but one that is interconnected or leads to other problems within the adolescents' world.

Pregnancy is a challenge in any woman's life regardless of the circumstance. While a variety of factors influence the adolescents' pregnancy experience, the ability to adapt to a pregnancy is greatly dependent on the meaning that the adolescent attaches to the pregnancy experience (Anderson, Elfert & Lai, 1989). A positive pregnancy outlook by the individual may increase the overall health status of the young woman and as a result, the overall health of her newborn (Giblin, Poland & Sachs, 1986).

Although most adolescents have the strength to cope with the developmental crises of adolescence, they may not have developed the strengths and skills to cope with pregnancy and parenthood. "Unfortunately, teenagers' sense of responsibility and ability to plan for the future have not kept pace with their sexual sophistication" (Stark, 1986, p. 28). The pregnant adolescent is often rejected by society, left without a supportive partner, a stable home or financial security and following delivery, adolescent parents are often unprepared for the responsibilities of parenthood and the obstacles which may prevent economic and social success (Moore et al., 1979). Therefore, early childbearing profoundly and adversely influences the educational, occupational and marital experiences of the adolescent. However, there is still no evidence in the literature of how the adolescent perceives these risks or what they mean to her.

### **Physiological Risk Factors**

While research on psychological risks of adolescent pregnancy presents a variety of perspectives, the literature on physiological risks of pregnant

adolescents describes a consensual shift towards a common point of view by researchers. The commonly discussed physiological risk factors associated with adolescent pregnancy include: young chronological age; poor maternal weight gain; inadequate prenatal care utilization; and low neonatal birth outcomes.

Over the last 30 years, the role of age in determining adolescent pregnancy outcomes has changed from an intrinsic biological barrier belief to being one of many factors related to pregnancy outcomes. Research from the 1960's and 1970's suggested that simply by virtue of their chronological age, adolescents are biologically immature and at greater risk than adults for obstetrical and neonatal complications or mortality (Battaglia, Frazier & Helleghers, 1963; Claman & Bell, 1964). Common obstetrical complications include: pregnancy-induced hypertension (PIH); toxemia, cephalopelvic disproportion (CPD); uterine dysfunction; iron deficiency anemia; sexually transmitted disease and poor weight gain. Common neonatal complications include: low birth weight infants, prematurity, and death (Stevens-Simon & White, 1991).

Current research findings, however, have shown that factors such as socio-economic status, family and peer relations and the environment influence adolescent growth and development in addition to biological age. As a result, research findings may reflect interaction effects rather than the true effects of chronological age (Coates, 1970). To account for the possibility of confounding factors such as race, gravidity, marital and socioeconomic status, studies have become more refined in their research design for assessing the relationship

between age and pregnancy outcome (Korenbrodt, Brindis, Loomis & Showstack, 1989; McAnarney, 1991; Steven-Simon & McAnarney, 1988).

Battaglia, Frazier & Helleger's (1963) quantitative study at Johns' Hopkins Hospital is a prime example of an adolescent study that did not control for confounding conditions. Using delivery data information for over 600 pregnant adolescents, study results revealed the following rates of toxemia with pregnant adolescents: 27.8% for those under 15 years of age, and 21.1 % for 15 - 19 year olds. According to Hollingsworth and Kreutner (1978), the sample used in Battaglia et al., (1963) research was biased because the sample consisted of 89% non-white adolescents and many participants had additional obstetrical complications. The toxemia rates proposed by Battaglia et al. (1963) were high in comparison to other research reports and did not account for confounding factors such as race, gravidity, marital or socio economic status within the sample. Clinical results obtained from a non-representative sample of a pregnant teenagers are, therefore, not generalizable to the population of pregnant teenagers.

A sample is more likely to be representative of the population when confounding conditions are controlled. In a study conducted by Felice, Ances, Granados, Hebel, Roeder and Heald (1981), 134 inner city pregnant adolescents were matched for age at delivery, race, socioeconomic status and parity. The researchers tested the hypothesis that "biology predestines young pregnant teenagers to have excessive numbers of low birth-weight infants" (p. 195). Half of the participants attended a special teen obstetrics clinic (nutritional, psychosocial

and medical interventions) while the remaining 67 adolescents attended the regular clinic. Research findings revealed significant differences in infant birth weight outcomes, namely that "only 9% of the infants of the teenagers in the Teen Obstetrics Clinic group weighed <2500 g compared with 20.9 % of the infants of the girls in the regular obstetrics group" (p. 193). The data did, however, suggest that teenagers, who are at risk for delivering low birth weight babies, may have better fetal outcomes when given prenatal care that focuses on individual nutritional, education and psychosocial needs (Felice & al. 1981). Thus, this study would indicate that the physiological health risks associated with adolescent pregnancy are not related to chronological age alone.

In a unique study by Gale, Dollberg and Seidman (1989), "an opportunity was provided to examine the outcome of pregnancy in teenage women from an affluent society that favours early childbearing" (p. 404). This research team compared 190 teenage primiparas with the same stable socioeconomic conditions, and living in the same geographical area with a control sample of 231 teenage primiparas in another area of Jerusalem. Study results indicated that the incidence of low birth weight infants was significantly lower ( $p < 0.01$ ) in the study group than in the control group. The mean birth weights for the study group was 3159 g (SD 536) and 2991 g (SD 605) for the control group. Notably, Gale et al.'s research findings support previous studies suggesting that social, cultural and economic factors rather than chronological age alone, are important determinants of fetal outcome among primiparous mothers.

Although earlier research suggested that adolescents were at greater risk for obstetrical and neonatal complications solely because of their chronological age, researchers have up-dated and altered their point of view to acknowledge the affects of social, cultural and economic factors on adolescent pregnancy outcomes. In efforts to explain the higher rates of certain complications observed among teenagers, researchers agree that maternal age may be a marker for social rather than biological disadvantage (McAnarney, Adams & Roghmann, 1978; McAnarney, 1991). Study findings revealed by Stevens-Simon and McAnarney (1988) and McAnarney (1989), reinforce the likelihood that the high-risk nature of adolescent pregnancy is not the result of young maternal age alone, but rather is the result of a variety of factors such as race, socioeconomic status, nutritional status, psychological stress and inadequate prenatal care. Therefore, the risk of developing pregnancy-induced hypertension appears to be more closely related to parity than to maternal age. Similarly, the risk of anemia is better explained by poverty and poor nutritional habits than young maternal age alone (McAnarney & Stevens-Simon, 1988). "Maternal age is, therefore, considered more a marker of morbidity than the cause" (McAnarney, 1991, p. 82).

The special risks associated with the pregnant adolescent are interdependent, reflecting a young person's physiological and psychological development. While most theory and research focuses on adolescent development and medical outcomes in teenage pregnancy, the literature lacks definitive and

detailed information about the personal and societal factors that make the difference between a successful and an unsuccessful pregnancy outcome.

### **Prenatal Education**

The increasing prevalence of adolescent pregnancy in British Columbia is of serious concern to health care professionals because of significant obstetrical, neonatal, psychosocial, economic and educational consequences. As health care professionals work with pregnant adolescents in a variety of settings, they seek innovative ways to improve perinatal outcomes through health care and education.

Programs that provide care and services to pregnant adolescents have multiplied in Canada and the United States in the past decade. The effectiveness of specialized teen programs on the resolution of negative consequences associated with teen pregnancy are, however, unclear. As identified by Neeson, May, Mercer and Patterson (1983), "previous research findings on the impact of specialized antenatal care on adolescent pregnancy outcomes have been conflicting" (p. 95). Researchers are unclear whether the advantages attributed to comprehensive prenatal programs reflect unique aspects of the care provided or the social and demographic determinants of program utilization. In a retrospective study by Slager-Earnest, Beckmann and Hoffman (1987), 50 urban, low income adolescents, ages 13 - 18, attended a specialized pregnancy education program and were compared to 50 pregnant teenagers receiving care at a regular obstetric clinic. The study sample was homogenous for race, income and geographic

location. Services in the specialized adolescent program were provided by a multidisciplinary team (physicians, hospital and community nurses, nutritionists and social workers) during the prenatal period. Demographic data were analyzed by use of means, standard deviations and chi-square analysis. Research findings revealed that adolescents who attended the specialized program demonstrated fewer obstetric complications than did those in the control group. The control group, for example, had higher rates of anemia (28%), infections and medical problems (72%) as compared to the intervention group's results for anemia (4%), and infections and medical problems (8%). Furthermore, the results indicate fewer postnatal complication for infants of mothers who attended the specialized program such as fetal heart rate, Apgar scores, respiratory distress and metabolic disturbances (Slager-Earnest et al., 1987, p. 427).

Comprehensive prenatal care is often associated with reducing the risks associated with adolescent childbearing. Korenbrot, Brindis, Loomis and Showstack (1989) conducted prospective research on 411 pregnant teenagers attending a teen pregnancy and parenting program (TAPP). Birth weight outcomes of adolescents attending this program were compared to birth weight outcomes of more than 2000 San Francisco teens who delivered prior to the start of the TAPP program. Data were collected from medical records in the California Center for Health Statistics and the TAPP program and controlled for age, race, parity and gender of the newborn. Linear regression analyses were performed to compare birth weight outcomes for TAPP and San Francisco teen births. Like Slager-Earnest

et al.'s (1987) study, the effects of a specialized prenatal adolescent program were associated with positive infant outcomes. Participants in the TAPP program delivered infants with better weight outcomes than San Francisco teens who did not participate in the program. TAPP participants demonstrated a low birth weight rate of 8.1% compared to the non-participants' rate of 12.0%.

Additional research that examines the outcomes of specialized programs for pregnant adolescents includes the work of Neeson, May, Mercer and Patterson (1983). They conducted a retrospective, comparative study to, "determine if teenagers [19 years and younger] receiving prenatal care in a general obstetrics clinic [group B] had comparable outcomes to teenagers [19 years and younger] receiving prenatal care in a specialized Young Women's Clinic [group A] in the same institution" (p. 95). In addition, "a low risk group of 20 - 25 year olds [group C] was evaluated on the same parameters as a control group" (p. 95). Neeson et al.'s (1983) research findings revealed that the Young Women's clinic (YWC) newborns had a significantly lower percentage of admissions to intensive care, higher mean birth weights, higher Apgar scores and percentage for average gestational age compared with the general obstetric clinic newborns. In relation to maternal outcome findings for the adolescent participants, Neeson et al. (1983) found no difference in weight gain, intrapartum or postpartum complications when comparing results of the adolescents attending YWC and the adolescents in the general obstetrics clinic.

On the contrary, several studies indicate that pregnancy outcomes of adolescents attending specialized programs are no different than those of young women who receive traditional medical services. In a comparative study, Elster, Lamb, Tavare and Ralston (1987) evaluated the effectiveness of a multidisciplinary adolescent pregnancy program, The Teen Mother and Child Program (TMCP) at the University of Utah. Two cohorts of adolescents, 18 years of age and younger, were followed through pregnancy, at 12 and 26 months after delivery. The TMCP program (n = 125) and a control group of adolescents receiving traditional medical care (n = 135) were assessed for obstetrical and perinatal outcomes, dependence on federal assistance, number of subsequent pregnancies, appropriateness of parental behaviours, and social and emotional adjustment to the parental role. Study findings revealed that special prenatal services had no more of an impact on pregnancy outcomes in adolescent mothers than did traditional services. However, findings revealed that specialized multidisciplinary services for pregnant adolescents had a positive influence on psychosocial outcomes after delivery. For example, 71% of the TMCP participants delayed a repeated pregnancy as compared to 61% in the control group; 62% of the TMCP participants graduated from school as compared to 48% of the control group; and 38% of the TMCP as compared to 48% of the control required financial assistance at 26 months. However, results of the study may be limited in their generalizability because subjects were not randomly assigned to the TMCP, subjects were predominantly

white, advantaged youth from urban areas and the study did not account for any additional services received by the control group.

In summary, the research related to pregnancy outcomes in adolescents concludes that specialized prenatal care and education may have some impact on adolescent perinatal outcomes. However, researchers have not established whether maternal outcomes, neonatal outcomes, or both, are improved by such education, nor is it known which outcome variables are the most relevant to measure in determining this relationship.

#### **Existing Comprehensive Prenatal Programs**

While health care professionals establish specialized education options for pregnant teenagers, the health care system is often constrained in its efforts to provide universal, continuous, comprehensive and cost effective health services. Various intervention strategies have developed over the past two decades to reduce the physical, psychological and social consequences of adolescent pregnancy and parenthood. Intervention strategies include: adolescent drop-in or mobile clinics; volunteer support programs; parent-skills training and special school and vocational up-grade training. Comprehensive educational programs that provide medical, psychosocial, educational, financial planning, family counselling, housing and nutritional services are offered to specifically meet the broad needs of adolescent clients (Peoples, 1979).

According to several researchers, the comprehensive education model for pregnant teenagers provides the following benefits: provider continuity;

coordinated service by a multidisciplinary team; client accessibility to a variety of health care professionals; increased emotional and resource support networks; and trust-building between health care professionals and adolescent clients (Elster et al., 1987; Olds, Chamberlin, Henderson & Tatelbaum, 1986; Polit & Kahn, 1985; Peoples, 1979).

In Canada there are a number of adolescent prenatal programs which incorporate the comprehensive education model into their design. Examples include Jessie's Centre for Teens in Toronto, the Special Delivery Club in Kingston, Calgary Health Services Program for Teens, PACES Teen program in Northern B.C. and Tupper Mini-School in Vancouver. Specific services included in the comprehensive education model are prenatal medical care, parenting education, social networking, financial budgeting and subsidy, clothing, food and housing assistance, transportation vouchers, babysitting, respite care and linked referral with other community resources. Furthermore, a number of perinatal outreach education programs (POP) aimed specifically at improving birth outcomes for pregnant adolescents operate under provincial ministry initiatives. POP programs operate from major urban centres but focus on individuals or families who are living in poverty. For example, 70-80% of POP participants are receiving some form of social assistance and basic needs for food and shelter are issues which often supersede the issue of pregnancy and newborn health (Fearon Blair, personal communication, June 1, 1994).

The majority of POP programmes target the improvement of health risk behaviours such as poor nutrition, smoking, alcohol and drug abuse as intermediate goals to achieving healthy birth outcomes. "Health behaviour and lifestyle change through counselling and education as well as general preparation for pregnancy and early parenthood are common program activities" (Terry Gordon, personal communication, June 1, 1993).

Potential conflict between the adolescent population and health care provider, in values and beliefs may need confronting when programs and services are being planned and evaluated. According to Kleinman (1978), when a wide disparity in values persists between the clients and the provider of health care, clients will generally avoid the service. Assessing the perceptions of adolescents regarding their health-related needs acknowledges the ability of adolescents to make independent decisions and enhances patient satisfaction and utilization of health care resources (Giblin, Poland and Sachs, 1986).

Health care professionals must assess their learners before planning relevant and applicable educational interventions (Stahler & DuCette, 1991). Health care professionals who work with adolescent clients need to learn: (a) the culture of the teenager client; (b) the value structure being expressed by the adolescent; (c) the adolescents' value system and personal response to teenage sexual activity, contraception, pregnancy, abortion, birth and parenting; and (d) the present developmental abilities of the adolescent (Herbert, 1987).

Examination of the adolescent population's values and beliefs are essential since neither adolescent nor health care provider acts in a culture or value-free environment (Kleinman, 1978). Therefore, the planning of adolescent services must be client-centred versus health care professional-driven.

Research specific to the prenatal health information needs of adolescents were studied by Giblin et al. (1986). In their study, 142 predominantly black, urban and low income adolescents in the third trimester of pregnancy completed questionnaires about their health information needs, living arrangements, personal relationships and feelings about pregnancy. The most frequently cited prenatal education topics focused on birth, including pain during labour and delivery, birth of a baby (99%), personal health including normal and abnormal body changes in pregnancy as well as what foods to eat (73%), fetal development (53%) and somatic complaints including depression, frequent stomach pains, headaches (45%), problems with school or family and sexuality (47%).

However, a major criticism of Giblin, Poland and Sachs (1986) research is that the findings do not reflect the true, personal perspectives of pregnant adolescent because the health interests survey used topics chosen by the researchers rather than topics generated from the participants themselves. Giblin et al. (1986) state that "survey items were chosen by review of previous health care assessments of adolescents and by the content of prenatal education programs" (p. 169). As a result, the list of topics presented in this study limits the participants' scope of thought, leads the reader in a specific direction, and implies

a message that "the topics must be important if the experts suggest them".

Therefore, despite the number of studies focusing on adolescent prenatal programs, the usefulness of research findings remains in question as many are based on unsubstantiated assumptions concerning the adolescents' personal perspective.

Health care providers seem intent on creating specialized programs for pregnant adolescents with little evidence of whether the information is what adolescents, themselves, see as important. Research carried out by Freda et al. (1993) revealed that client and care provider priorities and conceptions about what is important to learner differ. These researchers compared client and health care provider perceptions about which health topics were and were not of interest. Participants from private offices and public prenatal clinics (n=385) and 32 health care providers (physicians, midwives and nurses) were asked to indicate their levels of interest (very interested, interested or not interested) on a questionnaire containing 38 prenatal topics. Like the topic list from Giblin et al.'s (1986) research, the 38 items in Freda et al.'s study, reflected the topics "most often mentioned in the literature as being of interest to pregnant women" (1993, p. 238). Based on the research findings, the topics in which 50% or more of the participants indicated "very interested" were fetal development and nutrition and vitamins. Notably, however, topic areas are vague, containing no detail or explanation and, therefore, are open to interpretation by the participant. Additional research findings in the study by Freda et al. (1993) indicate that

women and health care providers differ significantly in interest of certain topics associated with pregnancy. Where clients express little interest in topic areas of alcohol (33%), cocaine (22.2% and, smoking (30.9%), health care providers assumed client interest would be higher, alcohol (84.4%), cocaine (59.4%) and smoking (81.3%). Conversely, health care providers perceived client interest on the use of forceps to be low at 37.5%, whereas the clients rated interest level at 76.6%. As identified by Freda et al. (1993), the rationale behind clients interest or non-interest in topic areas from the study are not known. The researchers state, "interest or lack of interest could reflect no perceived risk, denial of risk, lack of awareness or information already known" (1993, p. 242). The differences in client/provider prenatal interests expressed in this study, however, emphasize the danger of teacher-driven agendas on the dissemination of prenatal information and emphasizes validating the needs of the learner.

In several studies, researchers list the topics most commonly requested by adolescents about prenatal education however, the topics are derived by health care professionals and not by the adolescent client herself. Little information exists in the literature on the adolescents' desires, attitudes, beliefs or opinions on prenatal education. As argued throughout this discussion, personal perspectives of adolescents are essential for understanding their needs during the pregnancy experience.

### Summary of the Literature Review

In Chapter Two, literature relevant to the adolescent experience of pregnancy was reviewed. Theoretical perspectives were reviewed to identify maturational requirements, developmental tasks, abilities and experiences that the adolescent must accomplish in order to reach adulthood. The literature indicated, however, that with the addition of a pregnancy, the normal maturational process of adolescence is complicated with the developmental tasks of pregnancy: accepting the pregnancy, establishing a relationship with the unborn child, adjusting to changes in self and the couple relationship and preparing for birth and early parenthood (Rubin 1984). In addition to the numerous challenges associated with adolescent development, the literature identified a variety of psychosocial and physiological risk factors associated with adolescent pregnancy. Risk factors such as chronological age, socioeconomic status, family and peer relationships, nutritional status, limited education and cultural background were all examined and identified as having an influential relationship rather than a causative relationship to pregnancy and parenting outcomes. Furthermore, the literature reviewed provided insight into the wide variety of programs available for pregnant adolescents within Canada. The majority of teen pregnancy and parenting programs, however, are health professional-directed and lack input from the adolescent population itself.

While several researchers have attempted to identify the health learning needs of pregnant adolescents, none have identified or explored the desires,

attitudes, beliefs or opinions about prenatal education from the adolescents' perspectives. As defined by Kleinman's (1978) framework, the concept of health is culturally shaped and individually defined in each of the structural arenas of the health care system. Because the knowledge available almost exclusively reflects the professional arena, health care providers have little formal understanding of the explanatory model of the pregnancy experience from the adolescents' perspectives.

This study will attempt to generate knowledge about the concerns of prenatal education from the adolescents' perspective in order to better understand and relate to this unique population. Chapter Three will describe the research method used to identify and explore the pregnant adolescents' perspective.

## **CHAPTER THREE: METHODS**

### **Introduction**

Chapter Three begins with an overview of the research method used to conduct this qualitative study. The Chapter also outlines the process for selecting and recruiting the subjects, the characteristics of the subjects, the processes for data collection and analysis, and delineates how the researcher protected the ethical and human rights of the subjects.

### **Research Design**

Although a large body of knowledge exists in the literature on adolescence and adolescent pregnancy, there is a lack of theory or an explanatory model of the adolescent pregnancy experience. According to Kleinman's framework, the health beliefs, behaviours and activities in each arena are governed by a set of socially sanctioned rules. In relation to this study, the rules and beliefs within the popular arena (the pregnant adolescent) are much different than those within the professional arena (health care providers). Therefore, a qualitative research design was selected to elicit and capitalize on the dynamic, subjective and unique individual aspects of the adolescent pregnancy experience.

Qualitative research involves methods whereby characteristics, attributes and meanings of a phenomenon are identified, documented and interpreted (Leininger, 1985). This design is typically selected when little is known about a phenomenon, or when the need arises because of perceived biases or omissions concerning what is known (Sandelowski, Davis and Harris, 1989). The literature

review for this study has revealed that there is a lack of comprehensive, research and theoretical-based information about the adolescents' perception of prenatal education.

The naturalistic approach to qualitative research guided the choice of methodology for this study. A naturalistic research design provides a starting point rather than a final blueprint for action. The aim of the naturalistic method is to investigate and to describe phenomena, including the human experience, in the ways these phenomena appear (Omery, 1983). The data gathered using this method are not limited to observable facts or to objective empirical data. Instead, the data include all available information, together with the subjective meanings that these phenomena or experiences have for the pregnant adolescents in this study (Sandelowski, Davis and Harris, 1989). Theories are not arrived at a priori but rather emerge from the inquiry and interaction with the adolescents themselves. While naturalistic inquiry starts with a focus, the researcher is always prepared for that focus to change (Guba & Lincoln, 1985).

### **Research Method**

The purpose of this study was to identify and explore the issues and concerns about prenatal education from the adolescents' perspective. In order to elicit this information in a permissive environment that nurtures different points of view, focus group discussions were used as the major data gathering strategy. Focus groups are "carefully planned discussions designed to obtain perceptions on a defined area of interest through interaction with other people, in a non-

threatening environment" (Krueger, 1989, p. 18). Focus groups are special in terms of purpose, size, composition and procedure and are composed of seven to ten participants who are selected because they have certain characteristics in common (Krueger, 1989). For the purposes of this study, adolescent pregnancy was the common characteristic. Focus groups work because they enable the researcher to explore and to draw upon human tendencies as well as to produce qualitative data that provide insight into attitudes, perceptions and opinions of the participants.

Focus groups offered several advantages for this study. First, they placed people in a natural and realistic setting; a setting that the adolescents were familiar with, have used and felt safe in. The adolescents related to each other during the discussions because they shared a common experience. Second, the format used in focus groups allowed the researcher to probe, to explore further and to clarify the information identified and exchanged. Third, through group interaction and sharing, a unique potential existed for unveiling insights that otherwise may not have been recognized by the individual. In addition, focus groups provided the flexibility to pursue unanticipated issues not possible within the more structured methods of data collection such as questionnaires or surveys. Fourth, focus group discussions had a high face validity since the adolescents were seen as the experts. "What makes the data valid is privileged access with sufficient intensity and duration" (Guba & Lincoln, 1985, p. 193). The adolescents themselves generated the new knowledge. A final advantage was that focus

group discussions were relatively low in cost because several participants were involved at one time (Krueger, 1989).

### Assumptions

For the purpose of this investigation, the researcher assumed that adolescents had feelings, beliefs and concerns about prenatal education. It was also assumed that the expressed perspectives of adolescents were representative of their reality and that the adolescents described them as accurately as possible. Finally, the researcher assumed that while no two people have an identical lived experience, themes would emerge that were common to all of the participants.

### The Selection Process

Participants in the focus groups were recruited on the basis of their experience with the phenomenon being studied. In this context, pregnant adolescents themselves were considered as "experts" in the area under investigation. Inclusion criteria for participation in the study were defined as follows:

1. single and pregnant;
2. age 12 to 19 years inclusive;
3. able to speak and to understand English;
4. undergoing a normal, healthy pregnancy to date;
5. at 12 to 40 weeks gestation;
6. having a first baby.

Subjects were excluded from the study if they had any other major medical conditions such as chronic illness, disability or substance abuse.

With the assistance of the perinatal coordinator at the Vancouver Health department and the social worker from the Salvation Army's Maywood Residence, 48 adolescents from the city's "teens" prenatal program were identified as potential study participants. Information letters were sent out by the Health Department inviting the adolescents to participate in the study and to attend one of three scheduled focus group sessions (Appendix A). Consent forms were also attached to the mailing (Appendix B). As transportation and finances presented possible obstacles for attending the sessions, the focus groups were scheduled at Maywood Home, North and Mid-Main Health units. The three locations were easily accessible and familiar to all participants. While some participants phoned the health unit to indicate their intent to attend, others just showed up at a focus group session. A convenience sample of 19 adolescents was obtained through the recruitment process.

The focus group sessions were conducted on three different dates and times to allow flexibility and choice for the participants. While seventeen participants went to school, two others worked, therefore, one focus group was offered during the daytime and the two others, in the evening. Each focus group took approximately one and one half hours. Due to time constraints for each focus group session, the researcher believed that further contact with participants was needed to review and confirm the data collected. The participants, however,

did not wish to participate in follow-up focus group discussions. Therefore, at the end of each session, the researcher asked for volunteers who would agree to telephone follow-up for data clarification and validation purposes. Of the nineteen participants, twelve volunteered and provided their home/work telephone numbers for follow-up.

### **Characteristics of the Sample**

The study sample consisted of 19 pregnant adolescents, ages 15 - 19. Six participants were from Maywood Home, a residential program for single women and the remainder lived in the Vancouver area with friends, family or on their own. All participants were single and 13 of the 19 were not involved with the father of the baby. While the majority of the young women were still in school, two had completed high school and were working part-time. Family support during the pregnancy was described as mixed. Some of the adolescents were receiving help from family members while others had little or no contact. All participants came from either a single parent or step-family home situation and all of the young women were able to identify a family member or friend who had been pregnant as an adolescent.

### **Data Collection**

#### **Characteristics of the Focus Groups**

Originally the focus group sessions were designed to solicit the attitudes, perceptions and opinions of the participants by introducing topic areas for open discussion within the group. A list of sample questions was constructed for the

purpose of providing a loose structure for the investigator during the focus group (see Appendix C for sample questions). The proposed open-ended questions were intended to focus subject's thoughts during the discussion, but also to allow them the freedom to express their own ideas. However, as the focus groups progressed, the adolescents had a difficult time answering the original, broad and abstract questions. For example, when participants were prompted with "tell me about the types of experiences you have had with prenatal education?", the group responded with blank looks and no one answered the question. As a result, the questions were restructured to be more specific. In addition, whenever a question was asked, an example was given to clarify the context. For instance, when participants were asked to describe where they received prenatal education, they were provided with examples such as "the health unit", "family doctor", "books or videos". Furthermore, the researcher directed the participants to address certain topic areas by asking questions like: "tell me about the kinds of things that you talked about during your prenatal classes"; "what did you like or not like?"; "what kinds of questions did you ask in relation to your pregnancy?". When specific questions were asked with illustrative examples, the participants provided expanded answers with more detail and everyone had something to contribute. Encouragement and probing by the facilitator was also useful to clarify and validate information shared within the group. Statements like, "tell me more about that", or "do you mean..", "has anyone else experienced.." were used throughout the discussions for validation and clarification of information.

Overall, study participants articulated similar experiences with minimal variation in their ideas. Consensus within the group was confirmed through nodding, joint responses and verbal acknowledgement such as "yah, that's what happened to me" or "just like she said". However, to prevent the "echoing" of the same concept or idea within the group, questioning was constantly redirected to see if anyone else had a different point of view. After several attempts, it became evident there was little or no dissent among the group members regarding their opinions or perceptions. Participants themselves continually redirected the responses to include the points of others in the groups and expanded upon or gave examples in relation to what others had said.

A tape recorder was used to maintain an accurate account of information discussed during the focus groups. At the beginning of each session, participants were informed of the rationale for taping and how the information would be used. Verbal consent by participants was once again obtained for the recording of each focus group session. No one expressed concern about the taping and no one withdrew from the study.

### **Limitations**

The following limitations may have had some bearing on this study: (a) The intent of the focus groups was to promote self-disclosure among participants. For some individuals, self-disclosure came easily, and for others it may have been difficult or uncomfortable. Some subjects may have felt inhibited in expressing their true feelings during the focus group session. Others may have responded in

a way that they thought the researcher wanted them to; (b) owing to the small sample size and the fact that the researcher chose a convenience sample from one specific geographical area, the findings will not be representative of all single pregnant adolescents. This introductory study is exploratory and descriptive in nature and, therefore, health providers should not generalize the results.

### **Data Analysis**

Data collection, analysis, verification and the development of theoretical explanation occur simultaneously throughout the research process with the naturalistic approach; thus data analysis is open-ended and inductive (Guba & Lincoln, 1985). For instance, upon completion of each focus group, field notes were made by the researcher to describe as much of the interaction as possible. Notes included a description of the setting, how and where participants sat, types of verbal and non-verbal communication, impressions, general observations and feelings obtained during the discussions.

In addition to the researcher's field notes, focus group discussions were transcribed verbatim to constitute the written data. Data were prepared for analysis using a reductionistic strategy described by Knafl and Webster as "converting the data into smaller, more manageable units" (1988, p. 196) or in essence, packaging the data into categories and attaching a label to each one. Categories were then rebuilt, analyzed and presented in terms of themes which were conceptually relevant to the whole picture. The diverse clinical, theoretical and methodological expertise of members of the researcher's thesis committee

assured that a variety of perspectives were considered during the management and analysis of the data collected. Therefore, a combination of analytical resources, commonly referred to as triangulation (Fielding & Fielding, 1986), was used to maximize the range of data that might contribute to a more complete and holistic understanding of the adolescent pregnancy experience.

### Transcript Analysis

Giorgi (1975), Knafl and Webster (1988) identify several steps for influencing and interpreting data analysis. First, the researcher must identify the range of perceived responses by participants by getting a sense of the big picture. The researcher accomplished this first step by reading all focus group transcripts in their entirety, several times, in order to acquire a sense of the subjects' descriptions.

The second and third steps in data management and analysis required the extraction and identification of significant statements about the adolescents' pregnancy experience. The researcher, therefore, identified repetitive topics, feelings and comments made by the participants by classifying them into descriptive coding categories or "meaning units". The descriptive meaning units were highlighted and coded in the margins of each transcript. Subsequently, the similar reductionistic process used in identifying the major meaning units within the transcripts was used to identify subcategories within each of the major units (see Appendix D for a sample of meaning units).

As part of the fourth step, dominant themes were extracted from each of the major meaning units and their sub-units. The researcher examined the raw data from which the themes were taken in terms of the specific research questions being investigated. To illustrate, the researcher asked, "what does this statement or feeling tell me about the concerns of prenatal care from the adolescents' perspective?". In another example, the meaning unit entitled "responses to pregnancy" was further classified into three sub-units: emotional responses; understanding pregnancy; and perceived societal attitudes. A theme that dominated this particular meaning unit was the adolescents' increasing capacity for reflective thought. Participants' comments demonstrated that as the pregnancy progressed, so did cognitive development, making it possible for the pregnant adolescent to move beyond the limited "here and now" towards the realm of the abstract and the future. As one adolescent stated, "I went from worrying about me and my body to planning what life would be like for me and my baby". Following a process similar to that for constructing the theme presented in this example, the researcher confirmed and clarified proposed themes with twelve study participants who had volunteered for a follow-up telephone call.

Finally, once the themes were enumerated and validated in step five, the researcher attempted to integrate and synthesize the essential, non-redundant themes into a descriptive format. The description of findings summarizes and describes the adolescents' perspective of what is important in prenatal education.

### Criteria of Rigor

The truth value of this qualitative study resides in "the discovery of human phenomena as they are lived and perceived by the subjects and truth is, therefore, subject-orientated rather than researcher defined" (Sandelowski, 1986, p. 27). The issues of internal and external validity and reliability are dealt with somewhat differently in the qualitative approach than in the quantitative approach.

Credibility, rather than internal validity is the criterion against which the truth value of qualitative research is evaluated (Guba & Lincoln, 1981). A qualitative study is credible when the individuals having the experience immediately recognize it from the description as their own, and when, on being confronted with it, other individuals can recognize the actual experience after having read about it in a study (Sandelowski, 1986).

Fittingness, rather than external validity is the criterion against which the applicability of qualitative research is evaluated (Guba & Lincoln, 1981). Fittingness means that the findings can "fit" into contexts outside the study situation, and the audience views the findings as meaningful and applicable in terms of their own experience (Guba & Lincoln, 1981). For the purposes of this study, it is important to acknowledge that the study sample is small and that the findings will not be generalizable to all pregnant teenagers.

Finally, auditability, rather than reliability is the criterion against which the consistency of qualitative research is evaluated. A study "is auditable when another researcher can clearly follow the 'decision trail' used by the researcher in

the study" (Sandelowski, 1986, p. 33). Auditability was achieved in this study through clear description, explanation and justification of "(a) how the researcher became interested in the subject matter of study; (b) the specific purpose of the study; (c) how subjects and pieces of data were included in the study; (d) how the data were collected; (e) the nature of the setting in which the data were collected and; (f) how data were reduced; interpreted and presented" (Sandelowski, 1986, p. 34).

Other strategies used to achieve credibility included continuous validation of data through the focus group discussions, as well as continuous validation with subjects for representativeness of data and fit among themes. Validation, a process that entails returning to the informants for clarification, as well as ensuring confirmability of data, (Sandelowski, Davis & Harris, 1989) was used throughout the data collection process. For instance, the researcher attempted to validate participants' responses through paraphrasing what the group had said. Participants provided feedback as to the accuracy or inaccuracy of the researchers paraphrase and interpretation. In addition, 12 participants who volunteered for follow-up by telephone contact with the researcher were asked to clarify and validate information obtained through the focus group sessions. The researcher was able to ask questions and to obtain more detail on areas that were ambiguous or incomplete while confirming the information with the participants themselves. The data collected through telephone follow-up was documented and incorporated into the phone call with the next participant to determine whether it

truly reflected the group's perspective and shared elements with the pregnant adolescents' experience.

### **Protection of Human Rights**

Further to the consideration of study design, the researcher must respect the rights of all potential study participants by implementing "plans and procedures that protect individual rights of self-determination, privacy and confidentiality" (Woods & Catanzaro, 1988, p. 94). Rights of the participants in this study were protected by: (a) obtaining the approval from the University of British Columbia Behavioral Sciences Screening Committee for Research, the Vancouver Health Department and Maywood Home prior to conducting the study (see Appendix E); (b) providing a full description and explanation of the study and expectation of participants prior to obtaining their written consent (see Appendix A); (c) assuring participants that non-participation in the study or withdrawal from the study would in no way jeopardize their care or relationship with their health liaison; (d) reminding participants of their right to withdraw participation at any time; (e) informing participants in writing that data are anonymous and confidential and that taped data would be shared only with members of the thesis committee and then erased following the completion of the study; (f) informing participants that no names or identification would appear in any written reports; (g) assuring participants that the study involved no expected risks to themselves; (h) explaining the potential benefits and outcomes of the study; and (i) obtaining written consent from all subjects who participated (see Appendix B).

As this study addressed the perceptions of pregnant adolescents between the ages of 12 and 19, parental consent was required for one participant who was under the required legal age for consent. Consent was obtained with the assistance of the social worker from Maywood home who spoke with the adolescents' parents and sent them a copy of the information letter and a consent form. After consultation with their daughter, the parents mailed in the completed consent form so the 15 year old could participate.

Before each focus group session, participants were encouraged to ask questions or to seek clarification about the study. When participants were asked for permission to tape each session, no one expressed concern or refused to be taped. At the end of each session, the researcher asked for volunteers who would agree to telephone follow-up to clarify or validate the information discussed. Permission was given voluntarily by 12 out of the 19 participants both verbally and by writing their phone number on a piece of paper.

### Summary

Chapter Three contained an overview of the qualitative, naturalistic research design that was used to guide this study. The naturalistic approach was selected because it facilitated exploration of the pregnancy experience from the adolescents' perspective. A small, volunteer sample of 19 pregnant adolescents, obtained by the Vancouver Health Department, provided some of their perceptions about prenatal education. Focus group discussions were used as the technique to facilitate participants sharing their ideas, attitudes and opinions about

prenatal education. The data generated within the focus group discussions were categorized into themes based on noted commonalities and differences from within the group. The research findings from the three focus groups and the results of data analysis will be presented in Chapter Four.

## CHAPTER FOUR: RESEARCH FINDINGS

### Introduction

In Chapter Four, the researcher will present and discuss the findings obtained in this study in order to provide an introductory description of pregnant adolescents' perceptions about pregnancy and prenatal education.

The data acquired in this study reflect the personal perspectives and interpretations of nineteen pregnant adolescents who share a common experience. As directed by a naturalistic approach to qualitative research, the data emerged from the interaction and interchange of ideas by the adolescents themselves. While the researcher's original trigger questions were intended to focus participants' thoughts and to encourage expression of personal points of view, most adolescents had a difficult time answering the broad and abstract questions. Therefore, to elicit participation, the researcher re-structured the original focus group trigger questions to be more specific and clarified the context with examples. In response to this alteration, participants provided detailed and expanded responses and everyone in the group participated.

Participant responses were based on the adolescents' interpretation of the discussion questions and illustrated the way in which the participants chose to answer them. The data and responses, therefore, will be presented as they appeared in the focus group discussions.

The scope of the researcher's original study questions were expanded by the participants to include reactions and emotions about teen pregnancy, as well

as adolescents' perceptions about prenatal education. The research findings presented in this Chapter address the three key aspects of the pregnancy experience as articulated by the adolescents themselves: their emotional responses to pregnancy; previous experiences with prenatal education; and their expressed learning needs during the prenatal period. In addition, the researcher presents a summary of the adolescents' explanatory model for pregnancy and prenatal education in comparison to a model that operates in the professional's mind.

### **Perceptions of Pregnancy**

According to Kleinman's framework (1978), health care and education are interpreted and experienced differently by the professional, popular and folk arenas. If each arena is viewed as a sociocultural system with its own beliefs, values and norms, then an adolescents' concept of sexuality and chosen health practices in pregnancy is culturally shaped and individually defined. As health care professionals continue to work with pregnant adolescents in a variety of settings, it is important that they gain an understanding of the adolescents' own explanatory model of health and pregnancy if a therapeutic effect is to occur. The adolescents' in this study helped to define their own explanatory model by sharing and describing their points of view.

In communicating their personal perceptions of the pregnancy experience, the adolescents focused first on a range of emotional responses that were transitional throughout the pregnancy and, secondly, on their perspectives of how

society viewed pregnant teenagers. Both of these themes will be presented using ideas and examples generated from the adolescents themselves.

### **Emotional Responses to Pregnancy**

While the pregnant adolescent struggles with the complex demands of both adolescent development and pregnancy, her feelings and emotions undergo an equally dramatic change over the nine month gestation period. The young women in this study addressed this dramatic change by describing a conglomeration of emotions ranging from denial and shock, to anticipation and pride. What was commonly expressed within the focus groups, however, was a similarity in the sequence of emotional responses throughout the pregnancy experience. The sequence included denial, shock and disbelief, ignorance, hopelessness, abandonment and isolation, dependency, powerlessness, anticipation and pride.

#### **Denial**

Denial was described by the young women as a common initial emotional response to their pregnancy experience. Denial was considered as a time-limited response, which started with the suspicion that they were pregnant and concluded when the pregnancy was confirmed by a doctor.

While most of the young women suspected that they were pregnant, they refused to acknowledge the possibility of pregnancy or to have themselves examined, at first, by a physician. One young woman described her denial response as, " my gut feeling told me that I was pregnant, but I thought it would go away if I didn't think about it", while another stated, "I didn't want to find out

if I was pregnant, but I knew that something was wrong". The denial response was commonly described by respondents as a method for not having to deal with reality.

Denial, however, served a variety of purposes for individuals within the study. For several respondents, the emotional response of denial provided a defense for suppressing a situational crisis until they were mentally and/or physically able to deal with it. For others, denial was expressed as a method to cope with feelings of insecurity and uncertainty. Furthermore, some used their denial as a means to ignore potentially negative consequences associated with a pregnancy such as losing a boyfriend or having to quit school.

In summary, denial, was a way of denying unpleasant circumstances for the majority of the participants, especially as the majority of adolescents predicted potential failure, tension or change along with their pregnancy. The following comments from one young woman illustrates her attempt to avert the situation and to deny the possibility of pregnancy:

the situation seemed easier to handle if I ignored it or blocked it out of my mind. It would go away if I didn't think about it or give in to it. I made myself really busy, partied alot, hung out with my friends. I never told anyone. It couldn't happen to me. It never happens the first time. My boyfriend said it couldn't. I'm just stressed.

Because the pregnant adolescent is faced with rapid and unfamiliar change, she often finds herself without the necessary skills to cope (Friedman, 1992). As a

result, it is common for the pregnant adolescent to feel overwhelmed and to let avoidance type behaviours, like denial, take over.

Emotional isolation appeared to reduce the tensions of need and anxiety by allowing these adolescents to withdraw and remain emotionally uninvolved or detached. Herbert (1987) notes that the pregnant adolescent tends to be indecisive and procrastinates in times of stress, putting off the actions that have to be faced realistically. In relation to this study, the adolescent refuses to find out if she is pregnant or not.

### **Shock and Disbelief**

While denial was expressed as a common initial emotional responses to pregnancy, ongoing physical discomforts and inquisitions from family and friends forced many participants to confront their undefined situation. For the majority of participants, however, actual verification of the pregnancy was not done until well into the second trimester.

Upon validation of the pregnancy, the participants commonly described responses of shock and disbelief. One respondent stated, "I was shocked that the pregnancy test was positive... this could all be a bad joke...the doctor made a mistake". Another respondent expressed her disbelief by stating, "I didn't believe my doctor... until I heard the heart beat and saw the baby on ultrasound".

According to most of the young women, hearing the heartbeat and seeing the fetus on ultrasound made the possibility of a pregnancy now more of a reality.

However, the comprehension of how a baby could grow inside of them still appeared abstract.

For the majority of participants, pregnancy was described as "something that happens to other people", "it couldn't happen to me". With the exception of four participants who had chosen to get pregnant, the group made several references to their invincible or omnipotent attitudes about the possibility of conception with such comments as: "I wasn't having sex often enough to get pregnant", "I'm too young to conceive", "You can't get pregnant the first time", "Pregnancy happens to bad girls... it's all a dream. How could this have happened to me?" Many of the young women depicted their difficulty in relating the action of sex to the consequence of pregnancy. The adolescents' concrete mode of thinking, therefore, prevented many of the participants from foreseeing the possible outcomes of their sexual activity.

### Obliviousness

Along with the shock and disbelief associated with the validation of pregnancy, the adolescents described a common obliviousness towards their risk-taking behaviour. The majority of these teens did not realize or acknowledge the impact that sexual behaviour could have on their lives.

For several adolescents, facing pregnancy now meant acknowledging to themselves and to others they were sexually active. As one 18-year-old stated, admitting that she was pregnant was "like telling everyone that I was doing it" and that, "I must be really stupid because I obviously didn't know what precautions to

take to avoid getting pregnant". Holt and Johnson (1991) suggest that most young women do not anticipate getting pregnant when sexually active. In relation to growth and development, the young adolescent has not matured to the point where she can think about her actions as having consequences for the future. For the adolescent who is operating primarily at the stage of concrete operations, thought processes and behaviour focus on self-gratification and an orientation to the here and now.

### Hopelessness

The four respondents who had chosen to get pregnant, however, did not share the same invincible attitude towards sex and pregnancy as the other adolescents. Sexual activity was clearly described by these women as the necessary means for a positive pregnancy outcome. Teenage pregnancy was viewed by this group of women as the next logical step which was appropriate for, and congruent with, the values and lifestyles of family and friends. As one young woman stated, "my boyfriend wanted a baby.. and you wanna do it... so I stopped taking my birth control... but I really wanted to have a baby... my mom had me when she was young". The developmental task of gaining independence and having something to show for it, represented success, satisfaction and adulthood for these four adolescents. One young woman described her perception of her future as:

... having a baby is my only option right now. I want something that is mine. I can stay at home, don't have to work ... and my worker is

really good at getting me money when I need it. Besides, who can afford school or university these days...I'm not smart enough and for kids my age, it's virtually impossible to get a good job that pays enough.

Neel, Jay and Litt (1985) suggest that the feeling of hopelessness in relation to their perceptions of limited options are quite common for the adolescents of today. Through sexual relations and motherhood, adolescents often hope to find direction and purpose for their lives. For many adolescents, the future holds few positive possibilities and therefore early childbearing becomes a realistic and attractive option.

#### Abandonment and Isolation

Although the emotional responses of denial, shock and disbelief provided temporary distraction for acknowledging the pregnancy, feelings of abandonment and isolation prevented most adolescents from seeking help. The majority of participants did not see a doctor until the second or third trimester for fear of having to tell someone that they were pregnant. As described by one sixteen-year-old, fear was associated with the risk of, "being thrown out" or "left alone to fend for myself". Other adolescents indicated similar fears of rejection by family or friends using such comments as, "a pregnancy ruins everything", "they'd blow up or disown me", "my parents already hate my boyfriend" and "I don't want to be alone". In relation to her feelings of abandonment and isolation, one young woman shared:

I was always being accused of messing up and I knew that my dad would lay into me... I could hear him saying, 'you always screw up, don't you know any better'... and my mom...I knew that she'd be really disappointed. She didn't want me to do what she did, having a kid when she was in highschool. I didn't want to take the risk of telling them... it would cost me.

Participants described ambivalent feelings about the effects of pregnancy on their lives, their relationships with family and friends and their futures. Pregnancy could result in isolation and abandonment from the people they cared about.

Pregnancy disclosure was also interpreted by these adolescents as admitting fault or failure. They believed that their families and friends would view them as "irresponsible" or "stupid" for getting pregnant. As a result, the admission of a pregnancy meant risking the loss of their safety and support networks.

Ironically, while study participants believed that disclosure would have a negative effect on their lives, the majority received acceptance or support from a family member and/or friend. The following comments from a 15-year-old describes the unexpected response she received when disclosing the pregnancy to her mother:

my mother just looked at me...and started to cry. She said, "well, I guess we just deal with it". She asked me if I was feeling o.k.. offered to go with me to my next appointment. I couldn't believe it.

I really thought she was going to kill me. From that point on...I knew it would be o.k.

Another young woman in the group shared a similar disclosure experience:

My family is really religious... and I thought for sure that they'd hide me or have me go away. I was so shocked. I had to tell them twice that I was pregnant... just in case they hadn't heard me. My aunt wanted to be my labour coach. It made me feel really good. I feel really close to her now..like she's my sister and not my aunt.

For several adolescents, pregnancy meant making undesirable lifestyle change, which further differentiated them from their peers. For example, one participant was concerned that she couldn't go out with her friends to parties or go to the mall when she got "fat". For many participants, change was associated with dissociation from former school friends and having to find and link up with a new social network after childbearing. Others were afraid about not having enough money to buy clothes for themselves or having a decent place to live after the baby was born. The participants recognized they were now faced with making decisions and taking on responsibilities that were usually ascribed to adults.

### Dependency

As the participants attempted to meet their own needs throughout the pregnancy, the lifestyle changes and pressures associated with pregnancy resulted in an increased dependency on others. While the majority of adolescents claimed how important it was to become independent and to make it on their own, most

turned to their parents or other adults for help because they were emotionally, cognitively and financially unprepared for parenthood.

Feelings of dependency were further defined by participants in relation to their wants and desires within a prenatal program. The following response was typical in each of the focus groups: "make the people and services easily accessible and available for me". These teens had never negotiated within the health system to obtain either information or services for themselves. As one respondent stated, "I don't know where to go or what to ask for... I hate having to go to ten million different places and telling my story over and over to strangers", "I'd rather stay in one spot... let them come to me... sort of like one stop shopping". While these young women attempted to attain the developmental task of gaining a personal identity and achieving independence from their parents, they soon recognized the reality of their limited knowledge, skills and abilities to do so.

### **Powerlessness**

As the pregnancy progressed, the young women vocalized overwhelming concern about rapid weight gain and the unfamiliar physical changes within their bodies. The key emotional response described by the participants in relation to rapid physical change was powerlessness.

Not only were respondents having to cope with the process of becoming an adult and parent, but also with a pregnancy experience that they did not comprehend. Powerlessness was attributed to their lack of knowledge about

pregnancy, growth and development, tests and examinations: " no one explained what was going on... I had no idea why things were happening", "I was afraid to ask questions because it might make me look stupid", "make it relevant for me" and "let me know what is normal and what isn't". One respondent went on to describe her feelings of powerlessness in the following way:

I feel like I have no control over my own body. Doctors, nurse.. they won't tell me what's going on.. my body is going all over the place. This baby is taking over my life... it's like an alien. I can't do what I want any more. People tell me what I can and cannot do... even strangers. Why so many rules!

Similarly, another respondent described her feelings of powerlessness as:

It was so frustrating... the nurse kept say that I was too small for 32 weeks...she kept pushing me to gain more weight. I didn't want to gain any more. Never once did she tell me why I needed to gain the weight or how it related to my baby's health. She made me feel like I was doing the pregnancy thing all wrong! I didn't feel comfortable asking why it was such a big deal.

Yet, while participants emphasized their resentment towards health care professionals for not sharing information or answering questions during assessments, tests or procedures, most did not understand how to use the information obtained nor how to benefit from individual opportunities to ask questions.

Furthermore, the emotional response of powerlessness was linked to the notion that adolescents expected other people to help them. Herbert (1987) describes this attitude amongst adolescents as self-centredness, or egocentrism, where the adolescent views the world from only her point of view. Holt and Johnson (1991) refer to egocentric behaviour as an instrument for gaining power and control, especially at a time when the adolescent is feeling vulnerable and powerless.

For the majority of the young women, personal appearance and physical discomforts provided the major focus during the third trimester of pregnancy. They were worried primarily about themselves and their personal safety. However, during pregnancy, this behaviour puts the adolescent at risk preventing the teenager from focusing on the fetus and its well-being. Egocentricity was illustrated in one young woman's comments:

I can't picture myself having a baby though. I can't picture myself pushing this thing out. Get this thing out of me. It's scary thinking that... well in a few months I have to go through this pain and I don't have a choice.

The pregnant adolescent experiences a period of rapid change in physical growth and becomes acutely conscious of her body and body sensations. As one adolescent within the group described, "my body was doing things it had never done before... I felt out of control and didn't really know what to do". By the final trimester, their ever-enlarging abdomens and increasing size of breasts and

buttocks prompted many of the teenagers to try to control their appearance by dieting. Yet most were unaware of the potential adverse consequences to fetal health and their own growth needs. Roller (1992) notes that when there is a large discrepancy between the teenager's self-concept and her idealized self, there are also likely to be anxiety, oversensitiveness and feelings of powerlessness. It was common to hear negative self-image comments like:

I feel like a whale... It's hard to find clothes that fit...I have to wear my boyfriend's clothes. Everyone... people stare at me. You can see them thinking, is she pregnant or just fat? Sometimes I want to shout at them and say, 'yes I'm pregnant'!

Therefore, how adolescents see themselves depends not only on how others see them but on how they think others see them. These young women wanted to be accepted by their peers, yet they feared rejection because of a perception that being pregnant meant they were different.

#### **Anticipation and Pride**

In the last few weeks of pregnancy, the progression of emotional responses described by the adolescents shifted from those egocentric in nature towards responses that took other people into consideration. The common emotional responses described within the focus groups during the last few weeks of pregnancy included anticipation and pride. These responses were illustrated in one participant's comments:

I'm scared that I won't survive labour but I'm really curious to see what he or she looks like... this pregnancy has been forever and I just want to get my baby out. It's hard to believe that I'm actually creating a life. I kind of feel proud of myself... I did it all by myself.

The anticipation of delivery made the experience seem real for this young woman. As Rubin (1975) describes, an important developmental task of pregnancy requires accepting the reality of the unborn child and preparing for birth. At this stage of the pregnancy, the young women demonstrated a shift in their thinking towards planning for the future. Several participants talked about where they were going to live and how they would support themselves, while others focused on what supplies they needed to buy for the baby. As a result, participants demonstrated an ability to envision how their lives would be different with a new baby and how different decisions could affect their future. The concept of delivery meant consideration of another human being and taking on adult responsibilities.

#### **Adolescent Perceptions of Societal Attitudes**

While the adolescents were clearly able to articulate their own emotional responses and reactions to their pregnancy experience, they were also concerned about the attitudes and beliefs that society portrayed about teen pregnancy. Several participants made reference to the point that society considers "pregnancy acceptable if you're an adult, but not if you're a teenager". The societal attitudes perceived by the pregnant adolescents included: "judgemental"; "negative"; and "all-knowing".

Participants gave numerous examples of judgmental behaviours portrayed by the public towards them as pregnant teens. One young woman described her experience interacting with the public as, "people always stare – they give you the look", and "you know what they're thinking because it is written all over their face". It was not unusual for these young women to hear comments like, "do you know what you've gotten yourself into?", "she's just wanting to be loved", "poor thing", "how could you?", "sexually active at your age?", "you're going to regret it later" and "how old are you anyway?".

To the participants, members of society appeared very quick to display feelings of disgust and rejection. What concerned the adolescents most were comments that accused them of being irresponsible, immature and naive. One young woman described her frustration with the attitudes of people around her as:

People seem to get so funny...they look at me weird, make comments behind my back...as if I'm not capable of having a kid. I know my mom didn't want to tell her friends because she knew that they'd talk. Sure we're young, but I can be a good parent too. I hate this mightier than thou attitude. Like only adults can have babies...alot of them mess things up.

### **Perceived Attitudes of Health Care Providers**

The participants noted that the attitudes of nurses, doctors and other health care providers were displayed through verbal and non-verbal communication. Judgemental attitudes were often perceived by adolescents during physical

examinations, tests and procedures, through comments, instructions and methods of touch. Male physicians were described as being "rough" during examinations and insensitive to adolescents' concerns about privacy and modesty. One young woman described her vulnerability in relation to an interaction with her male physician:

When you're at the doctor's and you get your check up – I hate the exam thing... especially with my doctor, he's male. I get really embarrassed...asking questions how can he answer them? He's a man. Like he's been through this (laughter). They always say, 'don't worry', 'you're doing fine'. I don't know what he's doing half the time.

Another participant described her emotional responses to male versus female caregivers as follows:

He tried to tell me that I was bloated right? And I am sitting there contracting and I go, you don't know...I mean you are never going to go through this. I was really just pissed off. Women know what it is like. Women know how it is and how it hurts and everything else.

The adolescents indicated they felt embarrassed and intimidated by male doctors and as a result, felt uncomfortable asking "female-type" questions. Women health care providers, on the other hand, were perceived as "someone who could relate to their situation", "someone who knew what a pregnancy was like", and all the

feelings associated with it. The female touch was described as "gentle", "softer" and "caring". The caregivers approach, touch and tone of voice were all influential on the adolescents' perception of comfort and the quality of care they received.

In relation to patient counselling, the adolescents verbalized a discomfort with asking questions of health care professionals. Through interactions with hospital staff, most adolescents were made to feel that their "condition" was not acceptable and, therefore, most felt asking questions was inappropriate. Several respondents alluded to their fear of something going wrong in the pregnancy, yet when they asked caregivers about it, most received the standard answer, " don't worry about it. Everything's fine. You're feeling like this because your pregnant". During prenatal visits, questions were often dismissed as, "oh, it's nothing", and for the most part, adolescent clients were given test and procedural results without any rationale or explanation. The adolescents perceived this as, "they have no time for me", "they think that I'm a bad person", "they think that I am not able to understand". As a result of insensitive behaviours from health care professionals, most adolescent chose not to ask questions and, in return, felt labelled by the staff as "not caring about the pregnancy" or as "being an immature adolescent".

However, adolescents did make clear during the focus group discussions that they do want to know what is going on throughout the pregnancy experience. Adolescents want to know what is considered normal during a pregnancy and, more importantly, why changes occur. These young women wanted to have

control over their pregnancy experience and to understand how it would affect them.

In addition, interactions with health care professionals were described as "stereotyped". According to this group of young women, health care professionals viewed pregnant teens as "all alike" and not as unique individuals with different needs. One respondent shared her experience of this stereotypical attitude encountered during her prenatal visits:

The visit was so methodical... do this.. do that... never once did the nurse call me by name. I could hear her talking with other nurses at the desk saying, "they're all the same... do they know what they've gotten themselves into?" She had no idea about who I was... that my family was supportive and that my boyfriend and I were going to get married. It's like she had written me off... like I was doomed with no future.

Each adolescent is a unique individual with a different background and needs. No two teens are at the same stage of growth and development and each teen has been influenced differently by earlier life experiences. These young women wanted health care providers to take the time and interest to get to know who they are as individuals versus "just another teenager" or "number."

As the adolescents told their stories about prenatal clinic visits, it also became evident that the participants perceived the work of health care professionals as "schizophrenic" in nature. Several teens indicated that staff

appeared oblivious to the fact that patients were frustrated with the inconsistency in health services and staffing. One adolescent remarked on her concerns about being treated differently at each prenatal visit as, "you never knew which doctor or nurse you'd see at your visit" and "just when you found someone you felt comfortable with, they'd be leaving the clinic or that doctor would tell you she wouldn't be around for your due date". Other adolescents concurred with experiences of staff inconsistencies:

The staff repeated tests done at my last visit and then jokingly said after reading my chart... 'oops well, it never hurts to do it again'.

Don't the staff ever talk to each other.. or why don't they ask me?

There are days when the doctors seem organized... others... like they fall apart and don't know what they're doing.

The value of consistent staffing to build relationships of confidence and trust was clear to these adolescents. Consistency was defined by the adolescents as "seeing the same caregiver over and over", "recognizing your face and knowing your name" and "getting to know me and taking an interest in my situation". In fact, respondents often declined referral to other health care providers in order to remain with caregivers whom they had grown to like and trust.

Patient confidentiality was also described by participants as "judgementally handled" by health care professionals. These young women wanted assurance that health care providers would provide confidential care, instead, the majority of participants felt exposed and vulnerable each time they sought prenatal care. It

was common for participants to delay entry into prenatal care either because a physician insisted on parental consent for services, or because seeing the family's long term physician meant risking pregnancy disclosure to parents. In these situations, the adolescents interpreted the primary health care relationship to be between the doctor and their parents instead of between the doctor and the adolescent client. As a result, most adolescents did not consider the doctor as a confidante.

Adolescents do, however, seek services from professionals they think "care about teens". Several teens described the type of caregiver they felt comfortable with as: "concerned", "open to talking", "honest", "a good listener" and "patient", as well as, "gives individualized attention and cares about me".

The pregnant adolescents were sensitive to attitudes of staff and to the quality of the care received. When respondents were met with a caring response, they felt comfortable asking questions and in return felt that their health seeking behaviour was given legitimacy. However, as defined by the participants themselves, clinicians who failed to respond to their requests for help often increased the probability that they would not again risk turning to an adult for help.

While society has its own pre-determined values and beliefs about adolescent pregnancy, this study sample stressed the importance for health care professionals recognizing how their societal beliefs may affect personal practice with this client population. Because health care providers have little or no

understanding of adolescents' interpretation of the pregnancy experience, there is an increased risk for mis-communication and mistrust between the adolescent client and the health care provider. Pregnant adolescents are in particular need of sensitive and personalized health education as they attempt to cope with adolescence, pregnancy and imminent parenthood.

### **Prenatal Education Needs**

The adolescents' perceptions and concerns about pregnancy are distinct from those of health care providers and influence teens' responses to pregnancy. In addition, the adolescents' perception of the pregnancy experience will determine which health behaviours she will denounce or endorse. During the focus group sessions, adolescents were encouraged to describe the health behaviours that they associated with pregnancy. Prenatal education became the major focus of this discussion.

### **Previous Experiences with Prenatal Programs**

When asked about their learning needs for prenatal classes, the adolescents described varying levels of knowledge about the role of prenatal classes. Participants identified common conceptions of what happened in prenatal programs included: lamaze; breathing exercises; massage; relaxation techniques; information on nutrition; drugs and smoking; learning how a baby is born; medications available for labour; and how to survive the birth. When asked to describe what came to mind when envisioning a prenatal class, one participants answered:

Watching a baby being born. They make you do exercises.. tell you what to eat and not eat. I hear its lots of breathing stuff. I don't really know what they do. I just hope it's not boring. Like do they just talk... or do they do things?

In sharing their perceptions and stories about prenatal education, most adolescents indicated a lack of experience with babies and childbirth and therefore, it was hard for them to define the ideal prenatal program. During this brainstorming session, initial responses from the groups included: "I've never even seen, let alone held a newborn before" or "I've babysat kids, but never anyone so small, so I'm not sure what I need to know?". The adolescents found it difficult to envision the future with a newborn. Respondents were more focused on getting through the day to day issues of nausea, swelling and backache, as opposed to focusing on issues which addressed the care of a new baby or even parenthood. Relevance and need for prenatal education, as they described it, was focused on where they were now in the pregnancy or "the here and now".

#### **Adolescent Desires for Prenatal Education**

The adolescent participants were able, with guidance and specific questioning, to describe their prenatal learning needs in terms of program structure, educational content and preferred teaching strategies. The following section represents the common themes expressed by the adolescents for a prenatal program.

### Structure

For the participants, attending prenatal classes would provide an opportunity to meet other pregnant teens who shared a similar experience. Interaction with other teens could confirm that they were not alone or isolated. Most stated that it would be a relief to see others experiencing the same feelings of denial, shock, isolation, fear, and uncertainty. As described by several participants, meeting other pregnant teens might also provide a social network. A participant describes her expectation for prenatal classes:

I want to know that other people feel and are experiencing the same things you do... kind of like... yah.. I feel this way too... or that happened to me. Not so that you feel... well so alone. Being in a group with other people like yourself and age, they can relate to you.

Throughout the focus group discussions, the young women emphasized the importance of participation and interaction with their adolescent peers. Reference was made to existing childbirth classes within the community but "they were for married couples and teens wouldn't fit in or feel comfortable with them". While several adolescents were concerned about lacking a support person to take with them to an adult class, others saw large class size, older age of participants and the financial inability to pay, as obstacles for participating in the adult programs.

The adolescents were conscious that teens come from a variety of different cultural, educational, socioeconomic and financial backgrounds and, therefore, a

prenatal program would have to address diverse needs. Information needs articulated within the focus groups ranged from basic adolescent and fetal physical growth and development, to continuing education, financial assistance, negotiating relationships, custody rights, availability and access to community resources and housing options. Respondents, therefore, expressed a desire for a program format without boundaries so numerous issues could be addressed and explored. A participant described her wide range of information needs as:

You never know what will come up during the week. Like last week I needed help with finding a place to live. Someone said something about a social worker but I didn't know how to get one. The other thing has to do with my boyfriend. I don't want him to get the baby... so I needed information like that. School... well to get back... like get my grade 11... so you know.. there are so many different questions I need to ask.

In conjunction with a diverse range of learning needs, respondents stressed the importance of flexible prenatal instruction. Participants wanted an instructor who could easily change topics or activities whenever the need arose. This means that prenatal educators must have a strong knowledge and skills base and an ability to adapt to unpredictable and changing learning situations. In relation to program structure, one respondent made the following comments about prenatal classes:

It's great to have a set of topics for the program or say each class, but sometimes... say if I've had a really bad week with my

boyfriend... or if I had a doctor's appointment and got information that I didn't get...well, I'd want like to talk about that and maybe the planned stuff could wait. My needs may change from week to week... so the teacher would have to...well be able to shift gears or topics... maybe jump all over different topics.

As indicated in the literature, pregnant teenagers require services that meet a broad range of learning needs. A popular structure option presented by the group had each prenatal class opening with a forum or "concerns" session to address pertinent issues of the week. The group also stressed the importance of incorporating group ideas and feedback throughout the program. For example, if the group wanted to bring in a guest speaker, go on a hospital tour, or prepare a nutritious snack, the instructor would incorporate these ideas and arrange it for a future class. In essence, the adolescent participants wanted the opportunity to participate in planning the format, direction and focus of the services they received.

Program follow-up was another structure request from the participants whereby health care providers would follow teens throughout pregnancy and up to the first year of parenthood. For these adolescents, cessation of a service after delivery threatened the existence of their support network. Several participants viewed existing adult prenatal classes as inadequate because "they drop you afterwards" or [they] "think they can teach you everything you need to know

before the baby is born". One adolescent described her feelings about the importance of continued education and follow-up from health care providers:

I don't want to be cut off or dropped by anyone. If you spend time... months getting to know people in the class and sharing...well personal stuff, everyone becomes like family. The instructor... she becomes someone you say ... well you trust and can ask questions easily. I'd feel more comfortable seeing the same person... She'd know what I'd been through...and well I'd want them to see my son or daughter. I will need to learn more after the baby is born... a lot of information on the baby it won't be relevant until then anyway... I mean baby info isn't what I'm thinking about right now.

For this group of adolescents, the ideal prenatal program was not a program focusing just on pregnancy. Instead, needed and valuable service was defined as ongoing with consistency in health care providers.

Delivery of prenatal education was defined differently by the adolescents and health care providers. While most health care researchers suggest that prenatal care for the adolescent is best delivered by a multi-disciplinary approach—doctors, nurses, social workers, nutritionists and a prenatal educator—the adolescents in this study did not share the same vision.

On the contrary, the adolescents believed that coordination of prenatal education be the responsibility of one key health care provider versus a multidisciplinary team approach. The key individual was described as a "jack of

all trades", with "access to all resources like schooling, financial assistance, housing, legal information, breastfeeding help and parenting programs". The major priority for any adolescent prenatal education program was "one-stop shopping", and accessible services available as the teens needed.

Ideal, accessible service was linked to a drop-in centre philosophy. However, the adolescents recognized that the financial and human resources required for such programs were unrealistic given existing budget constraints and cut backs. Realistic time allotments for each prenatal education programs were then explored within the focus groups. In relation to time frame, 2 hours appeared to be the most popular allotment for each session, as it justified travel time. Such sessions allowed ample time for teaching, group discussions, activities and peer interaction. Participants also stressed the importance of variety, movement and interaction within the classes.

A difference was noted in the focus groups, however, in terms of what time of day was preferable. Study participants from the singles residential program were open to evening sessions because funding for taxis and prenatal classes was provided in Maywood's program. Conversely, participants who lived on their own, or with family or friends, expressed support for two other alternative programs: a health clinic or high-school-based program for pregnant teens. This group of adolescents wanted comprehensive services that were centralized. A school-based prenatal program, for example, would address their educational, psychosocial and obstetrical needs on a daily basis with minimum travel.

Transportation was a major concern for most participants, for reasons of safety, accessibility, time, convenience and cost.

In addition to the time allotment for prenatal sessions, participants expressed concern about program size and make-up. The ideal class size was described as eight to ten teen participants. Participants were also open to the idea of inviting a support person to attend with them, but only for specified classes. As some topics were considered "personal", certain activities or sessions were considered as "for teen moms only" and not for friends, parents or boyfriends. "Personal sessions" included discussions about their bodies, physical and emotional changes, resuming sexual relationships, and the roles and legal rights of boyfriends.

### **Desired Prenatal Content**

The input received in the focus groups clearly indicated that the young women were able to describe their learning needs and concerns about prenatal education. The information and topic areas sought were not strictly pregnancy-related but included a wide range of psychosocial issues. Topics identified as being most important included: physical and emotional changes during pregnancy, stress management, smoking, drugs and alcohol, how to control weight gain, how to deal with friends and family, tests and procedures during pregnancy, where to get financial assistance, housing options, legal rights of boyfriends, the birth process, unexpected situations during delivery, relaxation techniques, breathing and massage, and coping skills to "survive" labour.

Adolescents nearing their expected date of confinement incorporated baby topics into their list of interests which included: fetal development, layette needs, breast and bottle feeding, infant care, carseats and community resources postpartum.

While the adolescents identified numerous topics for discussion, particular emphasis was placed on rationale and relevancy. Participants wanted explanation of changes during pregnancy, the degree of normalcy and the relevance to their situation. It became evident that participants valued opportunities for discussing their own experiences and asking and giving each other advice and suggestions. While ideas for prenatal content were easily volunteered by the participants, they were more interested in the explanations for each topic area.

### Teaching Strategies

Throughout the focus group discussions, participants expressed concerns about content delivery. The teens had very definite ideas on what they did and did not want when it came to teaching strategies. The least popular teaching methods included lectures, handouts and the use of overheads and were unanimously voted as "boring", "uninteresting" and "tiring" due to information overload. These methods were viewed as teacher-centred and involved minimal interaction and participation between teacher/learner and peer/peer.

Conversely, strategies that adolescents advocated focused on participatory activities such as games, work stations, group discussions, mock budget planning and shopping, as well as role playing and case scenarios. One young woman described her need for creative learning opportunities as:

I get bored really fast, so for someone to talk all the time... well my mind wanders off. I want to do things. The instructor should keep the class moving, lots of action. This stuff is new... my situation is different from hers so I want to learn things for me. Things like what to buy for the baby, how much money I will need, where I can go for help or buy things from cheap.

Visual and tactile strategies were also given high priority with emphasis on hospital tours, videos, models, posters, and samples of actual equipment. Examples included: videos showing adolescent client deliveries; food sample and portion size models; fetal growth and development models; test and procedure story books; uterine and pelvic models to demonstrate and explain the birthing process; and hands-on equipment such as forceps; an amniotic hook; carseats; formula samples; and breast pumps. The combination of visual, auditory and kinaesthetic teaching strategies provided all clients with an opportunity for learning. In addition, the ability to touch, to see and to manipulate objects increased their knowledge and reduce fear of the unknown.

While the focus group discussions required some alteration in the structuring of questions, the adolescents clearly articulated their learning needs during the pregnancy experience. By asking specific and simplified questions and by providing a clear context for each question, the participants identified and described their emotional responses and reactions to pregnancy, as well as various

prenatal learning needs. These perceptions may provide some insight regarding why adolescents chose some health behaviours over others.

### The Adolescents' Explanatory Model

The prenatal period offers health care professionals a unique opportunity to help adolescents improve their health status and pregnancy outcome through targeted education. However, as described in Kleinman's framework (1978) and the preceding study findings, adolescents (popular arena) view their prenatal needs quite differently from that of health care providers (professional arena). The following table compares the beliefs and health ideals about prenatal education operating in the professionals mind as compared to that operating for the adolescent.

**Table 1. Comparing the Explanatory Models of the Health Practitioner and the Pregnant Adolescent.**

| Professional Explanatory Model   | Adolescent Explanatory Model   |
|--|--|
| Pregnancy outcome is influenced by how a woman perceives her pregnancy   | Pregnancy outcome is determined by what "I" do and do not do. Everyone expects me to follow certain "rules" when I am pregnant.                                  |
| Adults are developmentally prepared for pregnancy and parenthood: emotionally, cognitively and physically. Adolescents are not mature enough nor are they prepared for childbirth. | I am capable of having a baby and becoming a parent. Just because you're an adult, does not mean that you are ready for children. Adults can mess things up too. |
| The majority of pregnant adolescents deny their pregnancy well until the 2nd or 3rd trimester. They don't seem to see what they've gotten themselves into.                         | I experience a sequence of emotional response throughout my pregnancy that are situation-specific.   |

| Professional Explanatory Model   | Adolescent Explanatory Model  |
|--|---|
| Pregnant teens require specialized prenatal care coordinated and delivered by a multidisciplinary team.  | I want specialized prenatal education from one key provider who has a diverse knowledge, resource and teaching repertoire. I want a provider who cares about me and one that I can trust. |
| Teens require prenatal education that focuses on healthy pregnancy choices and gives them the skills necessary for parenthood and childcare.   | "My" prenatal needs change from day to day. My education needs to focus on the "here and now". I can't deal with future topics like infant care until it becomes an issue for me.         |
| Adolescent prenatal programs are best delivered as a structured series with set priorities for learning.   | Prenatal education is ongoing versus a set program. My learning needs continue throughout pregnancy and continue at least up to my baby's first birthday.                                 |
| Adolescent prenatal programs are more efficient and effective if they are teacher-driven. Health providers know what teens need to learn.  | "I" want prenatal education to be learner-centred. I want to participate in the planning and implementation of what I learn.  |
| Adolescents are not developmentally prepared to understand what is happening in pregnancy. If they don't ask questions, then they aren't interested or don't care about the pregnancy. | I want to play a part in my pregnancy. I want to know what is going on and why it is happening. I am often afraid to ask questions for fear that I will be labelled as "stupid".          |
| Teens need as much information about pregnancy and parenthood as health providers can give them. We are the experts in this area and should share our experience with them.            | I want information that is relevant to me and my situation. You are not me. I do not want to hear about your experiences. Focus on me and my needs.                                       |
| Early childbearing is associated with socio-economic, educational, physical and psychological consequences.  | Every teenager is unique with different life experiences, skills and abilities. Treat "me" as an individual. Enable and support me versus writing me off.                                 |

## CHAPTER FIVE

### Summary, Implications and Conclusions

#### Summary

The number of adolescent pregnancies continues to increase in the province of British Columbia. For health care professionals, this means a greater probability of encountering the pregnant adolescent in a variety of settings, at some point in their career.

While the literature includes significant theory for understanding various aspects of adolescence and adolescent pregnancy, few studies exist which document adolescents' concerns and perspectives about prenatal education. The framework of explanatory models used by Kleinman (1978) asserts that health is interpreted and experienced differently by health professionals than health care recipients. According to the researcher's experience with pregnant adolescents and the results obtained in this study, adolescents perceive pregnancy and prenatal education differently than do health practitioners. The similarities and differences between the explanatory models of health care providers and pregnant adolescents must be clarified and recognized in order to facilitate effective provider-client interaction and negotiation of mutually acceptable health care options. This research study was designed to identify and explore concerns about the adolescents' prenatal experience in order to provide information for health care providers on how to better support, educate and nurture this client population.

A naturalistic approach to qualitative research guided the choice of methodology for exploring the personal views of adolescents about pregnancy and prenatal education. With the assistance of the Vancouver Health Department and Maywood's Pregnancy Outreach Program, nineteen pregnant adolescents were recruited to participate in one of three planned focus group discussions. Focus groups provided an interactive opportunity for 19 young women to share insights, attitudes and opinions about how they saw their pregnancy and to define what they wanted in relation to prenatal education. In addition, focus groups allowed the researcher to probe and to clarify the information discussed by the participants.

While the focus groups were designed to solicit the perceptions and opinions of the adolescents, participants had difficulty answering the researcher's original, broad and abstract discussion questions. To promote participation, the researcher modified the discussion questions making them more concrete and specific. As a result of question modification, participants chose to expand their responses to address issues beyond the original research questions proposed in this study.

Due to time constraints and difficulties in eliciting a free flow of discussion in the focus groups, the researcher required further participant contact to review, validate and to clarify the data collected. Participants did not want to attend another focus group so the researcher obtained volunteers agreeable to future

telephone follow-up. Of the nineteen participants, twelve adolescents volunteered by providing their home telephone numbers.

Direction for data analysis was taken from Giorgi's (1975) and Knafl and Webster's (1988) steps for data management and analysis. As the researcher reviewed the focus group transcripts, repetitive and significant topics, feelings and comments were classified and coded into major and sub-major categories. Dominant themes were then extracted from each category and validated with participants for accuracy. Finally, the descriptive format found in Chapter Four was created through the integration and synthesis of the responses and themes obtained in the study.

The findings of this study indicate that this group of pregnant adolescents has specific concerns about prenatal education, as well as a diverse range of learning needs throughout the pregnancy experience. In addition, participants identified ideals, beliefs and expectations about pregnancy education that were different from those operating in the minds of health practitioners. The adolescent participants addressed three key aspects of prenatal education that were important from their perspective: their emotional responses to pregnancy; conceptions about prenatal education; and perceptions about their prenatal education needs.

Emotional responses during pregnancy changed in sequence according to the stage of pregnancy. Denial was experienced in the initial stage of pregnancy as a coping mechanism to withdraw and remain emotionally uninvolved with a potentially uncomfortable situation.

Shock and disbelief were described in relation to pregnancy confirmation when the adolescents were confronted with positive pregnancy test and ultrasound results. Conversely, teens who planned their pregnancies, perceived early childbearing as an attractive and viable pursuit in comparison to their limited career and advancement options. Motherhood provided an alternative to the emotional response and reality of hopelessness.

Participants also described feelings of abandonment and isolation in relation to pregnancy disclosure. Admission of the pregnancy presented a high degree of risk for them and the potential or fear of being left alone. As indicated by the participants, adolescents already have a limited support network at this stage of development.

In addition to feelings of denial, shock and disbelief and abandonment, the adolescents reported a continuous change in the progression of emotional response as pregnancy progressed. Dependency, was experienced as a direct result of the limitations associated with adolescent growth and development. While physically mature, these young women discovered they were emotionally, cognitively and financially unprepared for the role of parenthood. Therefore, the developmental tasks of personal identity formulation and independence from parents were threatened as they reverted to family and friends for assistance.

Another emotional response described by participants during pregnancy was powerlessness. The rapid physical growth and body changes associated with pregnancy conflicted with most teens self-concept of the idealized self. Pregnancy

differentiated them from the peer group resulting in feelings of vulnerability and powerlessness.

Finally, during the last few weeks of pregnancy, previous egocentric responses changed to interest in the future of the unborn child. The emotional responses of anticipation and pride made pending parenthood a reality for these young women.

Societal attitudes toward teen pregnancy were also discussed by the adolescent participants. Societal attitudes were described as "judgemental", "negative", and "all-knowing". The attitudes of caregivers expressed in both verbal and non-verbal communications influenced the adolescents' perception of comfort and the quality of care received from health care providers. Respondents ultimately wanted service and interaction with providers who "care about and understand teens".

Participants also described their concerns and learning needs for prenatal education, focusing on program structure, content, teaching strategies and interventions. These pregnant teens wanted a prenatal program that featured flexibility in structure and format. As this group of adolescents' needs varied from week to week, participants emphasized the importance of addressing issues most pertinent at any given time. They wanted prenatal educators to be knowledgeable and competent in various teaching methods and able to change from topic to topic, with little preparation time.

Participants stressed the importance of client care consistency when discussing program structure. They wanted one key care provider that they trusted and could confide in. This key individual, however, was described as having access to a multidisciplinary team and diverse range of resources.

Participants requested prenatal education content that addressed a variety of psychosocial issues in addition to focusing on medical aspects of health and pregnancy such as weight gain, blood pressure and fetal development. It was recommended that program content have "no boundaries", with "all parts of life being fair game". Prenatal content ideas included: educational completion, the legal rights of the father, housing options, how to get financial assistance, in addition to, how a baby is born, medication choices during labour and when to go to the hospital. The ideal health educator was referred to as "a jack of all trades"; with a solid theoretical and teaching background, and diverse awareness of adolescent resources.

The final component discussed by participants included preference for teaching methodology. Strategies that were of most importance included "applies to my situation", hands-on" and "visual". Participants wanted to learn about and understand the rationale for pregnancy changes and health care interventions. Participants desired simple, truthful and pertinent teaching strategies that were learner-centred and not teacher-driven.

While health providers acknowledge that pregnancy outcome is influenced by the health behaviours chosen by adolescents, practitioners continue to use a

health model quite different to the model chosen by pregnant teenagers. The findings in this study indicated that pregnant adolescents view pregnancy and childbirth as a "normal female thing" and see themselves as capable of having a baby. They desired personalized education from one key health provider versus care from a multidisciplinary team. The one educator must, however, have an understanding of adolescent development and a diverse knowledge and teaching repertoire in order to meet teens' diverse learning needs. In addition, participants identified a need for information focusing on "where I'm at now in my pregnancy" versus the traditional focus of health practitioners, giving out as much information as possible to prepare teens for future parenthood. Most importantly, the adolescents' explanatory model described health providers as enabling, supporting and assisting pregnant teens to acquire skills and knowledge for becoming parents.

### **Implications**

The findings in this study regarding adolescents' perspectives about prenatal education have important implications for nursing practice, education and research. The findings reveal evidence that pregnant adolescents can identify their own learning needs, concerns and desires for prenatal education. Furthermore, the findings indicate suggestions for planning and implementing adolescent prenatal programs, as well as, identifying future areas for research about prenatal education for adolescents.

## Practice

As the number of teen pregnancies continues to increase in the Province, greater numbers of health practitioners will be expected to deliver care and education to this client population. However, the manner in which practitioners deliver health care and education may differ from the expectations and desires of the adolescent clients.

Health practitioners must determine what the pregnancy experience "means" to each adolescent and to appreciate the teen's emotional perspective. The adolescents in this study described a variety of emotional responses throughout their pregnancy experience that changed and were situation-specific. While the transition through various emotional responses described in this study may not be representative of all pregnant adolescents, the findings suggest that health practitioners need to discuss and validate client's reactions to pregnancy during prenatal visits, on a regular basis. No two adolescents are at the same stage of growth and development, therefore, it is important that care providers and educators not stereotype pregnant teens nor treat them all alike.

The adolescents in this study also described their perceptions and concerns about the attitudes of health providers toward pregnant teens. That participants described health provider attitudes as "negative", "judgemental" and "all-knowing" suggests the attitudes of health practitioners require assessment through observation of interpersonal communication skills during client interactions. However, to validate the accuracy of teens' perceptions about health provider

attitudes, peer-to peer clinical evaluations must be conducted amongst health providers and educators. Peer observations of client/provider interactions provide opportunities for feedback to health professionals about how they portray and conduct themselves with clients.

Health providers and educators presently interact and provide services to adolescents in a variety of different settings: in schools, community health units, outreach clinics and office settings. The findings, however, suggest that pregnant adolescents want prenatal services based out of one, centralized location, throughout pregnancy. The participants also want accessible, available and coordinated services, in essence "one-stop shopping". While the majority of health practitioners believe that existing teen prenatal services are accessible and effectively organized, it is the researcher's experience that they are not. At present health services for teens operate independently of each other, during limited hours and in a variety of different locations (Friedman, 1992). For the adolescent client, limited transportation options and accessibility, restrictive clinic hours and multi-site services are not practical, nor realistic. Practitioner's, therefore, need to identify the locations of existing teen services within their communities and to identify strategies for service linkage and coordination. Public health administrators and prenatal coordinators need to share information about existing teen prenatal programs with other health providers to prevent duplication of and re-invention of existing services.

Furthermore, the findings indicate that adolescents want prenatal services delivered by health educators and practitioners who are open, honest and caring. Health providers, therefore, must make it comfortable for adolescents to ask questions and to interact freely with caregivers and/or educators. Comfort and confidence in the client/care provider relationship from the teens perspective will help to enhance health behaviour compliance and service utilization during pregnancy (Havinghurst, 1972). In addition, the finding that adolescents often feel uncomfortable and lack confidence in their interactions with health providers suggests that not all practitioners are skilled nor comfortable working with adolescents. Health practitioners need to learn or strengthen compassionate communication, negotiation and interpersonal skills to act openly, directly and honestly with pregnant teens. Prenatal coordinators and clinical supervisors may want to incorporate skill development for these areas in staff orientation and inservice sessions.

### **Education**

The findings of this study also have implications for nursing education. That pregnant adolescents have a broad range of physical, psychosocial and educational learning needs throughout pregnancy suggests that health educators must have a diverse repertoire of teaching strategies, knowledge and resources to draw from. While most academic programs attempt to incorporate teaching/learning methodology into the curriculum, students may not be adequately prepared to assess adolescent learners, nor to teach them. Educational

coordinators need to review curricula to ensure that the teaching/learning methodology being taught to students and staff is up to date and promotes current education trends. It is the researcher's recommendation that academic programs include more clinical time examining how adolescents learn in relation to the theory on adolescent growth and development and increase structured opportunities for students to practice interaction and teaching skills with adolescent clients. Teen pregnancy should be recognized as a sub-speciality area in nursing. Based on the researcher's past experience and the research findings, students should master their teaching skills, content delivery and prenatal knowledge with adult prenatal education programs before moving on to the challenging and demanding requirements of adolescent prenatal programs.

It is also recommended that established health professionals utilize continuing education opportunities to strengthen their knowledge and skills about adolescent growth and development to best provide support, education and nurturing for adolescent clients.

Educators and program coordinators must provide staff with more opportunities for self and peer-evaluation of inter-personal communication skills. Videotaping client/care provider interactions may assist nurses in evaluating their strengths and weaknesses regarding communication and promote opportunities for further practice.

## Research

Finally, the findings of this study also have implications for nursing research. This study's description of adolescent perceptions demonstrates the necessity for further use of inductive methods in the study of adolescent experiences with pregnancy, childbirth and parenting.

The findings that pregnant adolescents are able to identify their broad learning needs and desires for prenatal education suggests that further investigation is needed to understand adolescents' perceptions, concerns and experience during pregnancy. Additional studies need to focus on more detailed and accurate descriptions of how adolescents see prenatal education and its delivery.

For example, the findings that pregnant adolescents desire one key care provider requires further clarification and validation with the teens themselves. Health practitioners must also examine the advantages and disadvantages of one key player when providing adolescent programs as opposed to the advantages and disadvantages of a multi-disciplinary team approach. Further exploration is required to define who takes on the key provider role and how this individual delivers and evaluates adolescent services.

In addition to the findings that pregnant adolescents want services from one key health provider, research is needed to determine the degree of knowledge and understanding health professionals have about other provider roles and resources. While practitioners support a multidisciplinary team approach,

many health providers have a limited understanding of the roles of other team members. A key health provider requires a clear understanding of all health providers' roles for client referrals, coordinated caregiver planning and care.

Finally, while the results emphasized a need for teen-driven prenatal services, participants described existing health providers as "dictators" with "their own ideas about what to do" throughout pregnancy. The findings that adolescents perceive health practitioners as "negative", "judgmental" and "all-knowing" suggests that clinical research is required to observe adolescent client and health provider interactions to validate if these allegations about providers' attitudes are accurate or not. Health providers expect pregnant adolescents to adhere to their institutions rules when receiving service. However, as reinforced in this study, participants indicated that they want flexible, compassionate and non-judgmental service. These findings suggest that further research is needed to define the "rules" perceived by pregnant adolescents when receiving service and to then validate the accuracy of this perception through clinical observations.

While a variety of research studies have documented various aspects of the adolescent pregnancy experience, continued research efforts by nurses to understand the phenomenon of adolescents' perspectives about prenatal education demonstrates health practitioners' commitment to providing quality prenatal programs for adolescent clients.

## Conclusions

From this study arise several conclusions about adolescents' perspectives regarding prenatal education. Most significantly, this study suggests that pregnant adolescents are able to identify and describe their learning needs and desires around prenatal education. In addition, pregnant adolescents are aware of the stereotypes and attitudes that health care providers and educators hold regarding teen pregnancy. Further, the findings indicate that adolescents' perceptions determine the degree and quality of involvement with prenatal education and care utilization.

More specific conclusions derived from this study are listed below:

1. Pregnant adolescents experience a variety of emotional responses that change throughout the pregnancy experience and which may affect the pregnancy experience and outcome.
2. Pregnant adolescents view societal attitudes towards teen pregnancy as negative and un-supportive versus enabling.
3. Pregnant adolescents want the opportunity to discuss their pregnancy experience with peers and significant others. The majority of pregnant adolescents find it difficult to discuss their pregnancy experiences with health care professionals due to concerns about confidentiality, trust and acceptance.
4. Pregnant adolescents want prenatal programs that are flexible in structure and address content areas related to medical aspects of pregnancy,

educational, socioeconomic, housing, psychological, physical and relationship issues.

5. Prenatal education for adolescence is a specialty area requiring skills and knowledge about adolescent growth and development, teaching/learning methodology and therapeutic communication.

In Chapter Five, the researcher provided a summary of this qualitative, study regarding adolescents' perspectives about prenatal education. As well, implications for health practitioners practice education and research were presented and conclusions drawn.

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**APPENDIX A**  
**PARTICIPANT INFORMATION LETTER**

Participation Information Letter

Dear client,

My name is Suzanne Brawner and I am a student in the Master's Nursing program at the University of British Columbia. For my Master's thesis I am wanting to find out what your concerns are about prenatal education as a pregnant teenager. Over the past four years I have worked as a nurse at Grace Hospital caring for new mothers and their infants and I teach the teen prenatal classes for the Vancouver Health Department.

The number of teen pregnancies is increasing in B.C and therefore there is a need for teen prenatal programs. To design teen prenatal programs, I need your ideas. Your input will help nurses to understand the issues that you as a pregnant teenager face. It will also help nurses to be more responsive to the needs and concerns of teenagers like yourself.

If you are interested and agree to participate in this study, I will be inviting you to attend a two-hour discussion period along with other pregnant teenagers at one of the health units or another convenient location. I invite you to share your experience of what it is like to be a pregnant teenager. The discussion period will be tape recorded but no identifying information will be used in the study. Your will remain anonymous and all information that you share will be confidential. The tape recorded data will only be shared with members of my thesis committee and the tapes will be erased immediately following completion of the study. Tape recording the discussion period will enable me to concentrate on the ideas, concerns and issues that you and others express. No names or identification will appear in any written reports or in the final thesis document. I wish to assure you that you are under no obligation to participate in this study and that if you do agree to participate, you have the right to withdraw from the study at any time. Non-participation or withdrawal from the study will no way

**APPENDIX B**  
**PARTICIPANT CONSENT FORM**

The overall results of this study may be published or presented at conferences to provide nurses with knowledge and understanding about teenagers' concerns about prenatal education, and to help nurses become more responsive to the needs of pregnant teenagers. These results will also be available to you, the Vancouver Health Department, or Maywood Home, upon request.

If you consent to participate in this study as described, please sign below in the space provided. If you have further questions about the study, please ask the investigator prior to signing this consent form.

I understand the nature of this study and give my consent to participate. I acknowledge that I have received a copy of the participants' information letter and consent form.

Signature

Date:

**APPENDIX C****FOCUS GROUP SAMPLE QUESTIONS**

1. What is it like to be 15, 16, 17 ... and pregnant?
2. What comes to mind when you think of prenatal education?
3. What types of experience(s) have you had with prenatal education?
4. If you could design the ideal prenatal education program for teens like yourself, what would it be like?

**APPENDIX D****DATA MANAGEMENT AND ANALYSIS****Sample of Derived Meaning Units and Themes****Quotation From Transcript:**

"I wanted someone to say hey... congrats!! Be excited for me. I knew that my parents hated my boyfriend so I'd have to deal with that too. Ya... you just want people to be happy for you. Instead I felt like they'd blow up at me or disown me... making comments like, 'wait to go kid you got knocked up', 'stupid move - don't you know what birth control is?' People get so funny... they look at me weird, make comments behind my back. They treat me as if I'm not capable of having a kid. I know my mom didn't want to tell her friends because she knew that they'd talk. Sure I'm young, but I can be a good parent too. I hate adults' mightier than thou attitude. Like only adults can have babies. Alot of them mess things up".

**Meaning Units Derived From This Excerpt:**

- ◆ Desire for approval (by teens from adults)
- ◆ Judgement (by society)
- ◆ Condescending (adults towards pregnant teens)
- ◆ Disappointment (adults about pregnant teens)
- ◆ Fear of rejection (teens)

- ◆ Egocentrism (pregnant teens)
- ◆ All-knowing (adults and society)

**Underlying Theme As Validated By Participants:**

Societal Attitudes Towards Teen Pregnancy

- ◆ Negative and quick to label or stereotype
- ◆ Judgemental versus supportive and enabling
- ◆ Adults are all-knowing and pregnant teens are ignorant about their situation and future

**APPENDIX E**  
**THE UNIVERSITY OF BRITISH COLUMBIA**  
**ETHICS COMMITTEE APPROVAL**