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Antecedents to adolescent pregnancy: A qualitative study.

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ANTECEDENTS TO ADOLESCENT PREGNANCY: A QUALITATIVE STUDY

by

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A DISSERTATION

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ABSTRACT OF DISSERTATION
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Focus groups were conducted among African American male and female adolescents living in a large Southern city. Female participants had become pregnant while previously enrolled in an HIV intervention study; male participants were the current partners of the female participants and/or fathers of the female participants' children. Eight sessions were conducted, 4 for females and 4 for their male partners. Forty-two females participated, ages 16 to 20 years old; 26 males participated, ages 17 to 23 years old. A grounded theory approach was used to induce from the data any theoretical constructs that may explain the occurrence of unexpected pregnancy among the study population. Analysis of the focus group data revealed that unexpected pregnancy was related to sociocultural issues such as a paucity of perceived future life options and family and social support for teen parenthood. In addition, male participants expressed a desire to be more involved with their own children than their fathers were with them. Analysis further revealed representation of constructs from the theory of possible selves, social cognitive theory, and theory of reasoned action. This qualitative study provided an insightful view into the antecedents of adolescent pregnancy and identified theoretical constructs that may be relevant for further research and future intervention development in the area of adolescent pregnancy prevention.

DEDICATION

This dissertation is dedicated to my husband, George, for all of those evenings you cooked dinner, did laundry, and cleaned the house while I was studying, writing papers, or doing research at the library. Thank you for insisting that I take breaks on Sunday evenings so we could watch our favorite animated television shows together. Without your support, love, and understanding, I would not have successfully made it through the past 4 years.

I would also like to dedicate this dissertation to my niece, Savannah, whose existence has unexpectedly brightened my life. May this be an inspiration for you to pursue your life's goals and instill in you the fact that you can accomplish anything your heart desires.

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CHAPTER 1

INTRODUCTION

Statement of Problem

The United States has the highest teen pregnancy rates of all industrialized countries, with rates twice as high as Great Britain, which is the next highest nation (National Campaign to Prevent Teen Pregnancy [NCPTP], 1997). Nearly 1million teenagers become pregnant each year, and approximately 4 in 10 girls will become pregnant before they turn 20 years old. Of the teen pregnancies in 1990, about 14% resulted in intended births, 37% resulted in births that were unintended, 35% of the pregnancies were terminated, and 14% resulted in miscarriages (Alan Guttmacher Institute, 1994). Also in 1990, according to the NCPTP (1997), about 40% of all pregnant teens were 17 years old or younger; about half of all pregnant teens were Caucasian.

Teen pregnancy rates among girls aged 15 to 19 years old experienced a 23% increase between 1972 and 1990, from 95 to 117 pregnancies per 1,000 girls aged 15 to 19; this rate then declined in 1992 to 112 pregnancies per 1,000 (NCPTP, 1997). *Morbidity and Mortality Weekly Report* (Centers for Disease Control [CDC], 2000a) presented a further decline in adolescent pregnancy rates during 1995 to 1997, from 98.3 to 90.7 pregnancies per 1,000 girls aged 15 to 19 years old. Despite this downward trend, adolescent pregnancy remains a major public health concern in the United States.

Merely stating the pregnancy rates does not fully illustrate the pervasiveness of teen sexual behaviors in the United States, as statistics reflecting high-risk sexual behaviors lay the foundation for teen pregnancy. According to the 1999 Youth Risk Behavior Surveillance (YRBS) (CDC, 2000b), 50% of America's teens in Grades 9 through 12 have engaged in sexual intercourse at least once in their lifetime, and 36% reported being currently sexually active at the time of the survey; of students in Grade 12, 21% have had four or more sex partners in their lifetime. In addition, many U.S. teens are engaging in high-risk sexual behaviors that put them at further risk for pregnancy and sexually transmitted diseases (STDs). Of the teens surveyed in 1999, 42% had not used a condom at last intercourse, and only 20.4% of the young women reported using birth control pills at last intercourse (CDC, 2000b). For many teenagers, sexual intercourse is not a planned activity and often occurs in situations where drugs and alcohol may play a role and hinder an individual's decision to use contraceptives or abstain. According to the YRBS (CDC, 2000b), alcohol or drugs had been used by 25% of the surveyed teenagers at last sexual intercourse. This percentage was higher for men (31.2%) than for women (18.5%). Flanigan, McLean, Hall, and Propp (1990), in a study of unintended pregnancies among teens, reported that 50% of the teens had been drinking or using drugs before engaging in the act of intercourse that resulted in pregnancy.

A large percentage of U.S. teenagers are constantly putting themselves at risk for pregnancy and STD. While most teens in today's society understand these risks, many do not have a grasp of the long-term impact that sexual activity may have on their lives. Even if pregnancy does not occur, their reproductive health and mortality may be threatened by bacterial and viral infections that are asymptomatic. Moreover, it is doubtful that

teens realize they are putting themselves at risk for economic and academic hardship if their behaviors result in pregnancy.

Significance of Problem

The long-term impact of teen pregnancy has been well documented, and the consequences weigh heavily on teen parents, children of teen parents, and society. According to the NCPTP (1997), teenage childbearing decreases the likelihood of educational attainment with less than one third of teenage parents ever completing high school. In fact, delaying parenthood until age 20 or 21years old increases the odds of high school graduation by 50%. On average, adolescent mothers have more children than women who delay childbearing, which makes it more difficult to escape poverty, and almost half of all teenage mothers and over three fourths of unmarried teenage mothers begin receiving Aid to Families with Dependent Children (AFDC) within 5 years of the birth of their first child. In addition to consequences that directly affect teenage parents, the children of these teenagers are especially impacted by adverse consequences. Children born to teen mothers are 50% more likely to repeat a grade, perform much worse on standardized tests, and are less likely to complete high school than those whose mothers had delayed childbearing. Young adult children of teenage mothers are 30% more likely to be neither working nor going to school, and the sons of teen moms are 13% more likely to end up in prison. Daughters of teen mothers are 22% more likely to become teen mothers as well. Children born to teenage mothers are at greater risk for low birth weight and infant mortality, as pregnant teens often delay or fail to access prenatal care (NCPTP, 1997). Pregnant teens are also more likely to smoke or drink alcohol while pregnant, which further in-

creases the risk for low birth weight and infant mortality (Flinn, Davis, Shah, Zare, & Pasarell, 1998; Institute of Medicine Committee on Unintended Pregnancy, 1995).

Specific Aim

A large HIV prevention study was conducted in Birmingham, Alabama, among African American women, ages 14 to 18 years old. Recruitment into this study occurred in medical clinics, school health classes, and health departments. All recruitment sites were located in low-income neighborhoods with high rates of teen pregnancy, sexually transmitted infections, substance abuse, and unemployment. Eligibility criteria included being an African American woman between the ages of 14 and 18 years old, being sexually active in the previous 6 months, and providing written consent to participate in the study. While enrolled in this HIV prevention study, many participants became pregnant. In an effort to understand the factors related to their becoming pregnant, these women were invited to participate in a focus group study; current male partners and fathers of the participants' children were invited to participate as well. In addition to participation in the focus groups, participants completed a self-administered questionnaire that inquired about the same issues addressed in the focus groups; the proposed study utilized only these focus group data. The specific aim of this research was to apply a grounded theory approach to the focus group data and inductively arrive at theoretical constructs related to the occurrence of unexpected pregnancy among the study population.

CHAPTER 2

LITERATURE REVIEW

Antecedents to Adolescent Pregnancy: Quantitative Studies

For decades, researchers have attempted to identify factors that cause adolescent pregnancy. One of the most important conclusions made from these numerous studies is that there are not just one or two major antecedents to teen pregnancy. Instead there are multiple antecedents, each of which has a weak or moderate relation (Kirby, 1997). Although there are numerous potential causes of teen pregnancy, Kirby has developed succinct categories within which each antecedent may be placed. The categories are as follows: State and Community, Family, Peers, and Individual. For this discussion, these categories will be adapted and used to present various correlates to adolescent sexual behaviors and pregnancy as follows: State and Community, Family, and Peers and Individual. The first two categories will be the primary categories under review; the third category will be discussed briefly. It must be clarified that pregnancy is not a behavior but is the result of specific high-risk sexual behaviors such as early age of sexual onset, frequency of sexual intercourse, multiple sexual partners, and contraceptive use. These behaviors will be discussed below, because they are the best means through which to understand the occurrence of pregnancy among teens.

The first category presented by Kirby (1997) was State and Community. These antecedents to adolescent sexual behaviors and pregnancies include such factors as

socioeconomic status, labor-force status, ethnicity, household/community structure, and education levels. Certainly not every child can be categorized by his or her community, yet researchers have identified factors that put youth at greatest risk for high-risk sexual behaviors. A 1986 review of research by Flick found that living in a metropolitan area puts teens at greater risk for sexual activity, with 50% of all 15 to 19 year olds living in metropolitan areas having had intercourse in 1979 compared to a 40% projection for this age group overall. This report also found that younger adolescents living within a low socioeconomic stratum are at greater risk for early sexual initiation than children of similar age who are in a high socioeconomic stratum. Ethnicity is often considered a risk factor for teen pregnancy, and this review found that 40% more African American adolescents have been sexually active than Caucasian adolescents. However, the author pointed out that the racial differences might be due to the effects of poverty because higher percentages of African-Americans experience extreme economic hardships than Whites. Intent to get pregnant is also of concern, and a literature review by Weissberg, Gullotta, Hampton, Ryan, & Adams (1997) found that intention to get pregnant is also influenced by socioeconomic status, ethnicity, and marital status. They found that higher income teens are less likely to intend to become pregnant than lower income teens, and that African American and European American teens are less likely to intend to become pregnant than Hispanic American teens (Weissberg et al., 1997). Another literature review (Kirby, 1997) found similar results as Flick (1986) and Weissberg et al. (1997). This review specified that adolescents are at greatest risk for pregnancy and risky sexual behaviors if they live in areas with extensive violent crime, poverty, unemployment, high resi-

dential turnover, low levels of education, high divorce rates, and high rates of adolescent non marital births.

The Young Chicagoans Survey was an ethnographic research project conducted in 1979. Using a random sample of 1,000 African American young women ages 13 to 19 years old, Hogan and Kitawaga (1985) examined fertility behaviors of these Chicago teenagers. The authors found that African American teens in lower class areas had an initial rate of sexual intercourse that was 45% higher than observed among African American teens in middle and upper classes. Hogan and Kitawaga further identified that girls living in high-risk environments (lower class, ghetto, non intact family, five or more siblings, sister who is a teen mother) had rates of pregnancy that were 8.3 times higher than for girls living in low-risk environments (upper class, good neighborhood, intact family, four or less siblings, no sister that is a teen parent).

Barnett, Papini, and Gbur (1991) examined demographic and familial correlates of 124 sexually active adolescents. All subjects were Caucasian and recruited from health clinics and family planning programs in Northwest Arkansas; 57% were pregnant at the time of this survey. The results of Barnett et al. were consistent with previous literature. Pregnant adolescents lived in low-income households (annual income <$20,00 per year) more often than non-pregnant teens.

Using Cycle III data of the National Survey of Family Growth, conducted in 1982, Brewster, Billy, and Grady (1993) explored the role of community characteristics in determining sexual onset and the use of a contraceptive at that event. Analysis of these data found that community characteristics do influence a young woman's risk of becoming sexually active. The findings suggest that, when the reported social and economic

disadvantages of non marital pregnancy are high, young women take steps to avoid pregnancy; where the perceived disadvantages of non marital pregnancy are low, female adolescents are less likely to use contraception or abstain from sexual activity. Another interesting finding is that future expectations of young women mirror the experience of adults in their micro environment who are "like them." According to Brewster et al.'s results, this influence is more important than the influence of a community's social and economic characteristics.

Brewster (1994) used this same data set to explore neighborhood characteristics and race differences in non marital sexual activities of young women aged 15 to 19 years old. Brewster found that the risk of intercourse did not differ by race when neighborhood characteristics were taken into account. Both African American and Caucasian teens responded to structural constraints and opportunities in the same manner. Adolescent women of both races were more likely to engage in sexual activity when the perceived consequences to do so were low, whereas teens of both races were likely to delay sexual onset when the perceived consequences were high. Brewster concluded that race differences in sexual activity seem to reflect differences in the likelihood of exposure to various environmental constraints but not race-specific responses to these constraints.

To summarize this section, certain community characteristics do put adolescents at greater risk for high-risk sexual behaviors than those adolescents not exposed to such characteristics. Furthermore, it appears that various communities put youth at risk not because of ethnicity, but from the lack of social and economic opportunity. This idea of social environment effects is not new, as Durkheim postulated such sociological theories in the late 1800s. Beliefs and behaviors that reflect social and economic defeat can be-

come "reality" in social groups, and overcoming that reality is an arduous task. For that reason, high-risk sexual behaviors are more prevalent in communities of "social disorganization" (Kirby, 1997) than in communities of social and economic advantages.

The second category presented by Kirby (1997) was Family, which addresses the familial factors associated with adolescent sexual behaviors and pregnancies. The literature in this area of research is vast, and this discussion will not begin to encompass everything that has ever been written on the topic. However, the key findings regarding familial factors associated with adolescent sexuality will be addressed, which include parenting behaviors and family structure.

Parenting behaviors and their relationship with adolescent sexuality has been the focus of much research. The quality of the relationship between parent and child seems to be the most effective factor in reducing sexual risk among adolescents, when compared to parent/child communication and parental supervision. In Flick's (1986) review of the literature, parental involvement was found to decrease sexual activity. Similarly, Resnick, Bearman, Blum, Bauman, Harris, Jones, et al. (1997) found that parent/child connectedness was associated with adolescents' delay of sexual onset. This same study by Resnick et al. found that shared activities between parents and children served as a protective factor against adolescent pregnancy.

Whitaker, Miller, and Clark (2000) explored the concept of sexual typology and its relationship with various social, psychological, and behavioral variables among 900 high school students in Alabama, New York, and Puerto Rico. Students who expected to initiate sexual activity in the next year (anticipators) reported less parental closeness, communication, and supervision than students who had never had sex and did not plan to

have sex within the next year. Furthermore, female students who had had more than one sexual partner (multiples) reported less parental closeness and monitoring than students who had had only one sexual partner (singles). In addition, a linear relationship was found between greater sexual experience and poorer parenting behaviors.

In studying maternal correlates of sexual behavior among 751 Black adolescents, Jaccard, Dittus, and Gordon (1996) found that adolescents who are generally satisfied with their maternal relationships may be more likely to pay attention to and accept information about sexual topics from their mothers. Moreover, avoiding a mother's disapproval may serve as a motivator toward avoidance behavior, and adolescents who are unhappy with their parents may behave sexually in ways that directly oppose them. Study findings also indicate that strong parent/child relationships enhanced the delay of sexual initiation, but, once sexual onset began, the strength of parental relationships may not be a preventive factor in preventing subsequent acts of intercourse. Using data from the Longitudinal Study of Adolescent Health, Jaccard and Dittus (2000) found that higher quality relationships between adolescents and their mothers were associated with a higher probability of using birth control and a lower probability of both engaging in sex and becoming pregnant.

Barnett et al. (1991) found pregnant adolescents perceived less family strength than nonpregnant adolescents and that family strength was a strong predictor of teen pregnancy. However, the authors cited a methodological limitation in their study and could not determine if this perceived lack of family strength occurred before or after the pregnancy. These findings are consistent with research conducted by Fox (1980). Fox found that high-risk sexual behavior is associated with noncohesive and maladaptive

family behavior. Fox speculated that this "breakdown" of the family may encourage adolescents to seek attention and love through either a sex partner or giving birth.

Parent/child communication has been examined as a factor associated with adolescent sexual activity. B.C. Miller (1998) reviewed 30 studies concerning parent/child communication and found inconsistent results. He also reported that most studies indicate a stronger association for mothers' communication than fathers' communication, and this effect is stronger for daughters than for sons. Some studies have found an association between open, positive, and frequent parent/child communication about sex with adolescent delay in sexual debut and having fewer sex partners (Barnett et al., 1991; Jaccard et al., 1996). In analyzing data from the Family and Adolescent Risk Behavior Study, K. Miller, Levin, Whitaker, and Xu (1998) found that maternal discussions, which occurred before sexual onset, were associated with more frequent condom use by adolescents.

Despite the positive findings that associate positive, parent/child communication with decreased adolescent sexual risk behaviors, according to B.C. Miller (1998), there are just as many studies that have found no association. B.C. Miller speculates that these discrepancies may occur because of the temporal ordering of variables. For example, do parents talk to their children before sexual onset, or does the communication begin once parents become suspicious of the occurrence of sexual initiation?

The third parenting behavior discussed here is the concept of parental supervision. B.C. Miller, McKoy, Olsen, and Wallace (1986) found that adolescents whose parents exercise little supervision over dating and social activities tend to engage in sexual activities at an earlier age. Hogan and Kitawaga (1985) found similar results where parents with few rules and restrictions yield adolescents who are extremely sexually active and at

risk for pregnancy. Conversely, children whose parents are too strict and have a high degree of control are at high risk for pregnancy. In her review of research, Flick (1986) also found that lack of parental supervision increased sexual activity among female adolescents who were dating. Weissberg et al. (1997) recommended that efforts should be made to help parents increase positive communication with their children while effectively monitoring them and limiting their unsupervised activities among mixed-sex groups.

In addition to parenting behaviors, factors related to family structure and context are also correlates of teenage sexual activity and pregnancy. The National Campaign to Prevent Teen Pregnancy (1997) stated that daughters of teen mothers are 22% more likely to become teen mothers themselves when compared to daughters of mothers who delayed childbearing. Flick (1986) found that, in a sample of low socioeconomic status, female adolescents were more likely to be sexually active when other women in their family have low levels of education. This same review found that female adolescents who live in large families have a greater likelihood of being sexually active, and having a sister as a teenage parent role model is associated with greater sexual activity as well. Hogan and Kitawaga (1985) found that higher rates of pregnancy among teens living in large families are due to the lower quality of neighborhoods in which large families live and that parents with many children have less control over the dating behaviors of their children. Hogan and Kitawaga also found an association between teen parent siblings and increased sexual activity among adolescents. Their research indicated that girls from families in which at least one sister is a teenage parent have pregnancy rates 38% higher than girls from families where this has not occurred.

Research conducted by Zelnick, Kantner, and Ford (1981), Hogan and Kitawaga (1985), and Barnett, Papini, and Gbur (1991) found that a two-parent family environment is conducive to delayed sexual onset and pregnancy among adolescents. More specifically, Brewster (1994) found that adolescents not living with both parents at age 14 years were at greater risk for early age of sexual onset. In addition to household composition, Zelnick et al. (1981) found that parents' education levels are inversely related to the teens' sexual intercourse experience, whereas Brewster and Hayward, Grady, and Billy (1992) found specifically that mothers' education is inversely related to the risk of sexual activity among adolescents.

Overall, studies indicate that family composition may play a large role in influencing the sexual behaviors of children. Various factors in one's family may be a contributing factor to adolescent pregnancy, such as parents' education levels, being the daughter of a teenage mother, or having a sister who is a teenage parent. However, studies have shown that the development of positive, interactive relationships between parent and child can be instrumental in the delay of sexual initiation and the prevention of adolescent sexual risk behaviors as well as pregnancy.

The final category of antecedents is Peer and Individual, and includes such variables as peer pressure, locus of control, self-esteem, religiosity, perceived peer behaviors, attitudes, knowledge levels, academic performance, involvement in high-risk behaviors, and future orientation. Kirby (1997) characterized adolescents at risk for pregnancy as having friends whom they believe are sexually active, are themselves less involved in school, do poorly in school, and have low aspirations for their futures. He further de-

picted these adolescents as more likely to use alcohol and drugs and having more permissive attitudes toward premarital sex.

In his findings from the National Longitudinal Study on Adolescent Health, Resnick et al. (1997) found that delay in sexual onset was associated with higher levels of connectedness to school and higher levels of importance regarding religion and prayer. Also related to delay in sexual onset were higher grade point average and self-report of appearing younger than peers. When reviewing factors associated with pregnancy, no school factors were found, but length of time since age of sexual debut was related to history of pregnancy. Protective factors against pregnancy included perceived negative consequences of becoming pregnant and use of contraception at first and/or last most recent sexual intercourse experience.

Flick (1986) found several individual-level and peer factors associated with teen sexuality in her research review. She found that low grade point averages among male and female teenagers increase the likelihood of sexual onset within the next year, and adolescents without sex education initiate sex earlier than adolescents who have had sex education. This review also reported that low educational aspirations among young women are associated with increased sexual activity. Flick found that attending church is a protective factor against sexual activity; nonvirgins hold more stereotypical views of sex roles than virgins. Regarding high-risk behaviors besides intercourse, sexually active high school students engage in more "unconventional behavior." Interestingly, this review found that young male sexual initiators have higher self-esteem than older initiators. High levels of involvement with peers override parental involvement for male adolescents and are associated with early sexual behavior for both male and female adolescents.

Moreover, perceived frequent sexual activity among peers is strongly associated with increased sexual activity. In addition to sexual activity, this same review examined factors associated with contraceptive use. Adolescents who received contraceptive information as part of sex education were more likely to use contraceptives at first intercourse than those who had not received this information. This review found that the older an adolescent is at sexual debut, the more likely she will use contraceptives, and adolescents with a strong sense of individual control are more likely to use contraceptives. Adolescents who continued to use contraceptives had higher educational goals than those who discontinued use of birth control.

More recently, Whitaker et al. (2000) found specific individual and peer differences between students who did not anticipate sexual onset in the next year (delayers) and students who did anticipate sexual onset in the next year (anticipators). These researchers found that, compared to delayers, anticipators reported more cigarette use, heavy alcohol use, marijuana use, lower self-esteem, and less likely to have a role model; females only reported less control. Furthermore, anticipators reported having more peers who have had sex and used alcohol than students who did not plan to have sex in the next year. This team of researchers also found differences between students who had had only one sex partner (singles) and students who had had at least two (multiples). These differences included multiples having reported more lifetime alcohol use and marijuana use than singles, and multiples were also more likely than singles to have friends who had had sex. Other important findings were that multiples were more likely than singles to like school less, have more suspensions, and have repeated a grade.

Mentioned briefly in Flick's (1986) review of factors associated with sexual activity was the concept of sex roles. A 1984 study by Ireson found that traditional sex roles are related to the occurrence of adolescent pregnancy. This author found that pregnant teens perceive themselves as more competent in more feminine activities than other sexually active teens. Pregnant teens in this study also had lower occupational and educational aspirations than other teens. Hogan and Kitawaga (1985) found in their study of Black adolescents that the pregnancy rate was 27% higher among girls with low career aspirations.

Finally, other high-risk behaviors such as alcohol, tobacco, and drug use have been cited as antecedents to sexual activity among adolescents. According to Hingson, Strunin, Berlin, and Heerin (1990), teen sexual activity is usually unplanned and often occurs after the use of alcohol and/or drugs. These drugs impair the adolescents' ability to make responsible decisions about sexual activity, thus putting teens at increased risk for unplanned pregnancy. Another study of teens with unintended pregnancies found that half of the sample had been drinking or using other drugs before conception occurred (Flanigan et al., 1990).

To summarize, numerous individual and peer factors have been studied for their association with adolescent sexual activity and pregnancy. Such factors include peer pressure, self-esteem, perceived peer behaviors, locus of control, involvement in high-risk behaviors, and future orientation. This review found tht low educational aspirations and lower grade point averages have been associated with early sexual initiation as well as higher levels of sexual activity (Flick, 1986; Hogan & Kitawaga 1985; Resnick et al., 1997). High levels of importance regarding prayer and religion were also associated with

delayed sexual onset (Resnick et al., 1997). Drugs and alcohol were found to be predictors of unplanned pregnancy; such substances lower an adolescent's inhibitions, thus increasing the likelihood for engagement in high-risk sexual behavior (Flanigan et al., 1990; Hingson et al., 1990).

Antecedents to Adolescent Pregnancy: Qualitative Studies

In addition to the quantitative studies reviewed above, a limited number of qualitative studies, specifically focus groups, have been used to examine pregnancy and sexual risk behaviors among adolescents and young adults. Focus group research is an especially insightful tool for researchers during the formative stages of program development. Wingood, Hunter-Gamble, and DiClemente (1993) conducted focus groups among 18 low-income African American women, ages 18 to 25 years old, as a means to understand communication barriers that prevent the use of condoms during sexual intercourse; these focus groups were part of the formative process used to design and implement an AIDS prevention intervention for young African American women. Focus group findings revealed that the majority of participants (n=13) had the ability to talk to their sexual partners about safer sex, specifically those women who were beginning new sexual relationships or having sexual encounters with casual partners. Women in long-term relationships were less likely to initiate such conversations.

Despite the reported ease with which the participants were able to discuss safer sex with their partners, only four women reported the ability to actively negotiate condom use. The major barrier to condom negotiation was the issue of "trust." By raising the issue of condoms with their sexual partners, the women risked exposing themselves to ac-

cusations of having an STD or of infidelity. Yet condom negotiation was more effective for participants who had introduced condoms early in the relationship. Moreover, some women felt that they lacked the skills to enter into condom negotiation, and others lacked confidence in their partner's ability to properly use condoms (Wingood et al., 1993).

Wingood and colleagues (1993) found that, although participants knew condoms reduce the risk of becoming infected with HIV or an STD, the participants felt that condoms interfere with sexual pleasure and are uncomfortable for their partners. Wingood and colleagues also found a pattern of genderbased power differences. Most of the participants did not perceive themselves as having the power to negotiate condom use, and 16 of the women reported that the male partner had more control in deciding whether or not a condom is used. The women who felt powerless in their abilities to enforce condom use were more likely to engage in unprotected sexual activity than the participants who reported more control regarding condom negotiation.

Crump, Haynie, Aarons, Adair, Woodward, and Simons-Morton (1999) conducted a series of focus groups as part of the planning phase for the development of adolescent pregnancy prevention programs in Washington, DC; these programs are components of the National Institutes of Health – DC (NIH-DC) Initiative to Prevent Infant Mortality. Six 90-min focus groups were conducted among urban, African American young women ages 14 to 17 years old. This study examined the extent to which participants felt pregnancy would impact them personally and socially; their perceptions of contraceptive use were examined as well. In general, teens in this study were ambivalent about teen pregnancy. Although they indicated that delaying pregnancy beyond the teen-

age years is preferable, many statements suggested the personal and social benefits of teen pregnancy.

Regarding personal impact, the teens felt that emotional and financial stability are critical in adequately raising a child. It was suggested that female teens who have spent a significant amount of time around small children understand the amount of work involved in childrearing and that these teens know to avoid pregnancy. Participants also agreed that, although teen parenthood delays one's career and education aspirations, it does not prevent long-term success in life. In fact, many participants viewed teen pregnancy as a "manageable situation" and believed that teen parents who succeed at parenting and "keeping their lives together" should be respected not stigmatized. Moreover, many participants were disagreeable to the labeling of teen pregnancy as a problem and believed that teen motherhood has many benefits. Such benefits include being closer in age to the child and allowing young mothers to improve themselves for the sake of the child (Crump et al., 1999, p. 38).

When asked about social impact, participants in every group stated that everyone gets pregnant and that there is nothing unusual about becoming pregnant. Also, peer acceptance was not an issue, as participants described peers as supportive and nonjudgmental of teen parents. It was noted, however, that some females believed that having a baby will keep a boyfriend in the relationship or that having a baby provides an opportunity for unconditional love. Participants spoke negatively of these two circumstances, stating that many boyfriends will deny fatherhood or break off the relationship anyway and that teens who want a baby for unconditional love have emotional problems or troubled lives at home (Crump et al., 1999).

Contraceptive use was viewed as a way for individuals to control whether or not they get pregnant, but participants repeatedly mentioned the failure rates and side effects of nonbarrier contraceptives. Similar to the focus group findings of Wingood et al. (1993), a major barrier to condom use was boyfriend or partner disapproval. According to participants, many men view condoms as unpleasant or a sign of distrust. Study comments also indicated that some women are so concerned about pleasing their partner that pregnancy prevention is ignored during the act of intercourse.

Rosenthal, Lewis, and Cohen (1996) conducted two focus groups among inner-city women, 15 to 16 years in age, to explore their sexual decision-making processes and views of relationships with men. The mean age of sexual debut among the participants was 13.7 years. In this study, participants discussed the risk of being out of control in sexual situations, either because of the boyfriends' adamant behaviors or because of drugs or alcohol. Interestingly, many of the women relied on peer and family support to prevent them from being out of control. This tact was used to protect the participants from their partners' impulses, and this cooperative supervision was requested even when alcohol and drugs were involved. One young woman stated that her mom is present every time her boyfriend comes over. These comments support the findings of B.C. Miller et al. (1986) where lack of parental supervision was associated with earlier sexual onset among adolescents.

Sexual decision making among this group was also impacted by curiosity, desire, and sexual arousal. The decision to initially engage in intercourse, according to participants, was the desire to be accepted by female friends. However, curiosity played a role in trying new sexual behaviors such as oral sex. Some of the girls expressed sexual de-

sire and sexual mastery as influential in their sexual experiences. One participant described a scenario where she had not had sex in a long time, so she jumped on her boyfriend and demanded sex. She then discussed a situation where she pressured a partner into having sex despite knowing he had "a lot of things on his mind" (Rosenthal et al., 1996, p. 735).

When discussing relationships, Rosenthal and colleagues (1996) found that sexual activity was occurring in both emotional, intimate relationships and purely physical relationships. Oftentimes, when involved in intimate relationships, the judgment of the participants appeared to wane. For example, after having used condoms for several months with one partner, one participant went on Norplant and quit using condoms. Other participants stated that they tried to have sex with as many partners as they could, which was similar to the sexual conquests of the boys they knew. It was important to many female participants that males provide them with material items and respect. However, for the girls who were less comfortable with sexual behavior, receiving presents made them uncomfortable because they felt pressured to reciprocate with sexual behaviors.

In 1983, the Alan Guttmacher Institute conducted focus groups with male and female teenagers in five U.S. cities in order to investigate the poor contraceptive practices among adolescents (Kisker, 1985). Half of the focus groups were comprised of 16 and 17 year olds, and the other half were comprised of 18 and 19 year olds. The majority of these participants were Caucasian, coming from middle-class and lower-middle-class families. This study found that a lack of contraceptive use was attributed to unplanned sexual activity. For many of the participants, sexual debut was an unexpected event, and contraceptives were therefore not available, although some used the rhythm method or

withdrawal. Similarly, intercourse with a new partner is often unplanned, according to participants, which usually results in lack of contraceptive use. Some of the male participants feared that raising the issue of birth control would insult their partners and "shut things down" (p. 84), while some of the younger male participants noted that they usually waited for their partner to bring up the issue of birth control. Many female participants agreed that birth control is their responsibility but, if contraceptives were not available, would risk unsafe sex in lieu of a missed opportunity for intercourse. Participants did agree, however, that it was easier to plan for contraceptive use in established relationships.

When asked about fear of pregnancy, most of the female participants understood that lack of contraceptives increased their risk of pregnancy, but they also felt their risk was very small because of the infrequency with which they had intercourse. It took a pregnancy scare for many of the female participants to acknowledge the importance of birth control. One young man articulated that he does not worry about pregnancy, especially if he is not going to "see the girl again anyway" (Kisker, 1985, p. 85)

In 1995, Child Trends, Inc., began a multiyear study of adolescent motivations to prevent teen pregnancy, using both qualitative and quantitative research methods (Sugland, Wilder, & Chandra 1997). Funded by the Office of Population Affairs, this research was conducted to help guide the future of pregnancy prevention programs and policies. The qualitative component of this 1995 study included a series of 12 focus groups as well as group discussions; a summary of the focus group findings are presented in this review. Composition of these focus groups included 106 men and women of varying ethnic backgrounds: African American (n = 35), Mexican American (n = 37), and

European American (n = 34). Participants were primarily in Grades 11 and 12 in high school and unmarried; only 6% reported being parents, all of whom were African American young women. The socioeconomic status of participants varied, with 16% coming from households with very low income, 39% were from low-income households, and 45% reported coming from moderate income households. These focus groups were conducted in Baltimore, Maryland, and Houston, Texas. The following review is separated into three categories: (a) Adolescent Views About Sex, (b) Adolescent Views About Pregnancy, (c) Participants' Recommendations for Strategies to Encourage Prevention.

Adolescent views about sex varied from social norms to types of relationships. Participants agreed that having sex is acceptable behavior among their peer groups and that the notion of sex surrounds every aspect of teenagers' lives. Despite this social norm of sexual behavior, the participants did note a double standard regarding the appropriateness of sexual activity between men and women. Both men and women reported that currently abstinent or virgin men were taunted and teased, whereas abstinent women were rarely harassed for their decisions. Yet promiscuous men achieved an esteemed status among their male peers and promiscuous females are labeled negatively (Sugland et al., 1997).

Further inquiry into adolescent views about sex found three primary reasons that teens engage in sexual activity: (a) pressure from peers or from the potential sex partner, (b) to maintain a relationship, (c) to satisfy curiosity regarding the physical pleasures of sex. According to African American and Mexican American female participants, young men apply subtle pressure on young women to engage in sexual intercourse. Male participants did not report feeling pressured by women to have sex, although it was fre-

quently mentioned that men felt greatly pressured by their peers to have sex with women. This peer pressure was reported as difficult to manage because of the importance in gaining and maintaining respect among male peers. Female participants expressed that sexual activity was viewed as a means to secure relationships, fill an emotional void, or strengthen an emotional bond with girlfriends. Some teens felt that sexual relationships were sought to fulfill emotional needs that are not met by parents. African American participants described sex as part of a mutual exchange in relationships, either for control in relationships or for material needs such as money (Sugland et al., 1997).

When asked their views on pregnancy, it was primarily a concern only for European American participants. Conversely, Mexican American and African American teens expressed concern regarding the threat of STD and HIV not pregnancy. African American female participants also stated that their male partners often tell them they are sterile or that a health care provider has indicated that they cannot get pregnant. In contrast to these concerns of pregnancy and STDs, participants in all groups agreed that teens do not think about these risks while engaging in sex and that teens generally consider themselves invulnerable to pregnancy STDs (Sugland et al., 1997).

When asked specifically about pregnancy avoidance, participants felt that most teens do not want to become pregnant or get someone pregnant. All of the participants believed that pregnancy could interfere with one's plans for the future, and all participants concurred that most teens are unprepared for the emotional and financial responsibility of parenthood. However, while European American participants felt that pregnancy would completely disrupt one's future plans, Mexican American and African

American participants felt that pregnancy merely prevents a teen from attaining future plans in a timely manner (Sugland et al., 1997).

All participants reported that condoms and oral contraceptives were the most commonly used forms of contraception among teenagers. It was also expressed that these methods are fairly reliable in preventing pregnancy and that condoms are reliable in preventing STDs. The reasons for contraceptive use varied by ethnicity and gender, with African American male participants using contraceptives to prevent disease, while European American teens believed their peers used contraceptives to prevent pregnancy. Although these reasons for contraceptive use were reported, male participants in all groups stressed that males will not miss an opportunity to have sexual intercourse simply because condoms are not available (Sugland et al., 1997).

To further assist researchers in program development, focus group participants were asked to brainstorm and discuss strategies that would effectively prevent unintended pregnancies among teens as well as delay sexual onset. This activity generated five strategic categories: self, family, home and neighborhood environments, contraceptive and sexuality education, and society. In the self category, both African American and European American participants felt that teens need the ability to control sex urges as a factor in pregnancy prevention. More specifically, African American participants expressed that teens need more self-respect and self-discipline in order to prevent pregnancy; European American female participants felt that increased self-confidence and self-esteem would prevent pregnancy among their peers (Sugland et al., 1997).

Regarding the category of family, participants believed that sexual behavior can be reduced among teens if parents serve as better role models, more adequately educate

adolescents on moral issues, and help teens plan for future life options. African American male participants specified that more stable home lives are needed to curb sexual behaviors among adolescents. In addition to the family environment, participants felt that the neighborhood environment should play an important role in reducing adolescent pregnancy. European American male participants reported that drug and alcohol was usually involved in adolescent sexual activity, and these influences decrease teens' ability to consider the consequences of their sexual behaviors. These males further implied that communities should take a more active role in reducing these risk factors, which would also decrease the occurrence of adolescent pregnancy. Similarly, participants felt that society could be more effective in delaying sexual onset and preventing unexpected pregnancies among teenagers. For example, it was noted that teens need unrestricted access to contraceptives, especially condoms. African American participants would like society to provide more job training opportunities and activities with which to occupy their free time (Sugland et al., 1997).

Finally, these focus group participants illustrated the need for more extensive sexuality and contraceptive education. Within this category, it was expressed that sex education should focus on the consequences of teen sex, such as the financial, emotional, and social costs that pregnancy can incur. Along this same idea, African American and Mexican American female participants suggested babysitting as an effective discouragement for adolescent pregnancy, while European American male participants recommended using actual teen parents to educate other teens on the realities of teen parenthood. These participants also felt that teenagers need to see adult role models who avoided teen parenthood and are engaged in productive activities (Sugland et al., 1997).

Although the preceding qualitative literature review presented focus group studies conducted on both males and females, the review revealed no focus group studies comprised of couples that are adolescent parents. This paper, however, does contribute to the literature in this area as it provides a comparison of attitudes and beliefs among unmarried, adolescent couples regarding their unexpected emergence into parenthood.

Review of Grounded Theory

In the earlier part of the 1900s, field research and qualitative studies waned within the social sciences as the search for precise, standardized, quantitative methods came to the forefront. Qualitative research was viewed as unsystematic, impressionistic, secondary to rigorous quantitative research, and unable to support theory development. Instead, qualitative research was considered merely a process used in the refinement of quantitative instruments (Charmaz, 2000). Sociologists Glaser and Strauss (1967) challenged these beliefs with the publication of their book *The Discovery of Grounded Theory: Strategies for Qualitative Research.* In this book, they presented an approach called grounded theory. Grounded theory is an inductive method of data analysis where the researcher allows categories and theories to emerge from the data, in contrast to presupposing a set of data with an established theoretical framework; conceptualization of theory is derived from data (Rennie, 2000). Becker (1993) stated that the intent of grounded theory is to develop an account of a phenomenon that identifies the major constructs, in a set of data, and their relationships to one another. Thus, the constructs and relationships provide theoretical frameworks for the data, as opposed to descriptive accounts.

With the publication of *The Discovery of Grounded Theory: Strategies for Qualitative Research,* Glaser and Strauss (1967) presented written guidelines for systematic qualitative data analysis with explicit analytic procedures and research strategies (Charmaz, 2000). In grounded theory, data collection and analysis are overlapping processes. These overlapping processes are defined as a constant comparative method which includes the following strategies: (a) the simultaneous collection and analysis of data, (b) a coding process, (c) comparative methods, (d) memo writing, (e) theoretical sampling to refine the emerging ideas, and (f) integration of the theoretical framework (Glaser & Strauss, 1967; Charmaz, 2000).

Constant comparative method begins with open coding, where the researcher reads the transcripts line by line, with the purpose of identifying actions or events that may ultimately become themes or relevant categories in data analysis (Charmaz, 2000). This preliminary coding can be as simple as making notes in the margins or on note cards, and the coding is descriptive or written in the language of the text (Glaser & Strauss, 1967). Next, the researcher sorts the open-codes into axial codes (Charmaz, 2000; Rennie, 2000), which are more developed and refined categories. Axial codes are less descriptive and allow the researcher to begin establishing relationships among the data. The final coding process is selective coding, where core categories are identified and used to sort large amounts of data, which ultimately tie all of the categories together (Charmaz, 2000). Axial codes are sorted into these core categories, and conceptual codes are assigned. Charmaz (2000) purports that this entire coding process can be accomplished in two steps if the axial codes are established during the initial open coding proc-

ess. Regardless, the objective of this extensive coding process is to conceptualize a higher order of categories that subsume all of the initial descriptive categories.

In the midst of this coding and conceptualization of categories, grounded theorists are encouraged to write memos of their speculations, thoughts, and ideas about relations among the categories (Glaser & Strauss, 1967). Memos help researchers remain focused on their analysis, and are the intermediate step (Charmaz, 2000) between coding and the first draft of the final analysis. In memo writing, researchers can record initial interpretations and thoughts regarding the raw data and also record data from other sources to help make comparisons, identify patterns, and analyze properties of the categories. Charmaz (2000) contended that memo writing allows researchers to ruminate ideas regarding the data, set an analytic course, refine categories and define relationships within categories, and gain self-efficacy toward their ability in sufficiently analyzing the data. Memo writing can also be divided into three types: code notes, theory notes, and operational notes (Ryan & Bernard, 2000; Strauss & Corbin, 1998). Code notes describe the concepts that are being discovered, theory notes summarizes the researcher's ideas on what is happening in the text, and operational notes discuss practical matters in the data and analysis. Ultimately, the purpose of memo writing is to capture the researcher's initial theoretical notions (Glaser & Strauss, 1967).

Simultaneous with coding and memo writing, grounded theory utilizes a concept called theoretical sampling that is used to refine the emerging categories and ideas (Charmaz, 2000; Glaser & Strauss, 1967). According to Charmaz (2000), this function is necessary because a solid, grounded theory cannot derive from one single episode of data collection. Instead, researchers must seek out comparative data in order to set conceptual

boundaries for the emerging theories. Theoretical sampling can be accomplished by re-visiting the source of the data; it can also be conducted by sampling alternate people, events, historical documents, or other library materials (Charmaz, 2000; Glaser & Strauss, 1967).

A recent development in grounded theory is the incorporation of the conditional matrix, developed by Strauss and Corbin (1998). These matrices illustrate relationships between categories and sensitize researchers to actions, interactions, conditions, and consequences that are found in data (Ryan & Bernard, 2000). The matrix is comprised of a set of concentric circles, where each level corresponds to a different unit of influence. The center rings represent actions and interactions, the middle rings reflect individual and small group influences on action, and the outer rings represent national and international concerns (Ryan & Bernard, 2000).

To summarize, grounded theory provides an inductive approach toward qualitative data analysis, where researchers shape data analysis through interpretation and development of conceptual categories; these categories eventually evolve into theoretical constructs. The ultimate emergence of theory is facilitated through a systematic constant comparative method that involves the overlapping and simultaneous use of data coding, memo writing, and theoretical sampling.

Application of the grounded theory approach has been used extensively by social scientists to study an expansive array of qualitative and quantitative research projects. Sociologists Glaser and Strauss (1965), developers of grounded theory, first used this approach to study awareness of dying. Others have used grounded theory to examine subjects such as emotional and medical management of chronic illness (Charmaz, 1997;

Orona, 2000), cross-cultural studies (Jurich, 2000; Mizuno, 1997)) examination of inner-city gangs, medical professionals (Wiener, Strauss, Fagerhaugh, & Suczek, 1997), and reproductive health (Clarke, 1998; Clarke, 1997).

Grounded theory procedures have been used for diverse sociological, anthropological, and psychological studies. Its use has also expanded to nursing, education, and social work, and is often used in collaboration with other social science methodologies as well as with quantitative methods (Strauss & Corbin, 1998). Although these professions have varying purposes and subjects for their use of grounded theory, the one constant is their reliance on the ability of grounded theory methods to elucidate theory and concepts from data that are systematically collected and analyzed. Grounded theory methods, however, are not documented as having been used to study antecedents to adolescent pregnancy. The current study used a grounded theory approach as a means with which to induce the underlying theoretical constructs that may explain the occurrence of unplanned pregnancy among the focus group participants.

Interventions and Programs for Adolescent Sexual Risk Reduction

Numerous programs have been developed and implemented in attempts to decrease sexual risk behaviors and pregnancy among teenagers. Nearly all of these programs have found success in increasing adolescents' knowledge levels regarding high-risk sexual behaviors, yet only a handful of programs can claim any short-term or long-term behavior change. Throughout the years, researchers have reviewed these successful programs and identified the key components and methods that were utilized. The following discussion will present the characteristics of programs that have shown modest im-

provements and also describe the few programs that have been effective in reducing high-risk sexual behavior among adolescents.

After review of 30 commendable programs, Program Archive on Sexuality, Health, and Adolescence (PASHA) identified eight approaches of various interventions that were present in these successful programs. The eight approaches are as follows: abstinence, behavioral skill development, community outreach, contraceptive access, contraceptive education, life option enhancement, self-efficacy, and sexuality/HIV/AIDS education (Card, 1999). On average, programs from this PASHA review utilized four of these eight approaches, eight programs emphasized self-efficacy, and eight programs promoted abstinence but were not exclusive to that desired behavior; 10 of these 30 programs provided access to contraceptives. In addition to the eight approaches, PASHA also identified eight methods and/or techniques used in program delivery: adult involvement, case management, group discussion, lectures, peer counseling/instruction, public service announcements, role playing, and video (Card, 1999). This review found that most of these 30 programs incorporated group discussions, lectures, role-playing, and videos into their curriculum.

The Division of Adolescent and School Health (DASH) within the CDC has identified four curricula that are effective in teen pregnancy and sexual risk reduction (Kirby, 1997). These programs are Becoming a Responsible Teen (BART), Be Proud! Be Responsible!, Get Real about AIDS, and Reducing the Risk (RR). Based on these four curricula and the exemplary curricula identified by PASHA, a panel of experts from CDC found that, when compared to ineffective curricula, these effective curricula shared nine common characteristics: (a) focus clearly on reducing one or more sexual behaviors that

lead to pregnancy or HIV/STD; (b) incorporate behavioral goals, teaching methods, and materials appropriate to for the age, culture, and sexual experience of participants; (c) are based on theoretical approaches that have been effective in influencing other health risk behaviors; (d) last long enough to complete important activities; (e) provide accurate information about the risks of unprotected sex and methods to avoid this; (f) use a variety of teaching methods to help participants personalize the information; (g) use activities that address social pressures related to sex; (h) provide communication, negotiation, and refusal skills; and (i) select teachers or peers who believe in the program and train them (Card, 1999).

In addition to understanding the characteristics of effective curricula, it is important to have an awareness of the different types of programs that have been developed. For this review, five specific types of teen pregnancy prevention and sexual risk reduction programs have been identified: abstinence-only, abstinence-plus with sex education, abstinence-plus with AIDS education, life option development, contraceptive access, and multicomponent programs. The forthcoming discussion will present these six variations and effective programs of each (Kirby, 1997).

The first type of curriculum focuses on abstinence. Abstinence-only programs emphasize abstinence as the only acceptable means of preventing pregnancy and generally discuss peer pressure, family values clarification, and the importance of waiting until marriage for sex. Kirby (1997) found in his reviews that there does not currently exist any scientifically credible published research that demonstrates the delay of sexual onset or reduction of any other sexual activities. According to Haignere, Gold, and McDaniel (1999), most studies indicated that abstinence-only programs do indicate more positive

attitudes toward abstinence, but these attitude changes may not be long-lasting. In a memorandum to the Department of Health and Human Services, a task force representing the NCPTP stated that few abstinence-based programs experienced positive shifts in behavioral intentions, but these intentions did not yield to actual behavior change during follow-up (NCPTP, 1998). To give abstinence-only programs the benefit of the doubt, Kirby (1997) stated that the evidence on these programs is not conclusive, as most of them have had serious methodology flaws in their evaluations.

The second type of program, abstinence-plus, is much more comprehensive and covers sex education and HIV/AIDS education by addressing both abstinence and contraception. Abstinence-plus programs discuss condoms as a method of protecting against STDs and pregnancy and have been implemented in a variety of settings from schools to detention centers. In his review of 21 studies, Kirby (1997) found 13 that examined the impact of sexual onset. Of these 13 studies, 4 significantly delayed the onset of sexual intercourse among study participants. Eleven of these 21 studies examined the impact on frequency of sexual intercourse, and 5 programs found evidence that they reduced the frequency of sexual intercourse. Some of these programs have increased the use of condoms or contraceptives as well, specifically the programs that focused on AIDS education. In fact, six of nine AIDS education programs found significant effects, while three out of nine sex education programs found significant effects. According to Kirby, these programs appear to be more effective among African American adolescents than with any other racial group.

Postponing Sexual Involvement (PSI) and RR are two abstinence-plus, sex education programs that have experienced significant, positive outcomes. Developed at Emory

University School of Medicine and Grady Memorial Hospital, PSI targeted predominantly African American eighth graders from low-income families in Atlanta, Georgia (Franklin & Corcoran, 2000). PSI was conducted in classroom settings and incorporated into human sexuality and contraception coursework throughout 10 class sessions and was taught in 19 separate schools for a total of nearly 4,500 students each year. The theoretical framework for PSI is the social influence theory and is designed to involve students in discussions about social and peer pressures to become sexually involved; students then practice skills that will help them resist these pressures (Howard & McCabe, 1990). An important component of this program is that 11th and 12th grade peer leaders teach PSI (Kirby, 1997). Mentioned earlier, PSI experienced significant findings in an initial evaluation. According to Howard and McCabe (1990), by the end of eighth grade, students who had not received PSI were five times more likely to have begun having sex than students who received the program. These effects were sustained, as a greater percentage (39% compared to 24%) of no program students had begun having sex by the end of ninth grade than students who participated in PSI.

RR is another such program that has experienced positive changes. Kirby, Barth, Leland, and Fetro (1991) presented RR as a sexuality education curriculum based on social learning theory, social influence theory, and cognitive-behavioral theory. The curriculum was taught by high school or middle school teachers during 15 class periods. RR was initially implemented in 13 high schools in urban areas of California and was taught as part of a human sexuality course. Kirby (1997) presented the methods used in RR as experiential and focused on role plays. At 6-month follow-up, there was no difference in frequency of sexual onset between treatment and comparison groups. However, at 18

months there was a significant difference with 29% of the treatment group initiating sexual intercourse compared to 38% of the comparison group.

Many abstinence-plus, sex education curricula focus on AIDS prevention, which seems to be more effective among African American populations than other racial groups. HIV is more prevalent among heterosexual African Americans than heterosexual Caucasians or Hispanics, and Kirby (1997) speculated that African Americans may be more open to AIDS programs. This openness may explain why AIDS curricula are more effective among African American groups. Two abstinence-plus, AIDS curricula recommended by DASH (Kirby, 1997) and PASHA (Card, 1999) are Be Proud! Be Responsible! and BART.

Be Proud! Be Responsible! targets multiethnic teens in middle school and high school. Using the theory of reasoned action, this program utilized methods such as role playing, videotapes, games, and information about AIDS risk (Kirby, 1997). A 1988 study of this program in Philadelphia found, at 3-month follow-up, that program participants participated in significantly less risky sexual behaviors than students in the comparison group (Card, 1999). BART is an HIV/AIDS risk reduction intervention that was designed for African American youth ages 14 to 18 years old. Methods used were small group discussions, role plays, games, and videos that represent African American actors; BART also stresses the use of condoms for sexually active youth. Other techniques incorporated into BART include sexual assertion training, risk recognition, refusal skills, and partner negotiation. BART was initially implemented and tested in Jackson, Mississippi, where it exhibited positive findings. Among students who had never had sex at the start of the program, there was a significantly lower frequency of sexual onset among

program participants than comparison students. In addition, there was an increased use of condoms during sexual intercourse among program participants and a decreased numbers of sex partners (Card, 1999).

Increasingly more common in pregnancy prevention are community-based life option programs (Nitz, 1999). In 1997, President Clinton called for "schools and communities in every state to make service a part of the curriculum in high school, and even middle school" (O'Donnell et al., 1999, p. 176). As defined by Franklin and Corcoran (2000), life option programs approach pregnancy prevention and sexual risk behavior reduction through life skills training and increasing alternatives for disadvantaged youth. In this manner, children who have aspirations and "higher achievement orientation" will be more likely to delay early sexual onset and parenthood. Although the verdict is still out on the long-term effectiveness of these programs, several reviews on such programs indicate promising conclusions.

Nitz (1999) reviewed four life option programs, and all but one had a positive impact on the target population. Teen Outreach Program (TOP) is a weekly, school-based program that incorporates community service. Included in the school component are discussions on communication and decision-making skills, life options, and family relationships; community service is conducted as volunteer experiences either within the school or in the community. Evaluation of TOP programs has found that program participants were less likely to drop out of school or become pregnant while participating in TOP. To further illustrate, some life option programs offer job opportunities instead of volunteer community service. Youth Incentive Entitlement Pilot Project (YIEPP) is an example of one such program that has experienced positive findings. Kirby (1997) described YIEPP

as providing low-income adolescents with part-time jobs during the school year and full-time jobs during summer. In order to continue with these jobs, participants are required to stay in school. Four waves of data were collected annually from 1978-1981 (Kirby, 1997), and results indicated that program participants were less likely to become pregnant than adolescents who did not participate in YIEPP (Nitz, 1999).

A more recent life-option curriculum is the Reach for Health Community Youth Service (CYS) Program. As described by O'Donnell et al. (1999), Reach for Health CYS builds upon a community-based service program previously developed by Medgar Evers College Department of Nursing and Brooklyn School District 13 and targets sexual risk behaviors of African American and Latino urban youth. Community service activities available for youth who participated in this 1994-1995 study of two large, urban middle schools included placements in nursing homes, health clinics, and child day care centers. CYS classroom curriculum was adapted from Teenage Health Teaching Modules and was based on the health belief model and social learning theory. At 6-month follow-up, CYS participants reported significantly less recent sexual activity and scored more positively on the Sex Behavior Index than students in the control group. Further analysis revealed that CYS may have had a greater impact on eighth grade students than seventh graders, possibly due to programmatic differences between the two grades.

Multicomponent prevention programs are those that utilize two or more of the following approaches: classroom instruction, school-wide activities, provision of contraceptives, and media campaigns (Kirby, 1997). Conducted in rural South Carolina, an initiative called School/Community Program for Sexual Risk Reduction Among Teens was considered by Kirby (1997) as one of the most intense multicomponent programs. Card

(1999) presented this program as a community-wide, public outreach campaign where workshops were held in public schools, churches, civic groups, and universities. The focus of these workshops was sexual development, self-concept and self-awareness, values clarification, and communication skills. While contraceptive information was provided for teens that chose to become sexually active, abstinence was promoted as the best means through which to prevent pregnancy. Other critical components, according to Kirby (1997), were peer leaders; a school nurse who counseled students, provided male students with condoms, and took female students to a family planning clinic; and local media efforts. During implementation of this program, the pregnancy rate for 14 to 17 year olds declined significantly for several years. However, the pregnancy rate gradually increased as components of the program were eliminated, such as resignation of the school nurse and various teachers; termination of contraceptive access was also attributed to the increase in pregnancy rates (Kirby, 1997).

A second multicomponent program was the Self-Center, located in a low-income neighborhood of Baltimore. An adolescent reproductive health clinic called the Self-Center and nearby junior and senior high schools collaborated on this effort. Staff in both schools provided after school group discussions and a peer education program, whereas staff from the Self-Center provided counseling and reproductive health services in the clinic (Frost & Forrest, 1995; Kirby, 1997). Presentations were also made during homeroom classes and lunch hours (Nitz, 1999). According to Nitz (1999), a 3-year field test indicated that pregnancy rates for program participants decreased 30%, while pregnancy rates for comparison students (students from comparable schools not enrolled in the program) increased by 58%. Furthermore, program students who were sexually active

showed decreased levels of sexual activity and more effective use of contraception. Among abstinent students, a delay in sexual onset was recorded (Card, 1999).

Finally, any review of pregnancy prevention programs would be remiss without mention of programs that focus on contraceptive access, either school based or community based. According to data collected in the 1988 National Survey of Family Growth, nearly 2.8 million females, ages 15 to 19 years, sought family planning services from a health care provider in that year (Nitz, 1999). However, despite this frequency of adolescents who seek family planning, studies measuring the effects of clinic-based contraceptive access programs have found inconsistent results regarding their impact on teen pregnancy rates. The Self-Center, mentioned previously as a multicomponent program, did have positive outcomes with their clinic-based contraceptive access component. Similar to Self-Center, RESPECT (Responsible Education on Sexuality and Pregnancy for Every Community's Teens) utilized a multicomponent approach with a media campaign, and school- and community based components (Nitz, 1999). Nine clinics were involved in RESPECT, and they all expanded their hours, began teen-age walk-in hours, decreased waiting times in the clinics, and reserved hours for teens only. The RESPECT "catchment area" and a comparison area were evaluated for effects. According to Kirby (1997) and Nitz (1999), no significant changes were seen in contraceptive use or pregnancy rates within the RESPECT catchment area.

Similar to clinic based programs, schools that provide contraceptives either in a clinic or through other means such as a vending machine have failed to provide evidence that they increase contraceptive use or decrease teen pregnancy rates. Studies have shown that contraceptive availability does not increase sexual activity (Kirby, 1997).

According to Kirby (1997), the school-based, condom access program with the strongest evaluation design was in 10 Seattle schools. Five of these schools did not have a clinic but provided condoms in vending machines and baskets; another five schools did have clinics and provided condoms in strategically placed baskets. Pre- and post assessments of student sexual behaviors found that condom availability in the schools did not increase sexual activity and did not increase use of condoms among students in either group of schools. The St. Paul Maternal and Infant Care Project provided comprehensive care in middle and high schools for over 20 years. Services included sex education, family planning counseling, and pregnancy testing with provision of contraceptives at a nearby clinic (Nitz, 1999). There was no comparison group for this project, but an evaluation of birth rates between 1973 and 1976 indicated a 56% reduction in rates during that time period. Kirby et al. (1993) further studied the St. Paul project using school and public records for five years and multiple postclinic years. They found large variations in school-wide birthrates from year to year but could not support the St. Paul project as responsible for significantly reducing birth rates.

Overall, it appears that very few programs have had a widespread impact on reducing teen pregnancy rates, but several programs appear very promising for further application and research. Ideally, pregnancy prevention and sexual risk reduction efforts should employ a multicomponent approach that addresses the programming needs specific to multiple target groups within a community. However, many efforts cannot sustain a multicomponent approach and must focus on one or two types of programming efforts. Either way, Kirby (1997) recommended that program developers implement programs that "have the greatest evidence for success, give greater attention to the broad ar-

ray of risk-factors that reduce motivation to avoid pregnancy, and continue to explore, develop, and rigorously evaluate promising approaches" (p. 48).

The following study proposal utilized data from an AIDS intervention trial that developed, implemented, and evaluated an HIV prevention program for African American young women in Birmingham, Alabama. Participants in this intervention included sexually active African-American females, ages 14 to 18 years old. Participants were recruited and screened in medical clinics, school health classes, and health departments. All recruitment sites were located in low-income neighborhoods with high rates of teen pregnancy, sexually transmitted infections, substance abuse, and unemployment. See Appendix A for further description of this study population.

Although enrolled in this HIV prevention intervention, many participants became pregnant during the intervention timeframe. In an effort to explore the attitudes and beliefs surrounding adolescent parenthood, those participants who became pregnant were invited to participate in focus group interviews; the fathers of their babies were invited to participate as well. The study analyzed and discussed the data compiled during these focus group interviews.

CHAPTER 3

METHODS

Focus Group Methodology

Focus group research is a technique developed in market research used to gauge consumer reaction to new products or services and has been adapted for use in social science and evaluation research (Weiss, 1998). Focus group format usually involves a series of in-depth, discussion groups where 12 to 15 homogenous participants discuss the designated topic with each other and the facilitator (Babbie, 1998).

A critical component of focus group interviewing is the role of the facilitator. The facilitator is a person who leads the discussion and ensures that the participants remain focused on the designated topic. Facilitators shape a focus group and are responsible for eliciting maximum information from participants. Facilitators should be highly skilled in promoting involvement from all participants, while remaining objective toward the discussion topic. According to Krueger (1994), use of a trained facilitator is essential to obtain the desired input from focus group research. Also essential to quality data gathering is the use of an assistant moderator (Krueger, 1998), whose purpose is to record all comments, facial expressions, and body language of focus group participants.

Additionally, all comments should be recorded with an audiocassette recorder. Failure to record each focus group with audiotapes and the notes of an assistant moderator would create a void in the data management system and would undoubtedly yield inaccurate assumptions about the participants' input (Krueger, 1998).

As Saulnier (2000) suggested, focus groups can be used to complement the data gathered in quantitative surveys. According to Krueger (1988), there are five advantages of focus groups. First, focus groups allow social scientists to capture "real-life" data in a social environment. Second, this approach has flexibility. For example, the facilitator has an opportunity to clarify the intent of participant comments, and extreme ideas can be identified and negated by other participants (Robinson, 1999). The final three advantages to focus groups are high face validity, acquisition of quick results, and cost efficiency (Krueger, 1988).

Focus Group Study Sample

Participants for this focus group research were part of a larger, HIV prevention intervention trial mentioned previously in the literature review. Recruitment into the parent study occurred in medical clinics, school health classes, and health departments. All recruitment sites were located in low-income neighborhoods with high rates of teen pregnancy, sexually transmitted infections, substance abuse, and unemployment. Eligibility criteria included being an African American young woman between the ages of 14 and 18 years, being sexually active in the previous 6 months, and providing written consent to participate in the study. Of the 1,130 female adolescents screened over a 2-year period, 522 young women participated in the original study. These individuals were randomly assigned to either the control or treatment group. While enrolled in this intervention, 126 of the 522 participants became pregnant during the intervention timeframe, and these participants are the focus of this study.

Female participants of the parent study, described above, who had children while enrolled in the intervention were invited to participate in focus group interviews. The fathers of the babies were invited to participate as well. If the mother was not in contact with the baby's father, the current male partner, if applicable, was invited to attend. Letters were mailed to all 126 eligible mothers, with a form to return if interested. Female participants were asked to bring their male partners with them, but these male partners were not contacted directly to discuss participation. It became evident that this was a transient population, as nearly 60% of the letters were returned due to incorrect current addresses. Prior to implementation, the University of Alabama Institutional Review Board approved the study protocol (Appendix B).

Data Collection

The focus groups were conducted at the University of Alabama Family Medicine Clinic and consisted of a self-administered questionnaire (Appendices C and D) followed by semistructured focus group interviews (Appendices E and F), separate for men and for women. Female participants were reimbursed $30.00 if they participated without a partner; if the father of the baby or another male partner participated, the couple was reimbursed $75.00.

African American male and female facilitators, trained in focus group methods, conducted the sessions among groups of their respective genders. All focus groups were audio taped; in addition, same-gender assistants took notes during each focus group.

A total of eight focus groups were completed over the course of two consecutive Saturdays; four sessions each were held for men and women. Each focus group session

lasted approximately 90 min. An average of eight participants were in each session, and the group size ranged from 5 to 12 members. A total of 26 men and 42 women participated in the focus groups, and all participants were African American. This study was conducted 2 years after baseline for the parent study; therefore, all female focus group participants were 2 years older than prior to intervention, resulting in an age range of 16 to 20 years. Male participants were not asked to identify their individual ages as it may have implicated them as violators of statutory rape laws. Research suggested that men who impregnate female adolescents are often beyond the age of adolescence (Males & Chews, 1996), and the men may have chosen not to participate in this study if they had perceived a threat of prosecution. Although ages of the male participants were not specified, the focus group facilitators did estimate their ages as ranging from 17 to 23 years. All focus group sessions were recorded on audiocassettes, and session facilitators were responsible for transcribing their respective focus group data.

Management of Qualitative Data

Analysis of the focus group data was conducted using grounded theory methodology. However, the nature of these qualitative data, which were transcripts from multiple focus group sessions, required that specific steps of data management must be taken to ensure comprehensive analyses between and among each focus group session. The purpose of data management is to enhance the quality of one's data by reducing the possibility of error that can occur from the point of data collection and data entry to analysis. Management of quantitative data consists primarily of coding the survey instrument, cleaning the data set or identifying response errors, and setting up standardized data entry

guidelines that will decrease the possibility of invalid or incorrect data entry. Similar to quantitative data management, qualitative data management is also done to ensure high quality analysis. However, the less structured nature of qualitative data collection requires a more involved data management process of creating unique coding schemes and numbering techniques.

Mentioned previously, the focus group facilitators transcribed the comments from their respective sessions, and these transcriptions have been filed in a word processing software in preparation for data management and analysis. Data management of these transcriptions began with the creation of a "master" file, into which all transcripts were copied, and every line of each transcript was assigned a number; separate master files were created for male and female comments so that the data could be analyzed according to gender. Next, a copy of the master file was made and called the "working" file from which the participant comments were extracted for categorization within the "analysis" file. The analysis file contained the original focus group question guides, and, during the analysis phase of this study, participant comments were "cut" from the working file and "pasted" into the appropriate categories in the analysis file. The numbered master copies served as reference files to determine the original source of specific comments.

Next in this data management plan, the transcribed text in the master files was color coded according to group number and by gender. This process facilitated comparisons between and within the different focus group sessions. Because analysis of male and female data was conducted separately, the same color codes were used for both gender groups. Table 1 presents an outline of this color-coding scheme.

After assigning these group identification codes, the relevance of each comment in relation to the facilitators' questions was assessed and categorized accordingly. Krueger and Casey's (2000) four-point guide to long table analysis was used for this portion of data management. This approach, as defined by Krueger and Casey, is a low-technology method, and the term long table comes from the use of tables and floor space on which an individual can place individual quotes under the various categories. However, computers have become a useful tool for this method, as word processing software allows for the cutting and pasting of transcript quotes that were previously done with scissors and tape. Cutting and pasting of these data was conducted using Microsoft Word software.

Table 1

Data Management Color-Coding Scheme

	Female Data	Male Data
Group 1	Maroon	Maroon
Group 2	Green	Green
Group 3	Blue	Blue
Group 4	Black	Black

The long table approach began by reading comments in the working file from Group 1. Using Krueger and Casey's (2000) four-point guide to the long table approach, comments from the working file were then pasted into the appropriate category within the analysis file, while maintaining the source of each comment using the participants' placement numbers in each focus group. This process was followed until the comments

in Group 1 had been placed in the appropriate categories or discarded. The following paragraphs describe the aforementioned four-point guide (Krueger & Casey, 2000).

Point 1: Did the participant answer the question that was asked? If yes, go to Point 3. If no, go to Point 2

Point 2: Does the comment answer a different question in the focus group? If yes, move it to appropriate question. If no, go to Point 3.

Point 3: Does the comment say something of importance about the topic? If yes, paste it under the appropriate question. If no, set it aside.

Point 4: Is it like something that has been said earlier? If yes, start grouping similar quotes together. If no, start a separate grouping.

In this same manner, comments from every female and male focus group were reviewed and pasted according to this guide. Once this lengthy task was completed, the analysis file exhibited a visual presentation of comments that were color-coded under each focus group question. These color-coded comments indicated from which focus group each comment originated.

Analysis of Qualitative Data

Analysis of these focus group data was conducted using specific techniques from grounded theory methodology: coding, memo writing, theoretical sampling, and theory integration. Although each technique is presented independently in this discussion, actual analysis involved the concurrent use of all three.

In grounded theory, coding involves line-by-line conceptualization of the data and is often broken down into three steps: open coding, axial coding, and selective coding.

Open coding involves the preliminary, descriptive coding a researcher makes upon first perusal of the data, whereas axial coding involves the assignment of less descriptive, more refined codes that establish relationships among data. Selective coding, the final coding step, requires the establishment of broad core categories into which the axial codes can be placed. Many grounded researchers code their data in two steps, combining the processes of open coding and axial coding (Charmaz, 2000), and this abbreviated approach was used in this study as well.

The analysis plans for this study began with data coding, using the techniques outlined in grounded theory methodology. Coding of the focus group data involved reading the transcripts and assigning descriptive, informal codes to each comment line and combining the steps of open coding and axial coding. Each code was assigned a number, and corresponding comments were then given the same numeric code, thus revealing themes and patterns that appeared in the participants' comments. Next, core categories were developed, using theoretical constructs, which provided a framework for the previously assigned axial codes; the constructs were limited to those theories used in social science and health behavior research. To enhance objectivity of code assignments, the committee chairperson for this dissertation research project reviewed the validity of the axial codes to ensure that participant comments were aptly assigned. The male and female comments were given separate coding schemes. During these coding processes, informal notes, called memos, recorded initial thoughts that occurred while analyzing the data. Memo writing facilitates the thought process on category development, relationships within categories, and the maintenance of an analytic course throughout data analysis.

Simultaneous with coding and memo writing, theoretical sampling was used to confirm and refine the core categories and theoretical constructs that emerged in the analysis. This process can be accomplished by revisiting the source of the data; it can also be conducted by sampling alternate people, events, historical documents, or other library materials (Charmaz, 2000; Glaser & Strauss, 1967). Because the participants in this study remain anonymous and cannot be contacted by the principal investigator for further delineation of their thoughts, theoretical sampling was conducted using library materials in the form of a literature review. Previous research in the area of adolescent sexual behaviors was identified to support the themes and theoretical constructs that were found grounded in these data.

Final analysis of the focus group data involved integration of the induced themes and theoretical constructs. Comment narratives were used to illustrate the derived theories, and supporting literature was presented to support the findings. The final analysis illustrated the factors related to pregnancy among the study population and provided a theoretical basis for their inaction regarding unprotected sexual intercourse. Comment patterns and core categories between the male and female focus groups were analyzed as well.

CHAPTER 4

RESULTS

Focus Group Results

A total of eight focus groups were completed over the course of two consecutive Saturdays; four sessions each were held for men and women. Each focus group session lasted approximately 90 min. An average of eight participants were in each session, and the group size ranged from 5 to 12 members. All focus group participants were African American, and a total of 26 men and 42 women participated. Ages ranged from 16 to 20 years old for women, and the male focus group facilitator estimated that the male participants' ages ranged from 17 to 23 years.

The focus group data were rich in findings, and numerous themes evolved during the analytic process. However, only three primary themes are presented here, as they have the greatest opportunity for basic intervention and programming opportunities when compared to the excluded themes. Excluded findings are presented in Appendices G and H for review.

These selected primary themes are as follows: (a) future life goals and acceptance of teen parenthood, (b) attitudes regarding the involvement of African American fathers with their children, and (c) family and societal support for teen parents. Presented below is each theme and results of the specific focus group questions that comprise each theme;

male and female results are presented separately. The theme of future life options and acceptance of teen parenthood was induced from the female data only and therefore not included in the male focus group results.

Female focus group results. Theme 1 was future life options and acceptance of teen parenthood. Four questions were used to address this theme. The first question, which was Question 4e in the female focus group question guide, was "Did you feel like you had other options than having a baby? If so, what were they?" Participants were especially vocal in response to this question, with 27 (64%) of the 42 participants providing 38 different comments; some participants provided more than one comment. Twenty-four of the 38 comments explicitly pronounced abortion as not an option either because it was against their personal beliefs or because their family members or peers would not allow it. When asked by the moderator if anyone had thought about adoption, eight comments indicated that adoption was not a viable option primarily because it would be difficult to give up a child for adoption after having carried it for 9 months and gone through childbirth. One of these eight comments expressed concern that some adopted children are unable to locate their biological parents later in life and that the child would build up "so much anger towards you [the birth mother]."

Three of the 38 comments further noted that, once individuals choose to have sexual intercourse, they must then become responsible for their actions. The following comment is indicative of these three comments, "If you're old enough to sit up and lay up with a boy, you can take care of your responsibilities." The final three comments discussed options other than abortion and adoption. One participant stated that she had a

friend who left her baby at a hospital, and two other participants commended such programs that allow young women to do this. A fourth participant merely mentioned the "abortion pill," but no other comments were made regarding this option.

Not in included in these 38 comments regarding pregnancy outcome options is an in-depth discussion that occurred in the second focus group session when a participant stated that she has had two abortions. In response, several other participants asked if she had regretted her decision. This young woman explained that she did not regret her decision to abort two pregnancies, at which point several others discussed the possibility of sterility or "messing up your insides" if an individual has had multiple abortions. This discussion was concluded when someone defended the participant's decision to have the abortions by saying "you can't blame her, it was her choice."

Question 2, which was Question 6a in the female focus group guide, asked, "What are your plans for the future? Do you plan to stay in school?" When asked about their future plans, 10 of the 42 participants responded. Five of those 10 individuals stated that they were currently in General Education Degree (GED) school, high school, or college. Four participants were planning to go back to school in the future, and a final participant was currently working with no immediate plans for further education.

Question 3, which was Question 6b in the female focus group question guide, asked, "Do you plan to have more children before you turn 20?" Of the 19 participants who responded to this question, 15 (79%) did not desire another pregnancy before age 20 years old, and 3 participants (16%) did plan to have more children before age 20 years old. One participant (5%) was 19 years old at the time of the focus group and already

had two children 2 years apart from each other; she did not plan to ever have any more children.

The fourth question, which was Question 6c in the female focus group question guide, asked, "Are you hopeful that you will get a good job?" Of 42 participants, 31 (74%) responded; there were 40 total comments. Of the 40 comments, 23 stated that there is hope for a good job in the future. Six responses mentioned already having a good job, with one female stating, "I have a good job. I'm working as a teller at AmSouth." The sixth participant was leaving for the military in the weeks following the focus groups.

Four of the 40 comments discussed the level of degree one needs in order to obtain a good job and that having a degree does not guarantee a job in the field of one's major. Three respondents commented that they do not currently have jobs. One of these three respondents quit her job to stay home and take care of her premature baby; another stated that she wanted to be her own boss, as she "don't want nobody to tell me what to do." The final four comments were random remarks with one participant stating that she had an engineering degree and tried to get a technical job.

In summary, Theme 1 represented a group of young women who did not desire subsequent pregnancies before age 20 years old, yet have not established long-term school or career objectives. Moreover, their pregnancy outcomes options were limited to carrying the baby to term and raising the child themselves.

Theme 2 was family and social support for teen parents. The first question, Question 4eii in the female focus group question guide, was "How did the other options compare to having a child?" Six participants responded to this question, and one person

commented twice, resulting in seven comments. Four of the seven comments described changes that occurred with financial priorities. These participants described the costs involved in general baby care such as clothing, shoes, and daycare. The remaining three comments discussed freedom issues. For two participants, their freedom had not been limited because their families were always available for babysitting needs. One participant, however, stated that having a child prevented her from browsing through stores. Instead she had to go in, get what she needs, and get out.

The second question, which was Question 5 in the female focus group question guide, asked "How did people treat you once they found out that you were pregnant?" When asked how they were treated once others knew they were pregnant, 33 (79%) of the 42 participants provided comments; 68 total comments were made. Twenty-four of the 68 comments indicated extremely high levels of support, primarily among family members. Mothers and grandmothers were reported as being especially supportive.

Twenty of the 68 comments suggested very little support, especially from participants' fathers, school systems, peers, and sexual partners. Two participants reported that they had been pressured by the school system to withdraw from school, whereas six other participants commented that their peers were unsupportive. One individual mentioned that her friends did not want to be around her once she became pregnant, yet they all became pregnant as well. Eight comments indicated that their fathers were angry and unsupportive, while two comments mentioned lack of support from mothers. One comment described having received poor treatment from hospital nurses who told her she was too young to have a baby.

Fourteen of the 68 comments mentioned that their parents knew of the pregnancy before telling them. The insurance company called the unsuspecting parents of one participant, inquiring about the prenatal care the participant had received. For others, their mothers asked them directly, "You pregnant?" or "Did you come on your period this month?" Eight comments discussed the manner in which participants hid their pregnancy until the second or third trimester for fear of their parents' reactions. And the final two comments noted that the participants' classmates were not aware of their pregnancies. One participant went to another school until after the baby was born.

Theme 2 illustrates the familial and societal reactions to the participants' pregnancies. The following section, Theme 3, presents the female participants' perceptions and attitudes regarding the importance of a father's involvement with his child(ren).

Theme 3 was involvement of fathers with their children, and four questions were used to address this theme. The first question, Question 9 in the female focus group question guide, was "A lot of people today are saying that one of the biggest problems in the African-American community is that children are growing up without a father in the home. What do you think about this?" A total of 19 participants gave their opinions on this topic, and 15 of those 19 felt that African American children would benefit from growing up with a father in the home. Two participant responses reflected the attitude that children do not need fathers. These attitudes were expressed with comments like, "I grew up in a single parent home, and I'm okay," and "I believe a child doesn't really need a father." One respondent stated that fathers can still be available for their children even if the father does not live in the same household, while another suggested that a father figure is just as important as one's biological father and that other men could take a

father's place, "If you have a brother, brothers can do it. If you have an uncle, they can do it."

All but one of these 19 comments came from participants in the first two focus groups. When asked of the third and fourth groups, the only comment was "What's the excuse for White children." No other participants in those two groups remarked on this topic.

The second question, Question 9a in the female focus group question guide, was "How important do you think it is for your children to grow up with a father in the house?" Fourteen (33%) of 42 participants responded to this question. Twelve of the 14 participants felt it was important for their children to grow up with a father in the house; several mentioned that, even if the father was not in the same household, his involvement was still important. One commented, "I wish I had my father in my life." Yet another participant revealed, "I don't know my father, and I don't want the same for my kids." One participant declared that her child did not need his father. The father of her child was in jail, and she explicitly stated that she did not want him in her child's life. Instead, her boyfriend was "taking that place for him." The final response mentioned that although a father lived in the same household, it did not guarantee that he would be involved with the child. This same person stated that her child was more attentive to her boyfriend than to the child's biological father.

The third question, Question 9b in the female focus group question guide, was "What are the benefits that a father can bring?" Twenty participants provided 24 different comments regarding the benefits a father can provide for his child. Of the 24 comments, three suggested that fathers provided financial support and guidance, whereas nine

participants from the fourth group stated in general that fathers provided "extra support" without further specification on the type of support they provided. Five participants stated that fathers served as role models, especially for male children; two of these five participants expressed concern over their sons crying too much, and one stated that she did not want her "baby to be no sissy." Four comments concurred that fathers were beneficial to children because they explained sex better than mothers, and they "let you know about boys."

One of the 24 comments further indicated that fathers provided more effective discipline than mothers, whereas two other comments expressed the attitude that fathers were too strict, especially with girls. In reference to this response, a participant stated, "A father will lock a girl down. When you lock a girl down, that's what make them wild."

The final question relevant to the third theme, Question 9c in the female focus group question guide, was "How involved is your baby's daddy in your baby's life?" This particular question generated much discussion from all four focus groups, resulting in 29 specific responses from 21 participants. Ten of the 29 responses indicated that their child's father was involved; for 4 of these 10 respondents, the father of the child was married or engaged to the participant or living with the participant as a couple. Three participants reported that their child's father was not involved; the father of one participant's child was killed while dealing drugs, and the father of another participant's child was in jail. The third of these three respondents spoke at length on her ambivalence about the father's lack of involvement. She gave the opinion that "boys" feel that women need them and was determined to let the father of her child know that "I don't need you."

According to seven of the respondents, their current boyfriends had taken the place of the child's father. These situations were illustrated with comments such as "My baby is not missing nothing. My boyfriend is taking care of both of us," and "My baby listens to my boyfriend." Another two participants reported that the father of their second child was more involved with the first child than the actual father, "My first and second babies have different daddies. I would trade in the first one." The other participant reasoned that her second child's father was more involved with both of her children perhaps because he is older than the first father.

Family objections prevented the involvement of fathers for two participants. The grandmother of one respondent did not want the father involved with the participant's child. The paternal grandmother of another participant's child did not want her son involved with the child, as she was not convinced that the child was her son's. This participant quoted the paternal grandmother as saying, "That ain't my son's baby."

Five comments varied and could not be categorized with previous responses. One participant expressed the opinion that "Eighty-two percent of men ain't good. Their hearts have been broken," to which another participant replied, "Women aren't too good." The third comment noted that most fathers do not want to get involved with their children unless they feel that another man is taking his place in the child's life. This same individual further stated that, although many fathers were not involved with their children, the children would eventually "go to him whether he is there or not." The fifth of these comments shared the concept of "substitute fathers." This participant had found a male to serve as a father figure in her daughter's life, and according to this participant, "He works with her well too."

In summary, Theme 3 is comprised of participant comments that discuss involvement of African American fathers with their children, the benefits fathers bring to their children, and the involvement levels of their own children's fathers. Overall, comments regarding the importance of a father's involvement and the benefits of a father were sparse compared to the forthcoming male comments regarding this same topic. However, participants did provide detailed comments on the nature of the relationship their children had with his or her fathers. The following section presents male focus group results and the comments that comprise each theme.

Male focus group results. Theme 1 of the male focus group results was involvement of fathers with their children, and five questions were used to address this theme. The first question, Question 8 in the male focus group question guide, was "A lot of people today are saying that one of the biggest problems in the African-American community is that boys are growing up without a father in the home. What do you think about this?" Eight respondents gave their thoughts on this issue, and four of these eight stated that it was not a problem for African American males to grow up without fathers. This belief was expressed in such comments, "I feel that has nothing to do with it....What we are talking about today, it has nothing to do with that," and "It is what you make out of life and what you set your goals for; I did not know my dad until I was 13." In contrast, the four other respondents (50%) believed that it is very important for fathers to be involved with their children.

The second question, Question 8a in the male focus group question guide, inquired about involvement of the participants' fathers and asked, "Was this true for you?"

When asked if they grew up with a father in the household, 33 comments were given, and 11 of these responses described growing up without a father. One participant exclaimed, "A lot of guys say they cannot stand their father, but at least they had one." Someone in this same focus group agreed and commented that he "had to go find" his father. Another participant's father was uninvolved, because his father has been in and out of jail since the participant was born. For participants who grew up without their fathers, nine reported having had "surrogate" father figures in their grandfathers, brothers, uncles, and others.

Six participants reported having involved fathers who did not live in the same household or fathers who were constantly "in and out" of their lives. Of the 33 responses, four participants specifically stated that they grew up with their fathers; one participant stated that he was the only one of his friends who grew up with a father. Three participants grew up with fathers who were around or in the same household, but reportedly were not involved.

The third question, Question 8b in the male focus group question guide, was "How important do you think it is for your children to grow up with a father in the house?" Ten responses were given, and all of these responses agreed that it is important for their children to grow up with a father in the house. Two participants stated that it is important, especially for girls, to protect them from males like themselves. One stated, "What I fear is that everything I did and are still doing will come back to me." Another believed that male children need their fathers "because of the way society is."

The fourth question, Question 8c in the male focus group question guide, was "What are the benefits that a father can bring?" Participants were especially vocal re-

garding the benefits a father can bring, resulting in 42 comments. Twelve of the 42 responses indicated that fathers benefit children through effective discipline, with one participant stating that it takes two parents to adequately discipline a child. Another commented, "A boy needs a daddy that is going to make his ass cut grass and things like that." Eleven of the 42 comments expressed the belief that fathers benefit children by effectively teaching children about sex and educating boys "how to be a man." One participant specified, "A woman cannot show a man how to be a man." Other comments referred to a father's ability to teach males about "smoking reefer" and "about getting a girl pregnant." Another stated that a mother may "send you out of the house" for wanting to have sex, yet a father might "give you the key to his house." One participant stated his belief that a father "knows what it feels like to walk the streets."

Another 11 comments presented such benefits as financial and emotional security, stability, and self-esteem. One commented, "they [children] need to be safe, you cannot have them be flip-flopping," and another participant commented that children need "wisdom, guidance." A revealing response noted, "I think about how I felt when my mom and dad weren't able to come to things and how it made me feel." The remaining eight comments described fathers as beneficial role models for children. Several comments indicated that fathers provide children with guidance and "tell you what to do." According to two participants, children learn respect and responsibility by observing how their parents treat each other. One plans to tell his daughter that she should "Get someone that will be there for you like I am for your mother....Don't get with a loser!"

The final question, Question 8d in the male focus group question guide, was "How involved in your baby's life are you or do you plan to be?" Of 26 comments, 15

participants planned to be involved with their children or already were involved regularly. These comments elaborated on the participants' current levels of involvement and described the types of activities in which they and their children participate. One young father explained that he goes "to her events and things like her day care graduation." Another participant described how he and his son ride in the car together, and his son "listens to the music with me and he bobs his head." One respondent stated that children will remember how much time is spent with them, not how many material items were bought for them.

For seven participants, involvement with their children was dependent upon the mother of the child. Several claimed that the maternal sides of their children's families prevented them from seeing their children. Four participants told the mothers of their children that, if she was unfaithful, those participants would attempt to gain permanent custody of the children or the participants would remove themselves from the situation entirely. Three of the 26 comments described the participants' involvement with their girlfriends' children from other men. One participant noted that his girlfriend's daughter "calls me daddy....I am doing for her." Another respondent willingly took care of someone else's responsibility, because you "can't blame kids for what goes wrong." One final respondent was confident that his daughter's brother would be there for her when he was not.

To summarize, the results in Theme 1 illustrated a group of men who, in general, had limited personal experience with their own fathers while growing up. In contrast, the males reported high levels of involvement and desired involvement with their own chil-

dren. This theme also presented in-depth findings on the male participants' beliefs and attitudes regarding the benefits that a father brings to his children.

Theme 2 was family and social support for teen parents. Four questions were used to address this theme. The first question, Question 9 in the male focus group question guide, was "What did your family say when you told them you had gotten a girl pregnant?" Forty-two comments were offered in response to this question, 14 of which described parents who were excited about having a grandchild and were especially thrilled once the baby arrived. The mother of one participant kept promising to kick the participant out of the house, but once the baby arrived "she was happy to have that grandchild." Six participants had parents who stressed responsibility issues and were told to get a better job. One participant's mother asked the participant "to be there and to not run out on her [mother of the baby]." Four participants received support from their parents only after they were given a "speech" or "sermon" on what they had done; "they just have to say something," commented one participant. Three other respondents had similar reactions but, instead, their parents told the participants that they were not ready for the responsibility of a child and "there is no more just you, it is you, her and it." Two participants received complete support from their mothers.

Five of the 42 comments described receiving negative reactions from parents or that their parents "flipped out." One mother was afraid that her son would allow the child to grow up without his involvement, just as his father was not involved. One participant claimed that his parents "did not know I was doing it [having intercourse]." Four comments described mothers who were angry that they had not been told earlier of the pregnancy. Two participants explained that some mothers knew of the pregnancies but

waited to see if their sons told them. A final participant commented that his mother wanted to know for sure if the child was his, and all other participants in this same focus group agreed that their parents expressed this same concern.

The second question, Question 2 in the male focus group question guide, was "When one of your male friends has gotten someone pregnant, what do you think about him?" A total of 17 relevant comments were made in response to this question. Of these comments, five noted that the participants do not treat their friends differently once they impregnate someone. Four participants mentioned that society treats teenage fathers differently and that "folks are going to judge them." One participant explained that society considers "babies having babies" as a "problem," yet he believes "They were doing the same thing when they were our age...it has been going on for years." Two participants gave advice and help to their friends who were expecting a child, "if you are true friends, you will help him out on the side." Two more comments stated that "child support" was the first thing they thought about when their friends got pregnant. One participant reportedly told his friend, "she is about to skin you up," indicating that the mother of the baby would take financial advantage of the baby's father.

Once one participant's friend impregnated someone, the participant then knew that he "was going to be next." Another participant stated that pregnancy is likely to occur when a person is "out there like that," indicating that frequent sexual intercourse and multiple sex partners often result in pregnancy. One comment suggested that pregnancy disrupts a teenage mother's life more than a teenage father, "with the males, it is like, oh well, it is like destroy and conquer." The final single respondent felt sympathy for his friend who impregnated someone.

The third question, Question 10 in the male focus group question guide was "What do you think when one of your female friends gets pregnant?" When asked about their female friends who got pregnant, 4 of the 15 participants explained that their reaction depends on whether or not their friend knows who is the father of the baby. The participants had complete disrespect for young women who cannot identify the father of their babies, with one participant calling such women "freaks." These participants further explained that it is an unforgivable act for a woman to "put a baby on a man when it is not theirs" as it "hurts the father and the child in the long run." Four respondents were supportive of their female friends who became pregnant; however, one participant warned his friend that "the guy may leave" once he is told she is pregnant.

Three participants described their anger with girls they knew who became pregnant. One participant put his female friend "in the category with all of the stupid females." Two other participants had 14- and 15-year-old cousins who became pregnant, and the participants felt that their cousins had ruined their lives. One respondent's cousin was in National Honor Society and continued doing well in school after the pregnancy; however, the other cousin had been an honor roll student but eventually dropped out of school.

In response to this question, two respondents were quick to note that they do not have female friends. One comment stated that female friends will "set you up." Another participant offered to help his friend who became pregnant, and a final respondent stated that he would ask his pregnant friends if the baby is his, because "if she is a friend of mine, then I am sleeping with her eventually."

The final question, Question 11 in the male focus group question guide, was "What do you think most guys your age feel about a teenage girl who gets pregnant?" Eleven comments were given in response to this question, and 8 of those 11 comments explained that a girl's reputation determines how males their age react to a teenager's pregnancy. One participant stated that, if the young woman appears to have a bright future and "has a name for herself," the pregnancy is perceived negatively. Another stated that, if the pregnant teenager is promiscuous, she "got what she deserved." According to another respondent, if a girl who does not have a bad reputation becomes pregnant, then he perceives her as "an undercover ho." The final three comments indicated that a male's perception of pregnant teenagers is not dependent upon reputation. Instead, these young women are thought of as "messed up," "got caught," or "knocked up."

This final theme is comprised of comments regarding family and social support systems for teenage parents. The male participants' discussions indicated that most male participants received positive family support after having impregnated someone. Comments also revealed overall support for male friends who have become teenage fathers, yet their support for teenage mothers was dependent upon the reputation of the female; pregnant young women who were perceived as sexually promiscuous received less positive support from males than females who were perceived as sexually responsible.

The previous section presented male and female focus group data as components of specific themes. Because the male and female question guides were somewhat different, it was necessary to present these results separately for both genders. Now that the themes have been presented, it is necessary to identify the theoretical constructs that were induced from the participants' comments. The following section briefly describes each

theory and the relevant constructs. Chapter 5 will discuss the rationale behind the utilization of these forthcoming theoretical constructs as they appear in the specific themes.

Grounded Theory Results

The purpose of analyzing the focus group data using a grounded theory approach was to inductively arrive at themes and theories as they emerged from the data. The three induced themes were mentioned previously: (a) future life goals and acceptance of teen parenthood, (b) attitudes regarding involvement of fathers with their children, and (c) family and societal support for teen parents. These themes were further examined for their theoretical underpinnings, and, as a result, representation of constructs from three different health behavior theories became apparent: social cognitive theory, theory of possible selves, and theory of reasoned action. The following paragraphs present an overview of each theory and define the constructs that are represented in the data.

Social cognitive theory postulates that human behavior is explained through a triad of reciprocal determinism, where personal factors, environmental influences, and behavior continually interact (Glanz & Rimer, 1997). A basic premise of social cognitive theory is that individuals learn through the observations of other people's actions and the results of those actions. Eleven constructs of social cognitive theory have been developed for the purpose of understanding and intervening in health behavior, 10 of which are represented in the focus group primary and secondary themes. These ten constructs are described below (Baranowski, Perry, & Parcel, 1997).

1. *Reciprocal determinism* is the dynamic interaction of the person, behavior, and environment in which the behavior is performed.

2. *Self-efficacy* refers to a person's confidence in performing a specific behavior under varying circumstances.

3. *Observational (vicarious) learning* is behavioral acquisition that occurs by watching the actions and outcomes of another's actions.

4. *Outcome expectations* are the anticipatory outcomes of a specific behavior.

5. *Outcome expectancies* represent the values given to specific behavioral outcomes.

6. *Reinforcements* are responses to a person's behavior that increase or decrease the likelihood of behavior reoccurrence.

7. *Situation* is an individual's perception of the environment.

8. *Environment* refers to factors that are physically external to an individual.

9. *Behavioral capability* refers to the knowledge and skills needed to perform a specific behavior.

10. *Emotional coping responses* are strategies developed to cope with emotional stimuli.

Theory of reasoned action was developed by Fishbein, during the 1960s, in an effort to understand the relationship between attitude and behavior (Montano, Kasprzyk, & Taplin, 1997). According to Montano and colleagues, previous research had unsuccessfully examined the correlation between attitude and behavior, but the distinguishing factor between Fishbein's work and previous research attempts is that Fishbein made a distinction between attitude toward an object and attitude toward a behavior with respect to that object. The basic premise of theory of reasoned action is that the most important determinant of behavior is an individual's behavioral intention. Furthermore, the direct de-

terminants of an individual's behavioral intention are his or her attitude toward performing the behavior and his or her subjective norm associated with the behavior. Ajzen modified theory of reasoned action nearly two decades later by adding *perceived behavioral control* in order to account for external factors that may affect someone's intention and behavior (Montano et al., 1997); this modified version became known as the theory of planned behavior. Overall, the theory of reasoned action and the theory of planned behavior have seven different constructs: behavioral intention, behavior belief, evaluation, normative belief, motivation to comply, control belief, and perceived power. Four of these seven constructs, behavioral belief, evaluation of behavioral outcome, normative belief,, and motivation to comply, are represented in the focus group data. Behavioral beliefs are the attitudes one has regarding a specific behavioral outcome, and the value placed on that outcome is evaluation of behavioral outcome. Normative beliefs are those perceptions an individual may have regarding other individuals' (referents) approval or disapproval of a specific behavior, and motivation to comply is the individual's desire to do what his or her referent thinks about that behavior.

Markus and Nurius (1986) described theory of possible selves as a concept derived from research on the self-concept. Self-concept research postulates that self-knowledge can regulate behavior, particularly that of possible selves which are the future-oriented components of the self-concept (Stein, Roeser, & Markus, 1998). Components of possible selves include the following concepts of the self, *I expect to be*, *I wish to be*, and *I fear becoming*. When realized, these concepts can serve as motivators through which individuals achieve future goals. However, lack of possible selves realization can also result in high-risk behaviors, particularly among adolescents (Stein et al.,

1998). These concepts of theory of possible selves are found not in the actual participant comments but rather in what was not mentioned by participants. There appeared to be a lack of self-knowledge regarding what female participants *expect to be*, *wish to be*, and *fear becoming*.

In addition to the specific theoretical constructs presented above, the concept of r*eproductive maturity versus psychosocial maturity* was revealed. Although hypothesized in the literature, this model is not comprised of theoretical constructs but is relevant for further explanation of the attitudes and behaviors found in the focus group data. Reproductive maturity versus psychosocial maturity (Gross & Duke, 1980; Stevens-Simon & McAnarney, 1996) was described as the rapid physical maturation of a child that precedes cognitive maturation. This rapid physical maturation can result in participation of social relationships, behaviors, and outcomes for which the child is psychologically unprepared. Flinn and colleagues (1998) noted that young teens physiologically capable of reproducing may lack the decision-making, negotiation, and problem-solving skills that would enable them to make informed decisions about sexual intercourse. Revealed in the focus group data was an apparent immaturity among female participants regarding issues of fatherhood. For example, when asked the benefits of a father, participants in one focus group discussed at length the benefits of receiving fashionable children's clothing from the father and paternal grandparents; very few female participants mentioned the intangible benefits of a father's involvement, such as emotional support, role modeling, or discipline.

This section presented the themes, theories, and conceptual models that were induced from the data using a grounded theory methodology. Chapter 5 will discuss, in de-

tail, these themes and how they relate to the aforementioned theoretical constructs and models.

CHAPTER 5

DISCUSSION

The purpose of this study was to utilize a grounded theory approach of qualitative data analysis for the purpose of inductively eliciting theoretical factors and themes related to the occurrence of unexpected pregnancy among the study population. Stated earlier, the primary themes induced from the focus group data were as follows: (a) future life goals, (b) attitudes regarding the involvement of African American fathers with their children, and (c) family and societal support for teen parents. The following discussion will explore the theoretical constructs and models found in each theme.

Future Life Goals

The theme of future life goals was induced not from actual participant comments but from what was not mentioned. Female participants were asked to comment on their future school and career plans. Aside from the few who were currently enrolled or planning to return to school and the one participant who was joining the military, no one identified any specific future life plans or goals. Considering that all of these participants supported at least one child, this lack of identifiable long-term goals is striking. Theory of possible selves postulates that identification of one's *wished for, expected,* and *feared* future self can serve as motivators toward achieving long-term goals. A lack of possible

selves identification among adolescents can result in high-risk behavior and high-risk behavioral outcomes. In their paucity of specific long-term goals, participants in this study revealed a lack of conceived possible selves. Stein and colleagues (1998) examined self-schemas and possible selves as predictors of high-risk behaviors in eighth and ninth grade students, such as tobacco use, sexual behaviors, alcohol use, and poor school performance. A bidirectional relationship was found, where perception of the self as socially popular predicted participation in high-risk behaviors, and participation in risky behaviors contributed to the self-conceptualization as deviant with expected future deviant behavior. Oyserman and Markus (1990) studied the role of possible selves as they pertain to delinquency. They found that, among non-delinquent adolescents, their expectations and fears were significantly more balanced than delinquent youth, indicating that expectations serve as protective agents against becoming one's feared self. Additionally, the more delinquent participants classified their future selves as "depressed," "alone," or "junkie" (p. 122).

Participants in the current study were recruited from urban areas rife with lower socioeconomic status indicators such as poverty, broken homes, crime, and poor school districts. Young female adolescents in communities such as these may not have opportunities or reason to speculate on their future possible selves, because they are not exposed to the possibilities of higher educational goals and career options; in such cases, motherhood may appear as one of the few positive options available. Poor socioeconomic indicators are also predictive of whether or not pregnant teenagers choose to terminate or carry a pregnancy to term. A review by Flick (1986) found that female adolescents from one-parent households and those who have a teen parent sibling were more likely to de-

liver than abort their pregnancy; data from the current study indicate that a large portion of the female participants were raised solely by their mothers and that many have teen parent siblings. Also, the Penn Study (Freeman & Rickels, 1993) found that participants who delivered and kept their babies were much more likely to have dropped out of high school than those who had an abortion. Similar to participants in the Penn Study, most female participants in the current study had dropped out of school postpregnancy, and most had not yet returned at the time of the study; several male participants dropped out of college in order to help financially support their children.

Failure to identify one's future possible selves may be related to the participants' decision to participate in high-risk sexual behaviors. Without the appropriate environmental stimuli that are needed to formulate future life plans, female adolescents are not given a motivation with which to actively pursue avoidance of pregnancy. Moreover, adolescents who live in areas of poor socioeconomic indicators may have beliefs that there are opportunities beyond teen parenthood, but, without proper guidance, these beliefs may be perceived as unattainable for individuals of a disadvantaged background. Such isolationism and perceived lack of future life opportunities may result in a reversed conceptualization of one's possible self where females *wish* to become mothers and *fear* not being accepted by their parenting peers.

Further research is needed to more completely understand the relationship between social environments, pregnancy, and the conceptualization of future possible selves among female and male adolescents. Because the current political agenda regarding sexuality education in the nation's schools is focused on abstinence, there are ample funding opportunities with which to implement programs designed to enhance the per-

ceived future life options of adolescents. Such programs need not directly address the controversy between "safer sex" and "abstinence," instead adolescents will learn that attainment of long-term goals is less complicated and more feasible if parenthood is delayed.

Without opportunities to conceptualize one's future possible self, parenthood may be perceived as an attainable, worthwhile goal for many adolescents, and this may have been the motivation behind the participants' staunch resolve to take care of their responsibilities after having become pregnant. Nearly all female participants, and some male participants, were opposed to options of abortion and adoption, and examination of participant comments revealed theory of reasoned action constructs of behavioral beliefs, evaluation of behavioral outcomes, normative beliefs, and motivation to comply.

When discussing abortion and adoption, participants expressed unfavorable attitudes regarding their perceived negative outcomes of both pregnancy outcome options. Regarding abortion, participants feared negative consequences such as regret and emotional disturbance, "You're gonna regret it [abortion] for the rest of your life....It would tear me up emotionally," and "If I had an abortion, I would have a hard time being around them [friends] and seeing them with their children. I would see what it could have been like." Another participant stated negative financial outcomes of an abortion, "That [abortion] could have been money in my pocket." Interestingly, many participants hid or did not acknowledge their pregnancies until the middle of the second trimester. Therefore abortion was not a viable option for these particular teens.

Participants' behavioral beliefs regarding the outcomes of adoption included regret and the fear of wondering what the child looks like. For several women, the concept

of giving a child up for adoption after having carried the pregnancy and gave birth was inconceivable. Their time and emotional investments outweighed the potential positive outcomes of adoption. The following comments reflect these attitudes:

> "It's got to be hard to keep a baby inside of you for 40 weeks and give it away...you feel the baby moving inside of you."
>
> "I didn't go through all these pains for nothing."
>
> "No adoption. I don't want anyone to have my baby after I carried him for 9 months."

These attitudes clearly reflect the constructs of behavioral beliefs and evaluation, as the participants' negative anticipatory outcomes of adoption and abortion helped define their reasons for keeping the babies. However, there is some evidence that these participants were not adequately counseled on the various types of adoption available, which could possibly have impacted their preconceived expectations. To illustrate, one participant stated, "You would be wondering who your baby was with" if it were given up for adoption. With open adoption policies, biological parents have the option of knowing the adoptive parents. Another participant feared adoption because "The child can't look for you until they are 18. All that time they would have built up so much anger towards you....Some can't find their biological parents." Again, this participant was not made aware of various adoption policies. Adoptive and biological parents can maintain open relationships, if desired, where the biological parents can have contact with the child.

In addition to the participants' behavioral beliefs regarding abortion and adoption discussed above, their decisions to keep their babies were also in compliance with their perceived normative beliefs of parents, peers, boyfriends, and God. The following comments reflect these normative beliefs:

"There was nothing I could do about it then. I didn't believe in abortions, and my mama didn't either. I was 14; I was confused. I didn't want to get pregnant. There was nothing I could do about it."

"I went ahead and told my mother, because she said if you ever get pregnant not to do that [abort] because God will not honor you for that. You are not supposed to take anyone's life."

"My mama and best friend would have cursed me out."

"My baby's daddy said 'no' to an abortion."

"My mama wasn't hearing an abortion."

This theory of normative beliefs influencing pregnancy resolution decisions of pregnant teenagers is not a new concept. Marsiglio and Menaghan (1990) cited a 1980 study by Rosen in which the mothers of unmarried pregnant teenagers played a major role in the decision-making process regarding pregnancy outcomes for more than 50% of the study participants. This same review found that parents as well as peers are involved in this decision-making process, reflecting the comments presented in this study. Other studies (Brazell & Acock 1988; Eisen, Zellman, Leibowitz, Chow, & Evans, 1983) also support the influence of family members and friends regarding pregnancy outcome decisions, although these studies site their influence on one's decision to follow through with pregnancy termination. The Penn Study of Teenage Pregnancy (Freeman & Rickels, 1993) found that less than 5% of the pregnant teenagers chose a pregnancy outcome that contradicted their mothers' opinions. Further analysis revealed that, of the teens that gave birth, more than half felt their mothers supported the decision to give birth, yet, of those who had an abortion, only 6% felt that their mothers wanted them to carry to term. Smetana and Adler (1979) used the Fishbein model of intention and behavior to examine abortion decisions. Regarding intent to abort, this study successfully predicted intentions

from participant beliefs regarding consequences of the act, beliefs regarding consequences of alternate choices, and the perceived normative beliefs about the act.

The normative beliefs expressed in this qualitative study coincide with those of quantitative studies in which personal attitude and normative beliefs were statistically linked to pregnancy outcome decisions. The perceived negative consequences as well as the motivation to comply with perceived normative beliefs regarding abortion and adoption resulted in teenage parenthood for the female participants in this study. Perhaps implementation of programs that provide adolescents an opportunity to conceptualize their future possible selves would result in pregnancy avoidance behaviors and the ultimate prevention of adolescents having to decide between pregnancy outcome options.

Attitudes Regarding Involvement of Fathers With Their Children

The purpose of this study was to evoke theoretical constructs and themes from male and female focus groups. Thus far, discussion has been focused primarily on themes pertinent to female data for the simple fact that they provided more comments than the males. However, male participants revealed a unique and surprising perspective on the desires and expectations of fatherhood.

Marsiglio and Menaghan (1990) have found that adolescent fathers are generally portrayed as irresponsible and uninterested in their children conceived out of wedlock. In contrast to this portrayal, perceived family readiness among male participants is supported by the focus group data and operationalizes the concept of reciprocal determinism within social cognitive theory; reciprocal determinism is the "dynamic interaction of the person, the behavior, and the environment in which the behavior is performed"

(Baranowski et al., 1997, p. 157). This reciprocal triad is seen in male participants' desire to ensure that their children do not grow up with negative feelings toward them as fathers; the female participants did not present such passionate concerns regarding family dynamics. The reciprocal determinism represented here is also supported by the social cognitive constructs of observational learning, outcome expectations, outcome expectancies, self-efficacy, and behavioral capability.

Nearly all of the male participants grew up without an involved father, as did the females, and it seems as if the males were motivated by their fathers' absence to be effective, involved fathers themselves. Suggested in this finding is perhaps a motivation to prove superiority over their own fathers regarding fatherhood responsibilities. The ensuing discussion will provide rationale behind this reasoning.

More than half of the male participants grew up without an involved father, and most of their comments reflected a sense of perceived personal loss or insult as illustrated in the following comments:

> "A lot of guys say they cannot stand their father but at least they had one. I don't know where mine is. I have not seen him a day in my life."
>
> "My dad has been locked up all my life, he has been in and out of jail."
>
> "I always grew up with a stepdad. I finally met my real dad after 19 years, I saw him and that was it. He wanted to get together but I had no words for him. I am a man now."
>
> "Your dad can be in the same house and never be there for you."
>
> "The things I needed to know, he was not there to tell me."
>
> "You know what it felt like to not have a father. I grew up saying 'where is my father' or your baby's mama tells them [the baby] the same thing that your mom told you...that is, that their father was not a good person or this or that."

The depth and sadness revealed in the above comment, "A lot of guys...cannot stand their father but at least they had one," is insightful. This participant expressed envy for others who grew up with a father, regardless of the quality of his involvement. The unfairness of having grown up without an involved father or, for some, not even knowing who their father was has emotionally impacted these participants; for some, this emotional impact has yielded a teen father with high standards of fatherhood and reportedly high levels of confidence with which to pursue those standards. The pursuit of such esteemed fatherhood has been influenced through a reverse concept of observational learning. Instead of learning and valuing behavioral outcomes vicariously, these young men personally witnessed the negative outcomes of a father's absence. It seems that, through personal experience, male participants learned to value the importance of father involvement and have internalized the fathering qualities from which they want their children to benefit.

Male participants identified, at length, the qualities and benefits that fathers can offer a child, in fact, this topic created the most discussion of any previous question. Male participants offered the following benefits a father can provide: appropriate discipline, role modeling, education on sex, and financial and emotional stability. Examination of these benefits reveals those qualities that participants most desired in their absent or uninvolved fathers. Through personal experience, the males learned the ramifications of uninvolved fathers, and these experiences instilled in them highly valued outcome expectations regarding positive fathering skills. In fact, their comments on role modeling, sex education, and discipline were quite insightful, and it appeared as if the male participants had considered these concepts prior to the focus group study:

> "A little girl will look at her daddy and see the way he treats her mother. The first thing they say, and I have sisters, is 'my man will not treat me that way'.... You want to teach him to be a good father a good dad, to take care of his responsibilities."
>
> "...a boy needs a daddy that is going to make his ass cut grass and things like that. Without his dad he is liable to be sorry."
>
> "You need someone to tell them how to be a man. A woman cannot do it, the man has to be somewhere."
>
> "One parent cannot discipline a child; you need two [parents]."
>
> "Some kids have low self-esteem. People may say things to them like 'they don't have a daddy,' and they might breakdown."
>
> "Dad knows what it's like to walk the streets."

The social cognitive framework is often applied to adolescent health behavior interventions and programs, and sometimes included in those programs is a parent education component with which to enhance positive reinforcements in the adolescents' home life, regarding the desired behavioral outcome; communication skills are sometimes an integral part of such programs. This incorporation of parental involvement represents active utilization of the reciprocal triad in social cognitive theory, where the adolescents' environments are taught to reinforce, and perhaps model, their positive decision-making processes, which theoretically may result in healthful behaviors. In a review of sexual risk reduction curricula, Kirby (1997) mentioned the only two programs that have studied the actual effects of such programs. The first program, Girls Incorporated, found that that the program group was less likely to initiate intercourse than the control group. However it was noted that the program and control groups were not equivalent, and the result was not statistically significant. The second program increased parent/child communication but did not significantly delay onset of intercourse. This concept of parental involvement

as a preventive agent against high-risk sexual behaviors is interesting when applied to these male focus group data. Many young men agreed that fathers are more effective than mothers in educating sons on sexuality, yet these discussions further indicated the importance of a father's ability in teaching sons about sexual conquest or "how do I get this ass." Interestingly, the males desired father involvement not because they could have encouraged their sexual abstinence, for which many health educators strive, instead, they wanted their fathers' guidance in attaining sexual relationships. To illustrate:

> "...That's right. You might have a situation where a young man needs to talk to his father about a young lady he is seeing and can't talk to his mother and say 'mom how do I get this ass.'"
>
> "Mama don't have everything that daddy does....your mother cannot tell you where to put it."
>
> "There are some things that you can talk to your dad about, like when I started smoking reefer [marijuana], I was scared to tell my mom but I told my dad. He was cool with it....You can tell him anything. Like about girls, he may be doing the same thing that you are doing, your dad may like a lot of women too. You might get advice from him about that. He may give you the key to his house."
>
> "...or give you money for the hotel [reply to the comment above]."
>
> "If you are going to talk to your mother about wanting to have sex, she is going to look at you like you are crazy and tell you to sit your little dick on down."

In reality, many of these young fathers probably do not know if their fathers would have been so facilitating toward their teenage sons' sexual involvement. However, this is a poignant finding because it may indicate how these young fathers will interact with their own sons. If, in fact, their father/son relationships will involve communication regarding sexual conquest, it is critical that fathers know the facts on contraceptives, especially condoms. They must be encouraged to break down barriers and myths and educate their teenagers on such issues, in addition to the discussions on sexual activity. This

presents the potential need for parental education components that teach fathers not just basic communication skills but also how to effectively promote their children's use of contraceptives. Such programs could even teach fathers how to incorporate communication on their own previous risky behaviors as a catalyst toward their children's own decision-making process regarding safer sex. Because sexual conquest may involve having intercourse with multiple female partners, such educational components should also teach fathers how to communicate the importance of respecting women as well as protecting their own sexual health.

Inherent in these findings are significant cultural and public health implications. Funding must be made available for communities to conduct formative research before implementation of new programs; formative research will ensure cultural relevance and appropriateness of innovative programming efforts. Certainly, sexual abstinence is a worthwhile objective of sexual risk reduction programs. However, failure to fully understand the predisposing and enabling factors relevant to sexual behavior that exists in various target populations will result in inadequate programming efforts. Sexual abstinence may not be a realistic goal for male adolescents who have already experienced multiple occasions of sexual intercourse, especially if intercourse is an integral part of proving one's masculinity as suggested by Marsiglio (1993). Further research is needed to better understand how to overcome or modify these potentially life-threatening or life-altering standards of manhood inherent in sexual conquest.

Female participants, on the other hand, were unable to provide much discussion on the benefits of fathers, but the few comments provided referred to role modeling and financial support. Mentioned earlier, most female participants indicated having grown up

without involved fathers. For this reason, these young women may be unable to actually identify the benefits of a father, and to do so may incriminate them as having received an inadequate upbringing.

Although many female participants admitted that their babies' fathers were involved with the children, most fathers were not currently living with the children. The female participants' inability, or refusal, to discuss benefits of fathers may have been to protect their personal identities as adequate parents. Most of the young women believed that they were very good mothers, and to state that fathers could positively add to the parenting equation indicates that they are not doing enough themselves. For many participants, their current boyfriends currently helped in raising their children; perhaps the focus group question should have asked "What benefits can a father figure or male bring," as teenage mothers often do not marry their children's fathers. In such instances, different male figures may assume the father-figure role throughout a child's life. The following comments refer to such situations:

> "My baby is not missing nothing. My boyfriend takes care of both of us."
>
> "The one that I'm with takes care of us."
>
> "My baby listens to my boyfriend."
>
> "She's not missing out. She will go to my boyfriend before she goes to her daddy."
>
> "My baby don't like her daddy. She just looks at him. His brother [the father's] takes care of her though. She'll call my boyfriend 'daddy.' I think he [the father] came into the picture too late. I don't want to confuse her; she's around my boyfriend all the time."

Female participants may have felt reluctant to respond to the "benefits of a father" question for fear of betraying their boyfriends' involvement. Of concern, however, may be

the issue of young mothers discouraging involvement of the children's fathers and encouraging sole involvement of boyfriends, particularly if the children's fathers actually desire involvement with their children. As seen in the male participants' comments, the young men expressed disappointment that their own biological fathers had not been more involved in their lives. If young mothers, out of spite, are discouraging involvement of their children's fathers, the children may experience negative emotional impact as they mature.

A final explanation for the female participants' inability to identify benefits of a father may be their inability to think in abstract terms, which is a possible result of the participants' reproductive maturity versus psychosocial immaturity. It is likely that the female participants, at the time of the study, did not possess the capacity with which to think beyond tangible concepts, as the ideals of fatherhood often represent goals that are nebulous and perhaps more difficult to pinpoint, especially if they grew up without fathers. Such psychosocial immaturity was apparent in one particular focus group in which the participants associated the fathers' involvement with the importance of appropriate designer clothing for their children.

According to focus group comments, both female and male participants agreed that quality involvement with one's child is critical, and female responses concurred with the male reports of involvement with their children regardless of whether or not they live in the same household. Male participants provided great detail on interaction with their children and in the process actualized the social cognitive construct of behavioral capability by demonstrating their knowledge and skills of childrearing. The following comments illustrate this behavioral capability:

> "As far as being a dad, I think I am doing pretty damn good. I got two jobs, got my own car, bills, and I am still maintaining. You may think that it is going to be hard and you are going to be broke, but you can do it. I have another child on the way and I am still on my feet."
>
> "I go to all of her stuff, I go to her events and things like her day care graduation. She needs to see that somebody is behind her and with her, just little things."
>
> "I am with my little girl every weekend, everyday, we go to the park every Saturday."
>
> "I am there 100%. I mean he rides with me wherever I go, he listens to the music with me and he bobs his head. I am there."
>
> "How much time they spent [with their father is what children remember]. They don't remember how much stuff you bought them."

These comments indicate a longing to demonstrate their fathering skills, and they also represent young fathers who truly wish for their children to have positive fathering experiences, unlike what they received. In addition to these involved fathers, several male participants reported that their children's mothers and the mothers' families discouraged the fathers' involvement. Instead, the mothers of the children were encouraged to have the fathers "put on child support." Perhaps the families perceived the fathers as undesirable characters and did not want the children exposed to such perceived negative influences. In contrast, a couple of female participants reported that the paternal grandmothers discouraged the fathers' involvement with their own children, as they were not convinced that the children were their sons'. Similarly, these paternal grandmothers may have heard anecdotes on the reputation of the babies' mothers and may have reason to suspect paternity of the children.

When reviewing these particular focus group findings from a broad perspective, male participants portray a longing to establish a family. This longing may be a means through which to prove their masculinity and fathering efficacy. This concept of proving

masculinity through paternity is supported by Marsiglio (1993), who found that men whose parents had less education were more likely to view fathering a child as enhancing masculinity, compared to males whose parents had higher levels of education. This same study also found that African American men were more likely to say that paternity at that point in their lives would make them feel like real men. Ideals of effective and involved fathering are commendable qualities for young men to possess. However, men need not prove their worthiness as young teenagers. Research is needed to better understand how to convey the knowledge that young men can be even better fathers if childbearing is delayed and that high school or college diplomas are critical for adequate financial accountability as a father.

Studies have found that fathers of children born to teenage mothers are often older than the teenage mother, with nearly 40% of the fathers aged 20 years or older (NCPTP, 1997). A report from the Alan Guttmacher Institute (1994) stated that fathers of children born to teenage mothers are an average of 2.5 years older than the teen mom, with one fifth of the fathers at least 6 years older. If the ages of male participants in the current study reflect these statistics, therein may lay another explanation for the male participants' increased readiness for parenthood. Older men may feel more emotionally prepared for parenthood than the young women because of their potential age differences and, as Marsiglio (1993) found, anxious to prove their masculinity. Although younger women may feel less prepared for parenthood than men, the attention received by older men may fulfill the young women's needs for emotional security, love, and the desire to appear mature in front of their peers. The willingness of female adolescents to pursue relationships with older males makes them susceptible to pregnancy, as they do not have

the knowledge, skills, and future life options that are needed to avoid risky sexual behaviors. Moreover, if the men actually desire pregnancy as an outcome of their sexual unions, or are the least bit ambivalent about preventing pregnancy, then the likelihood of pregnancy would be even greater.

This greater preparedness for parenthood among male participants is intriguing, as one generally perceives female adolescents as having greater desires for parenthood than male adolescents. One might speculate that the young women had envisioned prepregnancy joys of parenthood, but these thoughts were deflated after becoming a mother. As primary caretakers of their children, female participants may have paid greater costs in becoming teen parents through the loss of educational and social opportunities.

The male participants' comments provided on fatherhood were poignant and insightful. Their fathering desires operationalize the social cognitive concept of reciprocal determinism, because the males planned to positively impact their children's family environments, which may result in decreased risk of the children's participation in high-risk behaviors as they mature. However, research is needed to explore the possibilities of delaying these fathering desires beyond adolescence. Young men must learn that their fathering skills can only be improved when one has attained emotional maturity, financial stability, and a means with which to properly care for a child. These findings also imply the need for aggressive parental education components in sexual risk reduction programs; these components teach not only communication skills but also how to communicate safer sex. In contrast, female participants' comments on fatherhood were insightful because of their lack of interest in this particular topic. More research is needed to elucidate this inability to conceptualize the benefits of fatherhood, and perhaps programs are needed to educate females on the critical role that fathers play in their

needed to educate females on the critical role that fathers play in their children's lives. Also, the female participants' despondence regarding motherhood provides potential programming implications, because these desires to have previously delayed childbearing could be used as a preventive tool for other adolescents in their local communities. Through observational learning, other young women could learn the realities of teen motherhood from teen moms who come from similar backgrounds but would have delayed childbearing if given the opportunity. Peer role modeling is a social cognitive approach often included in pregnancy prevention programs. However, role models are often merely strangers telling their life stories via videotape. Young mothers could be empowered as community gatekeepers and serve as role models within local schools and civic organizations. Developing a network of teenage mothers who serve as role models would embody the social cognitive construct of observational learning and promote change within the reciprocal triad. PASHA reported that role modeling is one of eight primary components found in effective sexual risk reduction programs (Card, 1999). Moreover, such a network could be easily facilitated through the local Boy's and Girl's Clubs, YMCA, or any other organization that specializes in adolescent programming.

Apparent in these data was the male participants' understanding regarding the importance of father involvement. Conversely, the female participants' data indicated an inability to state the abstract ideals of fatherhood when compared to the male participants. As illustrated previously, the social cognitive construct of reciprocal determinism was represented in the male participants' desires to be effective fathers, and this determinism is supported by the various social cognitive constructs of observational learning, behavioral capability, outcome expectations, outcome expectancies, and self-efficacy. Female

participants' comments indicate the potential for teen mothers to act as role models in local communities for delaying childbearing, which is a concept based on the social cognitive construct of observational learning. These findings are rich in implications for further research and programming efforts regarding father/child communication, delay of fatherhood, teenage mothers as role models, and mother/child bonding.

Family and Social Support

Family support for a teen parent can be a critical element in the teen's ability to pursue educational or work-related goals. Zabin and Hayward (1993) cited research that found family support as pivotal in overcoming negative effects of parenthood on an adolescent mother and that family support is more likely to be given by African American families than Caucasian families (see also Furstenberg, 1976; Furstenberg, Brooks-Gunn, & Morgan, 1987). The current study found that, in general, female participants received extensive maternal support. Male participants also reported strong family support, especially after their babies arrived; they also commented on their criteria for the provision of support to male and female friends involved in a pregnancy. These support systems operationalize the social cognitive constructs of reciprocal determinism, reinforcements, environment, and situation.

After having informed their parents of the unexpected pregnancies, some participants received negative initial responses, yet the large majority expressed that their mothers and grandmothers were eventually "happy" and "excited" about the pregnancies. Although Zabin and Hayward (1993) found that family support plays an important role in a teen mother's ability to overcome negative consequences of early childbearing, very few

participants in the current study verbalized their intentions for future school or career objectives, and they did not indicate that they were taking advantage of the opportunity to get high school and/or college diplomas. With this in mind, one can speculate that extensive family support may also serve as reinforcements for future pregnancies among young adolescents. The reality of being a new mom is that one is deprived of sleep and that the infant's needs usurp all other priorities in a parent's life. For teenagers, those initial priorities often include socializing such as parties, shopping, hanging out with friends, and even relaxing; an infant would theoretically cause all of those priorities to change. However, if family members, such as parents and grandparents, are generous in taking on the needs of a teen's child and the teen has freedom with which to continue behaving as a teenager, then that teenage parent has not experienced the realistic consequences of his or her actions. Thus, too much parental support may be perceived as reinforcement for one's high-risk sexual behavior.

Parental support as reinforcement for future pregnancies may perpetuate the notion of reciprocal determinism in adolescent pregnancy, because the positive family support does not yield behavior change in adolescent sexual risk taking. For teenage parents who are pursuing educational and occupation goals, family support may be pivotal in their success. However, for teenagers who do not have such goals, as previously indicated of female participants in the future life options discussion, family support must be modified to prevent the teen parents' perceptions of parental acceptance of unplanned pregnancy. In addition, families must provide support with the understanding that they are enabling the teen parents to ultimately enhance their lives as well as the children's. The dynamics of such family support may warrant further research, as the implications of

such research may provide family support systems with appropriate knowledge and skills that would enable them to balance positive support of a child who is also a teen parent and yet serve as agents of prevention for subsequent childbearing.

Studies indicate that teen fathers are often unable to actively participate in taking care of their children because of financial and/or structural constraints (Marsiglio & Menaghan, 1990). Although the men in this study did report high levels of involvement with their children, it is evident that the children were being cared for primarily by either the mothers of the children or the mothers of the children and their families. If this is true, then family members of the adolescent father suffer fewer consequences than the maternal family, as they are not responsible for helping raise the child. Paternal family members can provide support by occasionally babysitting or by purchasing baby clothes, but their support does not include sleepless nights and continuous care of the child. This form of support also operationalizes the social cognitive construct of reinforcements, as the lack of negative response from family members may validate the males' behavioral outcome of impregnating young women. A plausible explanation for extensive maternal support, however, may be found in the circumstances within which the teen mother was raised. Mentioned previously, many female participants indicated that their mothers had raised them. If that is the case, then their own mothers may have an understanding of the hardships associated with single parenthood and prefer that their daughters not have the same experience. This support, again, may be provided so that their daughters can improve their situation in life.

While most female participants reported their mothers and grandmothers as supportive of their pregnancies, many participants hid their pregnancies until at least the

middle of the second trimester. In fact, some participants claimed that their mothers were aware of the pregnancy before they were. Hiding one's pregnancy or refusal to acknowledge the situation qualifies as *an emotional coping response*, which is a social cognitive construct where coping strategies are used in order to deal with emotional stimuli.

According to Bandura (cited in Baranowski et al., 1997), excessive emotional arousal can create fearful thoughts, which result in defensive behaviors. Thus, an individual's fears, anxiety, or hostility are managed through those defensive behaviors (Baranowski et al., 1997). The construct of emotional coping responses operationalizes these defensive behaviors and is often used to help individuals learn healthy coping skills. Female participants in this study anticipated negative reactions from their parents and, therefore, concealed their pregnancies as a defensive behavior used to manage their own fears and anxieties associated with their parents' reactions. Although nearly all female participants eventually received emotional and/or financial support from their families, this particular coping response could have had resulted in serious pregnancy complications. Through delaying acknowledgement of their pregnancies, participants also delayed access to prenatal care. Prenatal care is especially important for pregnant adolescents, as their lifestyles may not be conducive to the development of healthy pregnancies. Teenagers are at risk for unhealthy lifestyle choices such as poor diet and participation in behaviors such as alcohol, drug, and tobacco use, which are lifestyles that can result in poor pregnancy outcomes. According to the NCPTP (1997), teenage mothers are at increased risk for giving birth to low-birth weight and premature babies, which increases the likelihood for infant death, respiratory problems, blindness, mental retardation, deafness, and

cerebral palsy. Moreover, delaying acknowledgement of one's pregnancy reduces the possibility of termination options.

The lack of family support teenagers perceived as imminent with their pregnancies may have the potential for serious pregnancy outcome complications; pregnant teens also reduce the availability of pregnancy termination options as well. These findings reinforce the need for availability of comprehensive sexual health education in high schools, either in a classroom setting or through a school nurse. Such education would educate adolescent females on the importance of receiving prenatal care as well as provide them with resources and avenues through which to receive prenatal services.

Regarding social support for parenting peers, male participants provided comments on their perceptions of both female and male peers who encounter unexpected pregnancies. Several participants stated specifically that they were either happy for their impregnated female friends or that they felt their pregnant friends had made a mistake in becoming pregnant. However, many more participants explained that their reactions toward a woman's pregnancy depend on the sexual reputation of that woman and whether or not she knows the paternity of the baby. Such qualifications for support of a young woman's pregnancy seem to reflect double standards of acceptable behavior for sexual activity among women. In one aspect, male participants discuss sexual conquest and the need for a man to have intercourse regardless of the concern for gaining a bad reputation, yet they agree that women who have multiple sex partners are considered "freaky" and that she "got what she deserved" with an unexpected pregnancy. These comments regarding a female's reputation reflect the social cognitive construct of situation, as male participants have accepted the notions of standard sexual behavior for women, as it is

perceived in their communities. Men in this study appear to be judging their acceptance of a young woman's pregnancy according to her reputation, which is based on rumor and speculation; thus, a teen mother's social support from male peers is dependent upon male perceptions that may or may not be true. Regardless of the validity of such accusations, it is inappropriate for males to disrespect the teenage mothers' situation, a situation for which males are in large part responsible. Furthermore, such negative social support is damaging to the capacity building efforts of local communities; peers should learn to support each other through adversity in order to facilitate community solidarity in the future. Such findings may imply the need for programming efforts among adolescents that address the validation of situational gender roles.

When discussing male peers who are also fathers, male participants described a peer support system that consists of paternal advice and continued camaraderie, which may have evolved as an adaptive response to the common occurrence of pregnancy among their peers. The social cognitive constructs of environment and situation are supported in these data. Environment is operationalized through the male participants' provision of opportunities for social acceptance and guidance. Such environmental support validates the males' role as a teen father and perpetuates the perceived norm of teen parenthood (situation). Interestingly, male support of a peer's fatherhood status is not dependent upon his reputed sexual history. Local African American communities would benefit if all teen parents received the same level of respect and support from their peers, regardless of circumstances surrounding the pregnancy.

The family and social support systems of these participants are dynamic and interwoven. In one aspect, teen parents are receiving extensive support from their families,

which theoretically would enable the teens to pursue their educational and career goals. Yet it appears that the strong family support is not being utilized for attainment of such goals and instead may be reinforcing the adolescents' perceptions of parenthood as an acceptable role for teenagers. The males' illustration of social support revealed a network of teenage fathers who support one another with advice and continued camaraderie. However, positive support for females is dependent upon the reputation of specific females and the circumstances surrounding their pregnancies.

The preceding discussion presented the application of theoretical constructs to better understand the occurrence of adolescent pregnancy among the study group. Induced from the data were constructs from social cognitive theory, theory of reasoned action, and theory of possible selves. Social cognitive and theory of reasoned action emphasize the concept that behavior is a result of the subjective value one places on the outcome of a behavior. In contrast, learning theories postulate that the strengthening of a desired behavior is dependent upon rewards or reinforcements such as operant conditioning but not cognitive abilities. Ultimately, a behavior can be built by rewarding "successive approximations" of the desired behavior, until that behavior is fully developed (Craig, 1992). Skinner (cited in Craig, 1992) researched the concepts of learning theories, and in this research he developed various experimental tools with which he studied operant conditioning. One such tool is called a "teaching machine." These machines taught students complex tasks, through a series of smaller, simple tasks, and the completion of each task was reinforced with positive feedback. According to Craig (1992), there are now computer programs that apply the same principles. Skinner also established the principle that immediate rewards are more effective than larger, delayed ones (Abrams,

Emmons, & Linnan, 1997). Contemporary learning theory is called behavioral analysis (Craig, 1992) and seeks to shape human behavior with techniques such as "token economy." This concept has been used in the modification of delinquent adolescents' behaviors, where adolescents earn tokens for good behavior, good grades, or being productive at work; the tokens are then used to buy items such as food, a weekend pass, or magazines. Craig (1992) stated that token economies have been effective in teaching children in a classroom setting.

Learning theory concepts were not induced from the data in this study. However, it is important to mention their potential utility for adolescent pregnancy prevention interventions. Application of learning theory concepts to sexual risk reduction interventions would require the use of a reward system as the motivation for teenagers to participate in pregnancy avoidance behaviors. For example, many adolescents might engage in high-risk sexual behaviors because of the immediate rewards that one receives, such as self-gratification or pleasure. Another perceived reward of high-risk sexual behavior might be its utility in keeping a partner interested in a relationship. Additionally, the perceived rewards of parenthood, such as peer acceptance or a child's unconditional love, might play a role in adolescents' ambivalence regarding contraception. The contemporary concept of token economies (Craig, 1992) provides a model on which to base a learning theory-based intervention, where researchers would replace adolescents' perceived rewards of sexual intercourse and/or teenage parenthood with other immediate rewards serving to discourage participation in high-risk sexual behaviors. Several previous programs have already used incentives to curb various high-risk behaviors, and such incentives included stipends and payments for completion of school activities, guaranteed

full-time jobs during summer, and guaranteed college admission (Kirby, 1997). According to Kirby (1997), these incentive-based programs claimed to have decreased adolescent birth rates and pregnancy rates as well delayed sexual onset, increased condom use among the sexually active participants, increased high school graduation rates, and decreased alcohol use. To increase the likelihood of adolescent participation, adolescents would have to inform researchers on the type of rewards that would encourage sexual abstinence or safer sex practices. If adolescents are provided an opportunity to assist in the development of a program designed for them, it may instill in them a greater desire to succeed in the program. This type of empowerment is not uncommon in health promotion, especially among researchers and practitioners who espouse a constructivist paradigm.

Health promotion relies heavily on quantitative methodologies and deductive research techniques, where theory-based instruments and/or interventions are administered to various study populations in order to answer a specific research question. In contrast, there exists an alternative school of thought in health promotion, identified as a constructivist paradigm. A constructivist approach is based on induction (Glanz, Lewis, & Rimer, 1997), where explanation of an issue is revealed through a series of qualitative techniques instead of through predetermined categories or theories; ethnography and grounded theory are methodologies that use a constructivist approach, and applications of it are often found in community development, education, and community psychology (Glanz et al., 1997; Labonte & Robertson, 1996). It is not recommended that all quantitative, deductive research be abandoned for a more constructivist paradigm. Instead, the two techniques should be used in collaboration, where the constructivist observations identify the

social realties and "long range endpoints" as conveyed by community members (Lewis, 1996). Such inductive findings can then be applied to the development of quantitative survey instruments or interventions for further research.

As illustrated in the quantitative literature review, very few programs have had an impact on reducing sexual risk behaviors among adolescents. Perhaps the sexual risk behaviors of adolescents should be addressed within a constructivist paradigm. For example, the use of focus groups, participant observation, and other qualitative research techniques might facilitate the induction of greater social concerns underlying the issue of adolescent pregnancy; such inductions would provide researchers with the knowledge needed to develop more effective sexual risk reduction programs for adolescents. The study presented in this paper provides one step toward a constructivist approach in understanding the occurrence of adolescent pregnancy in a midsized Southern city.

Implications and Conclusions

The specific aim of this research was to apply a grounded theory approach to the focus group data and inductively arrive at theoretical constructs related to the occurrence of unexpected pregnancies among the study population. Analysis of the focus group data using a grounded theory approach revealed representation of theoretical constructs from social cognitive theory, theory of possible selves, and theory of reasoned action. These theoretical constructs support the role of social environment as an antecedent to adolescent pregnancy as indicated in the themes of future life options, fatherhood involvement, and family/social support systems.

This qualitative study provided an insightful view into the antecedents of adolescent pregnancy, providing implications for further research regarding socio-cultural issues surrounding future life options, fatherhood, role modeling, family support, and peer support. Such research would facilitate the development of programs that effectively address these sociocultural antecedents to the public health issue of adolescent pregnancy and perhaps provide innovative primary prevention strategies for adolescents at risk for unexpected pregnancies. If given the opportunity, through adequate funding and programming, social environments have the capacity with which to support adolescents in their positive decision-making processes. Included in this environmental context are schools, parents, churches, local organizations, and peers. Involvement of these interpersonal and community-based factors is critical for forthcoming adolescents to appreciate and desire pregnancy avoidance behaviors.

Limitations of Study

This study was conducted on female participants who became pregnant while enrolled in a larger HIV intervention study; the female participants' current male partners were also invited to participate in the focus groups. Because these participants were recruited from a sample of African American adolescents enrolled in an HIV study, results of the current study cannot be generalized to all adolescent parents. However, the results do provide insight into the occurrence of pregnancy among African American teenagers living in a Southern, moderately sized urban area and provide implications for further research in this particular target population.

The age span of the study participants is vast and may have created an inherent bias in their comments. For example, younger adolescents may have provided more psychosocially immature comments at a greater frequency than participants who were in their late teenage years or early twenties. Further complicating this limitation was the inability to match participant comments according to participant age. The age range for female participants was established during recruitment into the focus groups, because their dates of birth were recorded on their baseline surveys in the parent HIV study. However, the focus group moderators did not ascertain individual ages from participants. Moreover, male participants were not asked to identify their individual ages as it may have implicated them as violators of statutory rape laws. Research suggests that males who impregnate adolescent females are often beyond the age of adolescence (Males & Chews, 1996). The men in this study may have chosen not to participate if they had perceived a threat of prosecution.

Through the process of grounded theory, it was induced that constructs of the theory of reasoned action were represented in many of the participants' comments. These constructs were thus used to further expound upon and discuss the corresponding comments. Theory of reasoned action is a "value expectancy theory," where behavior is a result of the subjective value one places on the outcome of that behavior. Value expectancy theories assume that an individual has the ability to utilize cause and effect logic and to consider "hypothetical alternatives" (Craig, 1992). According to Craig (1992), this ability to consider cause and effect is usually not developed until adolescence or, for some, late adolescence. If adolescents of this study group were cognitively or psychosocially immature, then it is possible that the application of constructs from the theory of

reasoned action might not have been appropriate, thus resulting in a possible limitation to this study.

This study found that male participants were quite pleased with fatherhood and that the participants had high expectations for personal, long-term involvement with their children. This finding may have been the result of a self-select bias; it is possible that only those males who perceived themselves as good fathers and who had positive ideals regarding the concept of fatherhood chose to participate in the focus groups.

Another limitation that must be addressed is the use of secondary data. When secondary data are collected, it is usually done with a different objective than that of the initial investigator. This difference in research objectives may affect the validity of secondary data, as the data were collected initially using instruments that do not measure exactly what the secondary researcher had in mind. Fortunately, the research objective for this study reflects the primary purpose of the focus groups, which was to gain insight into the beliefs and attitudes of adolescent couples that had become parents. Therefore, this specific disadvantage of secondary data use is not as relevant to the study. However, these secondary data do present a different limitation in that the principal investigator of this study did not personally moderate the focus groups. Instead, analysis was dependent upon transcripts and notes provided by the focus group moderators and assistant moderators. Transcribing focus group comments is an arduous and time-consuming process and poses a risk for error and subjectivity. Because the principal investigator of this study was not involved in either the moderation of the focus groups or the transcription process, this presents a considerable limitation to this study.

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APPENDIX A

DESCRIPTIVE STATISTICS OF PARENT STUDY PARTICIPANTS

Adolescents in the parent study were 14 to 18 years of age, with a mean of 16.0 years (*SD* = 1.2 years). The majority (90.6%) of these participants were enrolled in school. Participants reported living with their mothers only (57%), with both parents (22%), or with another relative (14%), with the remainder reporting living with non-family members. Past incidence of sexually transmitted infections were reported by about 28% of the adolescents. A history of pregnancy was reported by 40% of the adolescents, with 11.5% reporting current pregnancy.

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL FORM

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Institutional Review Board for Human Use

Form 4: IRB Approval Form
Identification and Certification of Research
Projects Involving Human Subjects

The Institutional Review Board for Human Use (IRB) has an approved Multiple Project Assurance with the Department of Health and Human Services and is in compliance with 21 CFR Parts 50 and 56 and ICH GCP Guidelines. The Assurance became effective on January 1, 1999 and the approval period is for five years. The Assurance number is M-1149.

Principal Investigator: DIX, EMILY

Co-Investigator(s):

Protocol Number: X010628001

Protocol Title: *Examination of Factors Related to Teenage Pregnancy: A Qualitative Study*

The IRB reviewed and approved the above named project on 01/24/01. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services. This Project will be subject to Annual continuing review as provided in that Assurance.

This project recieved EXPEDITED review.

IRB Approval Date: 1/24/01

Date IRB Approval Issued: 01/25/01

Marilyn Doss

Marilyn Doss, M.A.
Vice Chair of the Institutional Review
Board for Human Use (IRB)

Investigators please note:

The IRB approved consent form used in the study must contain the IRB approval date and expiration date.

IRB approval is given for one year unless otherwise noted. For projects subject to annual review research activities may not continue past the one year anniversary of the IRB approval date.

Any modifications in the study methodology, protocol and/or consent form must be submitted for review and approval to the IRB prior to implementation.

Adverse Events and/or unanticipated risks to subjects or others at UAB or other participating institutions must be reported promptly to the IRB.

470 Administration Building
701 20th Street South
205 934 3789
Fax 205 934 1301
irb@uab.edu

The University of
Alabama at Birmingham
Mailing Address
AB 470
1530 3RD AVE S
BIRMINGHAM AL 35294 0104

APPENDIX C

SELF-ADMINISTERED SURVEY FOR MALE PARTICIPANTS

You are being asked to answer these questions about yourself and girl(s) you have gotten pregnant. Your answers are confidential – DO NOT put your name on this paper (only a code will be put on your paper). Please answer honestly. Do not skip any questions. Thank you.

1. How many children have you fathered?
   _____ # of children

2. How many different girls have you gotten pregnant?
   _____ # of girls

3. Of the girls you have gotten pregnant, how many were girlfriends (that is, girls you had an emotional relationship with)?
   _____ # of girlfriends (put "0" if none)

4. Of the girls you have gotten pregnant, how many were just friends or sex partners (that is, girls you DID NOT have an emotional relationship with)?
   _____ # of friends or partners (put "0" if none)

5. How did you feel about getting a girl pregnant?

   1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Wanted her to get pregnant	Did not mind	Did not want her to get pregnant

6. Why did you or didn't you want her to get pregnant?

7. How would you describe your present relationship with your baby's mother?

   1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Not at all close	Somewhat close	Very close

8. Did your relationship with your baby's mother change when she became pregnant?
   _____ Yes, it got better
   _____ Yes, it got worse
   _____ No, it has not changed

9. Has your relationship with your baby's mother changed since she had the baby?
   _____ Yes, it has gotten better
   _____ Yes, it has gotten worse
   _____ No, it has not changed

10. Do you pay support for your child(ren)?
_____ No, none
_____ Yes, for some of my children
_____ Yes, for all of my children

11. If so, where do you get the money to pay for your child(ren)?
_____ From my family
_____ From my job
_____ Other: _____

12. Are you worried about how you will be able to afford to pay to support your child(ren) in the future?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all worried — A little worried — Am very worried

13. Did you think about how you would be able to support a child before you got someone pregnant for the first time?

No Yes

14. If yes, did you discuss it with the baby's mother?
_____ Never discussed with the baby's mother
_____ Discussed it before she got pregnant
_____ Discussed it while she was pregnant
_____ Discussed it after the baby was born

15. How well do you feel that you will be able to provide emotional support and the time necessary for childrearing?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all well — Okay — Very well

16. How much time do you spend with your children (babysitting, taking them places, etc.)?
_____ No time
_____ A few hours a month
_____ A few hours a week
_____ A few hours a day
_____ I live with my children

17. How much do you plan to be involved in your children's lives during the next 10 years?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all involved Very involved

18. How much do you feel that your fathering a child has affected you emotionally?
_____ it has **negatively** affected me a lot
_____ it has **negatively** affected me a little
_____ it has not affected me emotionally
_____ it has **positively** affected me a lot
_____ it has **positively** affected me a little

19. How much do you feel that your fathering a child has affected your family (e.g., your parents and siblings) emotionally?

_____ it has **negatively** affected my family a lot
_____ it has **negatively** affected my family a little
_____ it has not affected my family emotionally
_____ it has **positively** affected my family a lot
_____ it has **positively** affected my family a little

20. Did your father live in your house when you were growing up?

No Yes

If no, did you have a step-father that lived in your house when you were growing up?

No Yes

21. What was your relationship with your father (or step-father) like when you were growing up?
_____ He was around a lot, and we were very close
_____ He was around a lot, but we were not very close
_____ He was not around a lot, but we were still close
_____ He was not around a lot, and we were not very close
_____ I did not really have a relationship with a father

22. How would you describe your relationship with your mother?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all close Somewhat close Very close

23. How much did your father (or step-father) treat your mother with respect?

0	1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Father Not around	No respect Very much respect

24. Unprotected sex can lead to HIV or other STDs. How much did this influence your decision to have unprotected sex?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all Somewhat Very much

25. How worried were you that you might get HIV or another STD?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all Somewhat Very much

26. Do you have any regrets about fathering a child?

No Yes

27. If you could do things differently, would you?

No Yes

28. How would you do things differently?

APPENDIX D

SELF-ADMINISTERED SURVEY FOR FEMALE PARTICIPANTS

You are being asked to answer these questions about yourself and getting pregnant. Your answers are confidential – DO NOT put your name on this paper (only a code will be put on your paper). Please answer honestly. Do not skip any questions. Thank you.

1. How old were you when you got pregnant for the first time?
_____ years old

2. How many times have you been pregnant?
_____ times

3. How many living children do you have?
_____# of children

4. How did you feel about getting pregnant (the first time)?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Wanted to be pregnant	Did not mind	Did not want to be pregnant

5. If you have been pregnant more than one time, how did you feel about getting pregnant the second time?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Wanted to be pregnant	Did not mind	Did not want to be pregnant

6. Where do you get the money to pay for your child?
_____ From the daddy
_____ From my family
_____ From my job
_____ From AFDC
_____ Other: _____

7. Are you worried about how you will be able to afford to pay to support your child(ren) in the future?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Not at all worried	A little worried	Am very worried

8. Did you think about how you would be able to support a child before you got pregnant for the first time?

No Yes

9. If yes, did you discuss it with the baby's father?
_____ Never discussed with the baby's father
_____ Discussed it before I got pregnant
_____ Discussed it while I was pregnant
_____ Discussed it after the baby was born

10. How well do you feel that you will be able to provide emotional support and the time necessary for childrearing?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all well Okay Very well

11. How much time does your baby's daddy spend with your child (babysitting, taking them places, etc.)?
_____ No time
_____ A few hours a month
_____ A few hours a week
_____ A few hours a day
_____ he lives with the child

12. How old was your mother when she had her first child?
_____ years old

13. How many of your adolescent friends and relatives (such as sisters, cousins) have had babies?
_____ Most
_____ Some
_____ Just a few
_____ None

14. Unprotected sex can lead to HIV or other STDs. How much did this influence your decision to have unprotected sex?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all Somewhat Very much

15. How worried were you that you might get HIV or another STD?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all Somewhat Very much

16. How much do you feel that your having a child has affected you emotionally?
_____ it has **negatively** affected me a lot
_____ it has **negatively** affected me a little
_____ it has not affected me emotionally
_____ it has **positively** affected me a lot
_____ it has **positively** affected me a little

17. How much do you feel that your having a child has affected your family (e.g., your parents and siblings) emotionally?
_____ it has **negatively** affected my family a lot
_____ it has **negatively** affected my family a little
_____ it has not affected my family emotionally
_____ it has **positively** affected my family a lot
_____ it has **positively** affected my family a little

18. How would you describe your relationship with your mother?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all close — Somewhat close — Very close

19. How would you describe your relationship with your father?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all close — Somewhat close — Very close

20. How would you describe your relationship with your baby's daddy?

1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Not at all close — Somewhat close — Very close

21. Did your relationship with your baby's father change when you became pregnant?
_____ It got better
_____ It got worse
_____ It has not changed

22. Has your relationship with your baby's father changed since having the baby?
_____ It has gotten better
_____ It has gotten worse
_____ It has not changed

23. Do you have any regrets about having a child?

No Yes

24. If you could do things differently, would you?

No Yes

25. How would you do things differently?

APPENDIX E

FOCUS GROUP QUESTION GUIDE FOR MALE PARTICIPANTS

1. How do you think most guys your age feel about getting their girlfriends pregnant?

2. When one of your male friends has gotten someone pregnant, what do you think about him?

3. Do you think there are a lot of guys who want to get girls pregnant?

4. What are the reasons some guys want to get girls pregnant?

5. When you have gotten a girl pregnant, did you want to or not?

    a. What are some of the reasons you **wanted** them to get pregnant?
    b. If you **did not want** them to get pregnant, why did you not use birth control?
    c. Did your partner want to get pregnant (or mind that she got pregnant)?
    d. Did your partner influence your desire to get her pregnant?

6. When someone wants to get pregnant, they need to have sex without a condom or other birth control in order to accomplish it. But doing so puts them at risk for STDs including HIV. How do you think people your age decide what to do in this situation where they want to get pregnant, but they don't want to get an STD?

7. Did you worry about getting HIV or another STD when you had unprotected intercourse?

8. A lot of people today are saying that one of the biggest problems in the African American community is that boys are growing up without a father in the home. What do you think about this?

    a. Was this true for you?
    b. How important do you think it is for your children to grow up with a father in the house?
    c. What are the benefits that a father can bring?
    d. How involved in your baby's life are you (do you plan to be)?

9. What did your family say when you told them you had gotten a girl pregnant?

10. What do you think when one of your female friends gets pregnant?

11. What do you think most guys your age feel about a teenage girl who gets pregnant?

APPENDIX F

FOCUS GROUP QUESTION GUIDE FOR FEMALE PARTICIPANTS

1. How do you think most girls your age feel about getting pregnant?

2. What are the reasons girls your age want to get pregnant or don't mind getting pregnant?

3. Why do some guys want to get their girlfriends pregnant?

4. When you got pregnant for the first time, did you want to or did you mind getting pregnant?

    What are some of the reasons you wanted to get pregnant?
    If you did not want to get pregnant, why did you not use birth control?
    Did your partner want you to get pregnant (or mind that you got pregnant)?
    Did your partner influence your desire to get pregnant?
    Did you feel like you had other options?
        If, so, what were they?
        How did they compare to having a child?

5. How did people treat you once they found out that you were pregnant?

6. What are your plans for the future?

    a. Do you plan to stay in school?
    b. Do you plan to have more children before you turn 20?
    c. Are you hopeful that you will get a good job?

7. When someone wants to get pregnant, they need to have sex without a condom or other birth control in order to accomplish it. But doing so puts them at risk for STDs including HIV. How do you think people your age decide what to do in this situation where they want to get pregnant, but they don't want to get an STD?

8. Did you worry about getting HIV or another STD when you had unprotected intercourse?

9. A lot of people today are saying that one of the biggest problems in the African American community is that children are growing up without a father in the home. What do you think about this?

    a. How important do you think it is for your children to grow up with a father in the house?
    b. What are the benefits that a father can bring?
    c. How involved is your baby's daddy in your baby's life?

APPENDIX G

ADDITIONAL FINDINGS FROM FEMALE FOCUS GROUP DATA

How do you think most girls your age feel about getting pregnant?

Of 42 female participants, 16 responded to the question with a total of 21 different comments. Of those 21 comments, 7 agreed that young women their age desire pregnancy. One participant, who worked with school children, stated that elementary-age girls often express desires to have a babies. Three comments specified that girls do not desire pregnancy, "They don't want to be tied down."

Six comments were made in the third focus group regarding the physical appearance of young girls in today's society. These statements explained that young girls are becoming pregnant because they appear more physically mature than their actual age. One participant stated, "When I was 11, I looked like I was 17." Four comments in the second focus group indicated that teenage parenting is beneficial, as it teaches responsibility and "makes you grow up."

What are the reasons girls your age want to get pregnant or do not mind getting pregnant?

When asked the reasons girls their age get pregnant, 29 participants responded with 44 different comments. Twenty-three of the 44 comments expressed the belief that girls get pregnant to "trap," "claim," or "hold on to" a man as their own. Participants explained that having a baby is a way in which to "always be part of his [the baby's father] life." Eight comments explained that girls get pregnant because their peers also have children. In fact, three of these participants stated that "everyone was pregnant" at their respective schools.

Another participant said that she was the last of her friends to have a baby and that they were all excited about her pregnancy.

Another 8 of the 44 comments suggested that girls get pregnant because they feel that no one loves them and a child will be a source of unconditional love. Three comments expressed the idea that girls their age get pregnant because they do not understand the responsibilities that come with parenthood. One young parent said that young girls who are contemplating pregnancy need "someone they can talk to and get feedback so they understand that a child is not a toy or doll that can be put down after you get done playing with it." The final two comments suggested that girls get pregnant "just to say they have a baby."

Why do some guys want to get their girlfriends pregnant?

Sixty percent (n = 25) of the 42 participants responded to this question. Eighteen of those participants said that men impregnate their girlfriends in order to "trap" or "control" them. One participant noted that men impregnate girlfriends because no other men will want a woman who already has a child or is pregnant. This same participant also believed that men impregnate women in order to establish a perpetual avenue of sexual intercourse, so they can "get some more stuff anytime."

Five of the 25 respondents stated that most young men do not intentionally impregnate women. Instead, it occurs because of the irresponsibility or lack of maturity among men as expressed in this comment, "They're [men] not responsible....Guys aren't more mature like girls are...girls are way up there and have more knowledge than guys." One participant noted that young men want to impregnate women because all of their

friends have children, and a final participant stated that men do not think about the costs involved in parenting a child.

When you got pregnant for the first time, did you want to or did you mind getting pregnant?

This question was commented upon quite extensively, as participants took the opportunity to elaborate on the situations surrounding their first pregnancies. Thirty-five (83%) of 42 participants responded to the question. All 35 respondents stated that their first pregnancies were not planned, providing comments like, "I wasn't ready" and "Planned is when you have money and credit."

Several of these 35 respondents further commented, with 7 admitting that ultimately they did not mind getting pregnant. One of these seven comments stated, "Maybe I didn't mind, because I knew I could take care of my baby." For others, pregnancy improved relations with their parents and instilled in them a desire to do well in school, to "stand up and be a woman and take care of my baby." Three more participants also noted that they became pregnant for failure to think of the consequences that can result from sexual intercourse. One individual said that she was "...kinda being like a guy...just not thinking about what I was doing."

What are some of the reasons you wanted to get pregnant?

Four participants responded to this question. Two participants indicated that their boyfriends influenced their desire to become pregnant, with "the right boy will change you," and "all it takes is one boy to turn it around." One participant desired pregnancy

because her family was unkind to her and treated her like a maid. She believed that if she got pregnant her family would leave her alone. Once the baby was born, this participant learned that she could not go to school or do what she "wanted to do." The fourth respondent desired pregnancy because she wanted to "buy clothes, toys, [and] comb their hair."

If you did not want to get pregnant, why did you not use birth control?

When asked why birth control was not used if pregnancy was not desired, 27 (64%) of the 42 participants responded. Nine of the 27 respondents claimed to have gotten pregnant while on birth control pills or Depo Provera. One participant remarked that she got pregnant "off the shot," because the doctor was not putting "enough stuff in there." A third participant in this same group commented that she knew two other girls who got pregnant while on Depo Provera.

Seven respondents stated that they failed to use birth control for no specific reason; two of these seven women did not think they were susceptible to pregnancy. Another of these seven respondents described having a mother who wanted her to take birth control, but the participant refused because she did not want her mother to know she was having intercourse. She further noted that if she had listened to her mother, "I wouldn't have had my first baby and probably not my second."

For 6 of the 27 respondents, birth control was not an option because of unacceptable side effects, such as hair loss, weight gain, headaches; 1 participant smoked cigarettes and did not take birth control pills for fear of stroke. Four comments stated that pregnancy occurred either while altering their birth control method, immediately upon

getting off of birth control, or because the birth control prescription was not refilled in a timely fashion. A final respondent did not take birth control because she was engaged.

Did your partner want you to get pregnant or mind that you got pregnant?

When asked about their partners' desire for pregnancy, 19 (45%) participants responded. Of these 19 respondents, 15 believed that their partners did want a child, whereas 2 stated that their partners did not want a child. A third respondent explained that the father of her child did not know she was pregnant until after the baby was born, and the final respondent explained that neither she nor her boyfriend wanted a baby. However, they both accepted the fact and ultimately were happy about the pregnancy.

Did your partner influence your desire to get pregnant?

This question did not evoke many comments, resulting in responses from five different participants. Two individuals remarked that their partner did influence their desire to get pregnant the first time, and they both planned the pregnancy. For the other three, their pregnancies were unexpected; therefore, their partners did not influence their desire for pregnancy.

When someone wants to get pregnant, they need to have sex without a condom or other birth control in order to accomplish it. But doing so puts them at risk for STDs including HIV. How do you think people your age decide what to do in this situation where they want to get pregnant, but they don't want to get an STD?

Seventy-four percent (n = 31) of participants specifically answered this question, providing 36 different comments. In response to this question, 23 of the comments stated that couples should get tested for HIV and other STDs before attempting conception. Illustrating this attitude were comments such as "The couple needs to get tested," "You go to the clinic and both get checked out," and "Once you discuss having a child and you agree to have a child, go get checked." Eight comments suggested alternate ways in which to avoid STDs when trying to get pregnant, such as personally examining the person for signs of STD as one participant remarked. Two of these eight participants ask ed- sexual partners about their sexual histories, and the third participant mentioned that she was "assured" that her partner was free of STDs before having sex but did not explain how this assurance was gained. One participant mentioned, "You take your chances" when having intercourse, and another commented that her uncle, who is a policeman, suggested that her partner take a lie detector test.

Three of the 36 responses mentioned monogamy as the best way to avoid HIV and STD when trying to get pregnant. These three comments were made by members of the second focus group and instigated an in-depth discussion on faithfulness of partners. It was mentioned that monogamy is no guarantee because "you still don't know where he's been," and "some people are married and still cheat." One individual supported extramarital affairs by saying that "sometimes it's in the heat of the moment."

The final two responses stated that STDs are not thought about when one is trying get pregnant, that STDs are the "last thing you think about." One participant expressed that "you think about STDs last, and the baby first."

Although not direct responses to the question, several participants discussed whether or not they had been tested for STDs before getting pregnant. One person in the third focus group had been tested before getting pregnant. All others in that group ($n = 9$) admitted that they had not been tested, although one participant reported being tested "after the baby was made." Another participant, from Group 1, did not "get checked out," whereas a participant from Group 2 mentioned that she and her partner have "annual checkups."

Did you worry about getting HIV or another STD when you had unprotected intercourse?

Fifteen participants answered this question with one person responding twice, resulting in 16 overall comments. All of the 15 stated that they did not worry about getting HIV or another STD when they had unprotected intercourse. Three of the 15 did not worry because they and their partners had been tested for STDs or get regular "check ups." One of these individuals further explained that when you have a long-term, significant other, the idea of that person having a disease or having intercourse with someone else is not a concern. Six individuals did not worry about their susceptibility until after the unprotected intercourse had occurred or until after realizing pregnancy had occurred. These participants conveyed that the prospect of having intercourse or getting pregnant supercedes all other concerns, and the threat of STD is not "the first thing you think about" because "you're in the heat of the moment." One participant further illustrated this point by saying, "When you trying to get some, you're not thinking about that. You think about it later." Another "thought about the baby first, and the STD last." However, once one participant became pregnant, she thought "about everything else," meaning the

possibility of HIV and STD. One respondent stated that she did not worry about HIV or STDs because she "was taking the pill." Another participant and her partner were "just too close to worry" about STDs; another who remarked, "It's all about trusting that person", supported this comment

The one person who did worry about HIV or STD illustrated her concern when stating that she "flew to the clinic" after having unprotected intercourse. However, this comment contradicts an earlier comment by this same participant when she said "no," that HIV and STDs were not a concern when having unprotected intercourse.

Unexpected Findings in Female Focus Group Data

Two unexpected themes emerged from the female focus group data. The first involved issues of child behavior and discipline, with eight of the participants having provided anecdotes on their children's unruly behavior. One participant described how her 1-year-old girl beat up a 3-year-old by hitting her on the arm so badly that the other child received "a big red bruise" on her arm. Another participant in this same group commented that her child was put out of day care for beating up others as well. In another group, a participant stated that her child "will hit anybody if you look at her wrong." The young daughter of yet another participant hit another girl with a rock because she tried to take her crackers. One individual suggested that children should learn the difference between fighting and defending themselves, and this same participant further stated that her son tried to fight his teacher at school. In addition, she described how her son hits his maternal grandmother when she punishes him. Another participant mentioned that the teacher hit her child. When asked why, the child responded "because I hit her."

A second extraneous theme that emerged is the participants' emphasis on the appropriate brand name clothing for children. Upon being asked about the involvement of their children's fathers, extensive conversation was sparked in Focus Group 1 when a participant expressed dismay at her child's father and family because they bought the baby "Blues Clues" clothing. She stated "I don't mind my baby wearing character stuff, but they know he don't wear that type of clothes." This participant was further put out because the father and his family bought the child only one outfit. The focus group question at hand was superseded by further remarks on children's clothing. One participant informed the others that she did not let her child play in anything but "the best" and would not dare allow her child to go outside in a t-shirt and socks looking "dusty." Another participant expressed her frustration with the child's father having given his child "Blues Clues" and "Barney" outfits after the participant had given his niece "little Tommy [Hilfiger] dresses" for her birthday. In contrast, one participant stated that she had to shop at Wal-Mart and Children's Palace, because her son grew too quickly to purchase expensive clothes.

All participants were in agreement, however, that, if a mother wears nice clothing, it is inappropriate for the child to wear nothing but the best as well. This attitude was supported with comments like, "What do I look like walking out and I'm Chanel down, and my baby got Wal-Mart on," and "If she [the mother] is dressed in Polo and the baby go outside in Wal-Mart clothes and the first thing people are going to think about you is 'she ain't thinking nothing about her baby.'" Participants continued in this fashion for quite a while and did not conclude until the focus group moderator redirected the conversation.

APPENDIX H

ADDITIONAL FINDINGS FROM MALE FOCUS GROUP DATA

How do you think most guys your age feel about getting their girlfriends pregnant?

When asked how guys their age feel about getting their girlfriends pregnant, 26 comments were made on this topic. Eleven of the 26 comments suggested that most guys their age react negatively when they get their girlfriends pregnant. Participants felt that men who impregnate their girlfriends "have messed up" and "they don't want to be tied down." A few of these 11 comments referred to the responsibility issues inherent in parenting, with one participant stating, "They are worried about how they are going to take care of it financially." Another comment pertinent to responsibility issues indicated that men their age who become fathers "must quit playing," indicating that teen fathers should leave their carefree youthful lifestyles for one of responsible parenting.

Remaining comments did not directly respond to the question but instead were reflections on the concept of parenting. Eight comments discussed how one's priorities change after becoming a father. One participant illustrated this attitude with this comment, "you are going to want to have a car...dress nice, and you want to go out and have fun. But now you are going to have to stay in the house, you have to work." Another participant supported the belief that teenage fathers must not shirk responsibilities, "You cannot hang out with your boys anymore....You cannot buy the Jordans anymore for yourself, you have to buy them for someone else."

Four participants commented that having a child gives an individual a new perspective on life and women. One participant stated, "I look at women with a whole new point of view since I am having a little girl. I used to look at them [women] like she ain't nothing, I would treat them bad. But when I had my little girl, I thought about it."

Another confirmed this attitude, "It made me have a new outlook on women." The final three comments described having a baby as a positive occurrence.

Do you think there are a lot of guys who want to get girls pregnant?

Of the 23 comments made in response, 9 countered that more women want to get pregnant than men want to impregnate women. Many of these respondents further remarked that women want to get pregnant in order to claim a man as her own, and one respondent stated that women intentionally get pregnant to "get better welfare checks." Two responses further implicated females by accusing them of sabotaging birth control efforts, "They put a hole in the condom," or "They use protection when they start, then in the process...they put a hole in there."

Six of the 23 comments indicated that some men do intentionally impregnate women, especially if the woman is attractive, the "Halle Berry type." One participant claimed to know a man who attempted to impregnate every woman with which he had intercourse. In contrast, five respondents felt that men do not want to get girls pregnant, "...you don't see a lot of young Black single males saying, 'I am ready to have a baby.' It be those rich White boys with parents that have babies and get married." Another statement declared that young men are not trying to cause pregnancy; they are just "trying to hit and run." The final comment expressed concern that older men generally impregnate young girls, and this respondent wondered, "What in the world is going on."

What are the reasons some guys want to get girls pregnant?

Participants were asked to comment on why some men want to impregnate women, and 21 comments were given in response. Of these 21 comments, 5 indicated that there are no actual reasons men get women pregnant. Such comments suggested that some men "can't help it," and another participant explained the failure to pull out before ejaculation, "You just could not hold a nut and could not catch it in time." Two of these five respondents described having friends who have multiple children from many different women.

Five of the 21 comments indicated that men impregnate women because they like children. "Some just like to have children," commented one participant. Another participant knew a man in Georgia who has 20 children, because the man "...likes kids, and he tries to take care of most of them." Four participants commented that men want to "keep the girl there," or "do not want the female to go anywhere." One of these respondents admitted that he "don't want mine to go anywhere." Another four respondents believe the attraction a man has for a woman cause him to desire pregnancy, "Yes, you see a girl that you like and you just want to get her pregnant." The final three comments named "stupidity" in response to this question.

If you did not want them to get pregnant, why did you not use birth control?

Eighteen comments were provided in response to this question. Five participants reported that condoms were being used as birth control, yet pregnancy occurred when their condoms broke. For another five respondents, no actual reasons were given for failure to use birth control except for their uncontrollable urges and the "heat of the mo-

ment." One participant described these situations by stating, "...you want to get some, but you don't have protection," thus resulting in unplanned pregnancy. Another stated that "Safe sex is no sex, but a man is going to be a man." Further illustrating the lack of birth control use, "If we are here with a woman and the hormones starts to rage, we have to do something even if we don't have protection."

Three of the 18 comments mentioned the use of less effective means of birth control such as coitus interruptus and "shooting blanks." Two individuals did not use birth control because condoms take too much time, and another two stated that women lie to their partner about using birth control and intentionally get pregnant. The final respondent failed to use birth control, because he "hates condoms." This same individual did not want his partner on birth control pills or Depo Provera because their side effects include hair loss and ovarian cancer.

Did your partner want to get pregnant or mind that she got pregnant?

Of 18 responses, 10 indicated that their partners did desire pregnancy; 1 participant stated that his partner did not want to get pregnant. For two respondents, they knew pregnancy was not desired, as their partner already had a child. Another two commented that their partners knew the participants would take care of a child if it were his. Two more participants mentioned the ease with which young girls can be impregnated, and the final response came in unison, "young, dumb, and full of cum."

Did your partner influence your desire to get her pregnant?

Four comments were given in response to this question. Two participants felt that they were influenced by their partners' desire to get pregnant. Another two participants claimed that their partners did not influence them; the pregnancy was merely unplanned.

When you have gotten a girl pregnant, did you want to or not?

Of 23 responses to this question, 14 stated that pregnancy was not desired. For one participant, pregnancy was unplanned and he claimed, "The baby just snuck up on me." Another participant's pregnancy was undesired, and he was "trying to get someone else pregnant." The remaining nine comments stated that pregnancy was desired and planned. One respondent noted that he just had his fourth child; he initially became a father in the eighth grade.

When someone wants to get pregnant, they need to have sex without a condom or other birth control in order to accomplish it. But doing so puts them at risk for STDs including HIV. How do you think people your age decide what to do in this situation where they want to get pregnant, but they do not want to get an STD?

Six of the 12 responses remarked that both sex partners should get tested for HIV and other STD before attempting pregnancy. Three comments noted that a condom should be worn to protect against both pregnancy and STDs; one participant stated that he "don't try to aim for unprotected sex and a child period!" One response mentioned monogamy as the best way to have a baby while avoiding STDs, and another recommended the avoidance of sex with strangers for STD prevention, "I try not to do it with a com-

plete stranger." A final comment noted that women would not admit to having an STD if asked by a potential sex partner.

Did you worry about getting HIV or another STD when you had unprotected intercourse?

When asked if they worried about contracting HIV or another STD while having unprotected intercourse, 6 of the 15 responses claimed that they did worry. However, two did not worry about HIV or other STDs. Three respondents explained that they could tell when a woman has an STD, either through ill-smelling odors or the inability to have an erection, "I guess your dick has a brain of its own. It has a sixth sense."

Two respondents stated that HIV and STDs are a concern, because condoms "don't work all the time," and "sometimes you don't know when the condom busts, you could be in there raw." The final two comments admitted that HIV and STDs are not worried about until after intercourse occurs; one participant may worry about disease "a day or two after" intercourse.

Unexpected Findings in Male Focus Group Data

The focus group moderator inadvertently asked participants how pregnancy affected the relationship between teenage parents, and he received some interesting comments. For one participant, his relationship with the mother did not change until after the baby was born at which point they "pulled apart." The relationship totally dissolved after the participant went "sideways" and was unfaithful; however, he just reestablished his relationship with the baby's mother. Another participant admitted that his relationship had gotten "a little rocky" during the pregnancy (the baby was due 1 month after the focus

group session). Another participant asked the other focus group participants how he was supposed to remain faithful during the pregnancy, when she is too moody to have intercourse. This participant felt that he had treated her well and deserved better treatment, and he remarked, "She has got to give you something to satisfy you if she is not giving you any." Three participants felt that the mothers of their babies were mean during the pregnancy, with one commenting that he sometimes "snaps back" at her. Another participant understood the moodiness, but believed women take advantage of it.

Two participants felt that pregnancy causes a woman's feelings for the father of the baby to intensify and that couples become closer. Another stated that one's feelings for the woman might decrease, but the shared responsibility of a child changes the dynamics of a relationship. A final participant stated, "The most valuable thing that a female can give a male is a child...you have to start being a man." This same respondent explained that when the mother of the baby becomes emotional, the male must "sit down with her and ask her how she feels."

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I certify that I have read this document and examined the student regarding its content. In my opinion, this dissertation conforms to acceptable standards of scholarly presentation and is adequate in scope and quality, and the attainments of this student are such that she may be recommended for the degree of Doctor of Philosophy.

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