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University of Alabama at Birmingham, 1991

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BECOMING PREGNANT: PERCEPTIONS OF BLACK ADOLESCENTS

by

MARGARET GUTHRIE TENNYSON

A DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Science in Nursing in the School of Nursing in the Graduate School, The University of Alabama at Birmingham

BIRMINGHAM, ALABAMA

1991

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ABSTRACT OF DISSERTATION
GRADUATE SCHOOL, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Degree D.S.N. Major Subject Community Mental Health Nursing

Name of Candidate Margaret Guthrie Tennyson

Title Becoming Pregnant: Perceptions of Black Adolescents

One million adolescent pregnancies occur annually in the United States, with the highest incidence of adolescent pregnancies among Blacks. The potential risks for an adolescent pregnancy can involve physiological, psychological, and/or sociological factors. Furthermore, Black adolescents experience potential risk factors associated with low socioeconomic status and lack of prenatal care. Therefore, the purpose of this study was to discover the perceptions of Black adolescents about the phenomena in their life at the time of conception. Eleven pregnant, Black adolescents comprised the sample for this qualitative inquiry. The subjects completed three interviews: (a) at 37 to 39 weeks of pregnancy, (b) 1 to 3 days postpartum, and (c) approximately 3 weeks following delivery. Data were analyzed according to methods described by Patton. Three categories of themes which emerged from the interviews were unthinking, blaming, and mistake. In the category of unthinking, the adolescent perceives that they were not thinking of pregnancy at the time of

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intercourse. For them, pregnancy "just happened." With blaming, the adolescent will blame external forces for their pregnancy, such as their partner. In the category of mistake, the adolescent claims their pregnancy was a mistake. Therefore, the major theme that evolved from the data is the inevitability that pregnancy would occur. A summary of factors thought to influence pregnancy showed that the adolescents had the knowledge about how to prevent pregnancy and their knowledge is primarily evidenced by unthinking. The subjects enjoyed activities away from home and were either a close family, or did not communicate. The relationship with their partner prior to pregnancy was considered to be "close." Additionally, the subjects described themselves as happy, and correlated happiness with having material objects. An interpretation of the findings suggests that the primary phenomenon in the life of the subjects at the time of conception is the inevitability that pregnancy will occur. Unthinking, blaming, and mistake are categories of inevitability. Identification of stressors from Neuman's Systems Model was not found to be useful. More natural inquiry is indicated using the grounded theory methodology to develop a theoretical basis for the meaning of pregnancy for Black adolescents.

Abstract Approved by: Committee Chairman Janice Gregg

Program Director Elizabeth Stullenbarger

Date ____________ Dean of Graduate School Jerry L. Hickey

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CHAPTER I

Introduction

One million adolescent pregnancies occur annually in the United States (Barret & Robinson, 1986; Delatte, Orgeron, & Priest, 1985; Stout & Rivera, 1989). Moreover, in the late 1980s, 1 in every 10 adolescents, age 15 to 19 years, became pregnant each year (Starn & Paperny, 1990). Further, the National Center for Health Statistics (NCHS) (U.S. Department of Health and Human Services, 1990a, 1990b) reported that in 1988, adolescents aged 15 to 17 years had birth rates 6% higher than the year before, and higher than any year since 1977. The highest incidence of adolescent pregnancies occurs among low income blacks (Davis, 1989; Smith, 1990).

There are several reasons why adolescents get pregnant. Engaging in sexual intercourse at an earlier age is one reason given for high adolescent pregnancy rates (Franklin, 1988; McAnarney & Hendee, 1989). Davis (1989) and MacDonald (1987) report the demise of the family as another factor which contributes to the high numbers of adolescent pregnancies. Moreover, MacDonald reports that adolescent pregnancy and drug use are highly related. MacDonald notes that adolescents, who use drugs, may experience a loss of

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inhibition, or they may believe that drugs enhance sexual pleasure.

Additional factors, which include low socioeconomic status and decreased levels of education, are attributed to high pregnancy rates for black adolescents (Apte, 1987). There is also a belief that black women may deliberately become pregnant because they have no ambitions or lack opportunities for personal success. Others believe that these women become pregnant for financial rewards (Dunn, 1987).

Dash (1989) conducted intensive interviews with black adolescent mothers and reported that they deliberately chose to become pregnant. Furthermore, Dash views peer pressure as the most significant factor contributing to black adolescents becoming pregnant. Other authors also view peer pressure as a contributing factor which may lead to pregnancy (Davis, 1989; Sweet, 1987; Tauer, 1983; Turetsky & Strasburger, 1983). Some authors reported inadequate communication about sexuality by parents and sex educators as reasons for adolescent pregnancy (Lowry & McGinnis, 1989; MacDonald, 1987; Nolin, 1988). Tauer (1983) identified several reasons why adolescents may become pregnant: (a) to promote self-esteem, (b) to have someone care about them and to care about someone else, (c) to experiment, (d) to feel grown up, (e) to touch someone and to be touched, (f) to feel good, and (g) to get even.

Another author described adolescent pregnancy from a motivational perspective (Burke, 1987). She reports that

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teenagers' basic human needs influence their behavior. The needs are identified as: (a) belonging, (b) intimacy, (c) desire for passion, (d) competency and curiosity motives, (e) need for dominance and submissiveness (f) rebelliousness, and (g) identity. According to Burke, the interaction of these needs may motivate the adolescent toward sexual activity and pregnancy.

Statement of the Problem

The potential risks for an adolescent pregnancy can involve physiological, psychological, and/or sociological factors. In addition, black adolescents experience potential risk factors associated with low socioeconomic status (Apte, 1987) and lack of prenatal care (Olds, London, & Ladewig, 1988; Smith, 1990).

Physiological risks for the black adolescent and her baby may include premature births, low birth weight infants, pregnancy-induced hypertension, cephalopelvic disproportion, and iron deficiency anemia (Curtis, Lawrence, & Tripp, 1988; Davis, 1989; Olds et al., 1988; Smith, 1990; Zuckerman, Amaro, & Beardslee, 1987; Zuckerman, Walker, Frank, & Chase, 1986). There are also physiologic risks related to early onset of sexual activity and numerous partners. Examples include cervical carcinoma and sexually transmitted diseases (Curtis et al.; Kegeles, Adler, & Irwin, 1988; Olds et al., 1988; Porter, 1987). Olds et al. note that adolescents 15 to 19 years old have the second highest incidence of sexually transmitted diseases in the United States.

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Psychological risks may be equally profound for the pregnant adolescent. Zuckerman et al. (1987) report that depression does exist among adolescents. The adverse affects of drug usage may also cause depression among adolescents. Further, depression associated with pregnancy may affect the adolescent as a single cause of depression or in conjunction with an existing depression or drug problem. Unsuccessful completion of developmental tasks is another side effect of pregnancy that has psychological consequences. According to developmental task theory, the process of living consists of individuals working their way from one stage of development to the next by solving problems that are met at each stage. Havighurst (cited in Thomas, 1979) states:

> If a person is successful in achieving each task, she is happy and receives the approval of her society. This success builds a good foundation for accomplishing later tasks. If the individual fails with a task, she feels unhappy, society does not approve, and she faces difficulty with later tasks. (p. 126)

The occurrence of pregnancy for an adolescent may further inhibit her ability to successfully complete developmental tasks. Examples of unsuccessful attainment of developmental tasks for a pregnant adolescent may be manifested as educational deprivation, social isolation, and financial problems (Curtis et al., 1988; Davis, 1989; Ruff, 1987).

The medical and behavioral problems associated with adolescent pregnancy become the responsibility of society. The financial drain on society is evident by necessary

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welfare, social service, and educational programs. Medical expenses concerning the predisposition for preterm and low birth weight infants places an enormous burden on society (Davis, 1989).

Statistics related to the consequences of pregnant black adolescents further illustrate the significance of addressing adolescent pregnancy prevention. According to the NCHS (1990), adolescents and women over 40 years of age are more likely to bear low birth weight (less than 2,500 grams) babies. Moreover, the NCHS reports that the incidence of black low birth weight babies increased from 12.7% in 1987 to 13.0% in 1988, the highest level since 1976. The rate for white low birth weight babies decreased from 5.7% in 1987 to 5.6% in 1988. The infant mortality rate in blacks is approximately two times the rate for whites and black women are 3.6 times more likely than white women to die from maternal complications (Olds et al., 1988).

The high adolescent pregnancy rates and the multiple problems associated with adolescent pregnancy establish the basis for conducting formal investigation with this population. Therefore, the purpose of this study was to discover the perceptions of black adolescents about the phenomena in their lives at the time of conception.

Need

Pregnancy prevention interventions are usually directed at increasing the adolescents' sexual knowledge and decision-making skills concerning sexual behavior. Sex

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education programs are designed to provide this knowledge, and a variety of programs are offered to adolescents. Examples are: (a) school-based education, (b) school-based clinics, and (c) community-based education.

A critical review of the literature on sex education in the schools was conducted by Stout and Rivera (1989). These researchers reported that traditional sex education programs in junior and senior high schools had little or no effect, either positively or negatively, on altering the age of onset or frequency of adolescent sexual activity, on increasing contraceptive use, or on preventing unplanned teenage pregnancy. Their review also included two studies of school-based clinics which reported a decrease in adolescent pregnancy rates. However, these studies had methodology problems. An example is one study which did not have a comparison group.

Furthermore, from a study of community-based education, Vincent, Clearie, and Schluchter (1987) reported a decrease in adolescent pregnancy rates in one county, as compared to adolescent pregnancy rates of similar counties. Nevertheless, the investigators could not distinguish among intervention modes to identify which particular intervention(s) were related to the decrease in adolescent pregnancy rates.

Trudell (1988) conducted an ethnographic investigation of a school-based sex education program and reported teacher-related problems in sex education programs. The conclusions were that the teacher had little time for

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reflective thinking, appeared concerned with "getting through" the material, and was unable to synthesize her own ideas for in-depth discussion and problem solving.

Sex education must continue to be a mode of primary prevention for adolescents. Nevertheless, because of the increasing adolescent pregnancy rates and potential risks involved, further avenues for prevention interventions must also be explored.

Conceptual Framework

The Neuman's Systems Model (1989) is a framework to clarify how nurses can provide care for adolescents concerning sexuality and pregnancy issues. The model is a wellness model and is based on the concepts of stress and the individuals' reaction to stress.

Stressors are tension-producing stimuli which may cause disequilibrium. The point of entry into the health care system for both the client and caregiver is at the primary prevention level (before a reaction to stressors has occurred); at the secondary prevention level (after a stressor reaction has occurred); or at the tertiary prevention level (following treatment of a stressor reaction) (Neuman, 1989).

The goal of primary prevention is to "promote client wellness by stress prevention and the reduction of risk factors" (Neuman, 1989, p. 35). The goal of secondary prevention is to "provide appropriate treatment of symptoms to attain optimal client stability or wellness and energy conservation" (Neuman, p. 36); while the goal of tertiary

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treatment is to "maintain an optimal wellness level by supporting existing strengths and conserving client system energy" (Neuman, p. 37). The prevention strategies addressed in Neuman's Systems Model are the method for describing the significance of this study for nursing.

Significance

The consequences of adolescent pregnancy are of special concern for nurses. Examples of nursing interventions at each level of prevention will describe the role of the nurse in providing adolescent care.

Primary prevention is to identify stressors occurring in non-pregnant adolescents and to intervene to prevent pregnancy or sexually transmitted diseases. Nurses may address primary prevention as teachers of sex education courses (Brosnan, 1987; McAnarney & Hendee, 1989; Zuckerman et al., 1986) and as essential caregivers at adolescent clinics (Apte, 1987). In clinics, nurses may examine patients and offer family planning information.

Secondary prevention is directed at keeping the adolescent in the health care system to provide optimal prenatal care, resulting in a positive pregnancy outcome. Pregnancy counseling by the nurse is essential at this time.

Tertiary prevention by nurses is related to the complications which can result from a high-risk pregnancy, metastasis of cervical carcinoma, or a sexually transmitted disease. Nurses may be in hospital or home/hospice settings for implementing care to these patients. Further, nurses

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provide interventions directed at preventing subsequent adolescent pregnancies for the individual.

The examples of nursing interventions illustrate nursing care which may be provided at all levels of prevention. Nevertheless, a major responsibility for nursing would be to develop, through research, primary prevention interventions for adolescents.

The results of this study may indicate that nursing interventions must be creative, and they may need to also address the interrelationships of adolescents' physiological, psychological, developmental, and sociocultural variables. Additionally, the results of this study may indicate the need for nurses within the interdisciplinary nursing pool (public-health, mental-health) to provide primary prevention for adolescents to decrease the incidence of teenage pregnancy. Also, this study may validate the need to develop interventions based on variables identified by an exploratory study.

By understanding adolescents' perceptions of becoming pregnant, interventions for practice can be developed from variables identified by the subjects. This is an exploratory study from a phenomenological perspective. Research from a phenomenological perspective attempts to understand the meaning of events and interactions to ordinary people in particular situations (Bogdan & Biklen, 1982).

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Research Question

The research question formulated for this study is: "What are the perceptions of black adolescents of the phenomena about their lives at the time of conception?"

Definition of Terms

The following terms are operationally defined for this study:

Perceptions - verbal reports by the subjects of what they were feeling around the time they conceived.

Phenomena - the facts, circumstances, or experiences related to the adolescent at the time of conception, as described by the subject.

Time of Conception - when an ovum is fertilized by a spermatozoon, estimated by the last menstrual period (LMP).

Black Adolescent Primigravida - a woman between the age of 14 and 18 years who is in the third trimester of pregnancy for the first time.

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CHAPTER II

Review of Literature

The literature was reviewed to correspond with the responses from the adolescents concerning their pregnancy. The variables addressed in the review are sex education, religion, lifestyle, relationships at the time of pregnancy, and self-feelings. Also included are reviews of studies similar to this study.

A major focus of adolescent pregnancy centers around the adolescent's growth and development. Erikson's Epigenetic Theory was selected for review because of its focus on adolescents and applicability to adolescent identity.

Sex Education

Much literature exists on sex education for adolescents. The review includes parent/adolescent communication, sex education techniques, and appropriate timing for offering sex education.

Parent/Adolescent Communication

The mother was considered to be the primary source of information concerning sexuality issues. Fisher (1988) administered questionnaires to 190 college students and their parents to identify variables related to family discussion of sexuality. Fisher concluded that it is the

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mother who is generally responsible for discussing sexually related topics with both sons and daughters.

Tucker (1989) administered questionnaires to 179 black females ranging in age from 13 to 80 years, representing 53 family units, to identify the major source of information about sexual issues. The investigator concluded that mothers were the major source of sex-related information.

Some researchers suggest that the adolescent's value system is related to positive communication with parents about sexuality issues (Green & Sollie, 1989; Nolin, 1988). Green and Sollie examined the effects of a church-based sex education program on sexual communication between adolescents and their parents and peers on sexual topics concerning values, sexual attraction, and sexual identity. Pretests and posttests were administered to 26 experimental group subjects and 25 control group subjects, 14 to 18 years of age. Both groups belonged to similar church youth groups and had similar socioeconomic status. The experimental group participated in a sexuality class. The investigators concluded that over time, communication about sexual topics with parents as compared with peers increased significantly following the sexuality class.

In 1988, Nolin administered questionnaires to 84 matched sets of mothers, fathers, and their high school age son or daughter to explore the relationships linking direct and indirect parent-child communication about sexuality, similarity of parent and child in sexual value, and adolescent sexual behavior. Furthermore, focused interviews

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were conducted with small groups of parents and children to enhance understanding of the process of communication. The investigator found that direct parent-child communication about sexuality is more extensive for daughters than for sons. Analysis of behavioral data for adolescents age 16 years and older showed that the adolescent, especially the sons, is more likely to be a virgin if the parents' value similarity advocates virginity. Data from the focused interviews suggested that son-daughter differences in communication patterns are due to the greater likelihood of mothers to communicate about sexuality. Parents also reported that they implicitly teach sexual values through communication about related issues and through example.

Newcomer and Udry (1985) conducted interviews with 1,100 junior high school students and found that adolescents are frequently ignorant of their parents' attitudes toward sex-related issues, and parents and adolescents frequently disagree about the kinds of sex-related conversations they have had. Furthermore, the investigators suggested that parents should know that young adolescents do not necessarily hear or retain what parents believe they are communicating. The data indicated that neither parental attitudes toward premature sex, nor parent-child communication about sex and contraception appear to affect teenagers' subsequent sexual and contraceptive behavior. Newcomer and Udry reported that methodological problems occur when measurement of parent-child communication on parental attitudes are based on reports of just the parent

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or just the child. For example, the adolescent's perception of the mother's attitude may influence the adolescent's behavior; however, it may not reflect the parent's actual belief.

Sex Education Techniques

Research has been reported in which a variety of techniques and curriculum development for pregnancy prevention have been used. Starn and Paperny (1990) developed two interactive computer games designed to capture the attention of adolescents and to foster more responsible reproductive attitudes. The sample consisted of 718 Hawaiian high school students, and questionnaires were administered to experimental and control groups. The investigators concluded that gaming techniques produce knowledge and attitude changes favoring responsible adolescent sexual decision-making.

Leisa (1987) designed, developed, and evaluated a gaming-simulation as a communication technique for education about adolescent pregnancy. Pretest and posttest groups were administered a test to measure knowledge related to adolescent pregnancy. The investigator reported there was no significant difference between the pretest and posttest groups as measured by an Assessment Form on adolescent pregnancy.

An abstinence promotion program for 6th and 7th graders is a sex education technique that was examined by Christopher and Roosa (1990). The program consisted of sessions focusing on self-esteem, communication, skills,

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peer pressure, and teaching values that sex should be confined to marriage. The investigator reported that the only change shown by the 191 participants was an increase in precoital activity; this increase was not shown by the 129 subjects in the control group.

Eisen and Zellman (1986) conducted interviews with 203 adolescents in a pretest-posttest design to evaluate a 15-hour sex education program based on the health belief model (HBM). Results indicated that the adolescents who regard pregnancy as a serious condition to which they feel susceptible are more likely to have acquired the knowledge that may help them avoid it. Also, those adolescents who perceive fewer barriers to contraceptives are more knowledgeable about contraceptive methods. The investigators concluded that motivation is a key component in the acquisition and retention of sexual knowledge.

Recommendations for more effective sex education techniques have been made and include suggestions for relating content to the specific culture of the adolescent (Scott, Shifman, Orr, Owen, & Fawcett, 1988); a school-based program that combines educational and health care services (Quinn, 1986); and an adolescent program that combines career and reproductive planning (Quinn). Major flaws associated with sex education programs concerns the quantity and quality of sex education received (Marsiglio & Mott, 1986); the fact that neither pregnancy nor contraceptive education exert any significant effect on the risk of premarital pregnancy among sexually active adolescents

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(Dawson, 1986); and that there continues to be a lack of administrative and community support for personnel responsible for sex education courses (Trudell, 1988). Additionally, Fine (1988) suggests that the anti-sex rhetoric surrounding sex education inhibits the development of sexual responsibility and subjectivity in female adolescents.

Timing for Sex Education

Forrest and Silverman (1989) conducted a survey of public school teachers who provide information about sex education in grades 7 through 12. The teachers' specialties included biology, health education, home economics, school nursing, and physical education. A total of 4,241 eligible teachers responded to the survey, with the highest response rate among the nurses. The investigators reported that the sex education teachers regard pressure from parents, the community, or the school administration as the major problem they face in providing sex education. Nevertheless, other problems reported were the lack of appropriate materials on the subject, and students' reactions or lack of interest. Retention of knowledge is also a concern with inappropriate timing for offering sex education courses.

Brosnan (1987) conducted a study with an n = 359 (experimental group) and an n = 51 (control group) to investigate long-term retention of knowledge as well as perceived benefits of an elementary sexuality program presented to fifth and sixth grade students attending parochial schools in Texas. The posttest was administered 2

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years following the initial testing. The investigator concluded that the experimental group had a higher percentage of students with passing scores at both grades, 76.8% and 90.2%, respectively. The much smaller control group received passing scores of 62.5% and 84.2%.

Dycus and Costner (1990) implemented and evaluated a human sexuality curriculum for seventh graders. The investigators concluded that the pregnancy rates dropped significantly from 30 births in a county in North Carolina in 1984 to 8 births in 1985, for 12- to 15-year-old girls. A total of 364 students participated in the initial course in 1985, and 38% were from low socioeconomic backgrounds. Moreover, the investigators reported that pregnancy rates remained down for early adolescents. However, the investigators did not account for abortions among the girls. Furthermore, the pregnancy rate for the previous year 1983, was eight girls, the same as for 1985 when the program was implemented.

Brown (1987) investigated 282 subjects ranging in age from 13 to 19 years, with 66% from a middle socioeconomic status, and formed experimental and control groups to examine the relation between a comprehensive sexuality education course and the self-perception of adolescents. The investigator concluded that the students' level of reproduction knowledge is increased by taking a health class. However, students retained only 50% of that knowledge 9 weeks after taking the class. According to

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Brown, sexual behavior cannot be affected by knowledge that is not retained.

Religion

The degree of the adolescent's religiosity is said to have an influence on their sexual responsibility and behavior (Forste & Heaton, 1988; Sweet, 1987). Forste and Heaton examined interview data from 7,969 women aged 15 to 44 years from the National Survey of Family Growth (NSFG), Cycle III in 1982. The investigators concluded that a stable, structured environment decreased the occurrence of first intercourse for females between the ages of 12 and 19 (Forste & Heaton). Furthermore, the investigators reported that frequent church attendance reduced the likelihood of experiencing first intercourse at all ages.

Studer and Thorton (1987) suggested that identification with a religious group appeared to provide the adolescent with role models and a sanctioning system that operates to discourage sexual activity and consequently, do not offer help with contraception for adolescents who become sexually active. Collins and Robinson (1986) suggested that religiosity is not associated with either knowledge of, efficiency of, or favorability toward contraceptive use. In a study which explored religiosity between nonfathers and unmarried adolescent fathers, Hendricks, Robinson-Brown, and Gray (1984) reported that fathers did not differ from nonfathers in the degree that they were religiously oriented.

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Lifestyle

Limited literature was identified which focused on factors relating to adolescents' lifestyle. Conclusions from a study of religious commitment, truancy, and evenings away from home were shown as being strongly linked to individual differences in marijuana use (Bachman, Johnston, O'Malley, & Humphrey, 1988). Other researchers (Mayer & Jencks, 1989; St. John & Rowe, 1990) suggested that the environment contributed to an increase in black teenage pregnancy rates.

The lifestyle of a teenager was more fully examined by Magilvy (1987) through an in-depth view of the life of 50 teenagers aged 13 to 17 years. The teenagers described the label for the group to which they belonged, and the type of music, clothing, and activities that distinguished each group. Most subjects belonged to either formal organizations, such as church or athletic groups, or they identified with informal groups, such as teens who frequented a recreation center. Pregnancy seemed to be accepted by some groups, while others were aware of the difficulties of teen parenthood. Also, jobs, education, and families were valued as important to teenagers. However, Magilvy did not report the race or socioeconomic status of the sample for the study.

Relationships At The Time Of Pregnancy

The research literature primarily focused on the relationships among parents and adolescents. Olson and Worobey (1984) investigated the differences in the

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mother-daughter relationship of pregnant and nonpregnant adolescents. The data were collected from 40 nonpregnant and 20 pregnant adolescents. Instruments used for the study were the revised Parent-Child Relations Questionnaire (PCRII), designed to measure parental behavior toward children as perceived by the adolescent; Mother-Daughter Relations Questionnaire which refers to specific behaviors; and a questionnaire to measure the affective mother-daughter relationship as perceived by the adolescent. The investigators found that the pregnant group perceived fewer demands, a more casual relationship with the mother, and more rejection. More affection and disclosure were perceived by the nonpregnant subjects, as well as more love, attention, and interdependence. The investigators concluded that more significant findings might have emerged if a larger sample of pregnant adolescents had been available.

Townsend and Worobey (1987) investigated the perceived relationships between 95 mothers and their adolescent daughters, including samples of pregnant (n = 19) and nonpregnant (n = 76) adolescents. Questionnaires were administered to each mother-daughter dyad; however, most of the responses were from Caucasian subjects (n = 16 pregnant, n = 72 nonpregnant). The investigators reported that the percentage of mothers working outside the home was significantly different for the two groups, with the pregnant group having more mothers employed outside the home. Moreover, the investigators found no significant

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differences between the groups in intimacy, attachment, and strength of feeling.

Toffolo (1988) investigated 60 volunteers from two inner city high schools and included equal numbers of never pregnant and pregnant adolescents matched on age, race, and socioeconomic status. The purpose of the study was to determine whether never pregnant adolescents differ from pregnant adolescents in their perceptions of parental nurturance, control, and communication, and in their own level of self-esteem and acceptance of responsibility; effect of presence of father in the home was also analyzed. Instruments used for this study were an adaptation of the Iowa Parental Behavior Inventory used to measure adolescent perceptions of parental nurturance and control; the Barnes-Olson Parental Communication Scale, Adolescent Form; the Rosenberg Self-Esteem Scale; the Gordon Personal Profile; and an interview schedule developed by the investigator. T-tests were used to compare mean scores of all variables, except presence of father in the home. The investigators concluded that pregnant adolescents' perceptions of mother and father nurturance and communication with mother were significantly higher than perceptions of never pregnant adolescents; post pregnancy self-esteem was lower than pre-pregnancy self-esteem, and both were lower than that of never pregnant adolescents; and scores on responsible attitudes toward adolescent pregnancy and sexuality were significantly higher for never pregnant adolescents.

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The relationships of one-parent families and adolescents' sexual behavior was also reported (Miller & Bingham, 1989; Newcomer & Udry, 1987). Miller and Bingham replicated an earlier study conducted by Zelnik and Kantner in 1979. The investigators used data from the previous study which included a national survey of 1,571 15- to 19-year-old female adolescents. The investigators concluded that female adolescents who have been raised by a single parent are more likely to have nonmarital sexual intercourse than young women from intact marriages. However, they cautioned that when the data were controlled by other variables such as age, race, social class, and religion, the effect of parents' marital status on daughters' sexual status was greatly reduced.

Newcomer and Udry (1987) conducted a study from interviews with 501 white virgin teenagers to provide further understanding of the relationship between parental marital status and the initiation of coitus by adolescents. The investigators concluded that girls in a single mother household were more than three times as likely as those living in both natural parent households to be sexually active.

Rodgers and Rowe (1988) used the Adolescent Sexuality (ADSEX) Dataset collected at the Carolina Population Center between 1978 and 1982 to identify the influence that siblings can have on adolescent sexual behavior. A total of 1,909 respondents filled out questionnaires in the first rounds. At each site, respondents also filled out similar

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surveys 2 years later, with an 80% response rate. The sample was 25% white male, 25% black male, 27% white female, and 23% black female. The investigators concluded that older siblings are less sexually active than younger siblings at the same age, and younger siblings of nonvirgin older siblings are more active than those whose older siblings are virgins. However, the investigators reported that the siblings selected were close in age.

Self-Feelings

Some investigators claim that adolescent mothers have a lower self-esteem than never-pregnant adolescents (Horn & Rudolph, 1987; Toffolo, 1988). Horn and Rudolph (1987) compared self-concepts of adolescent mothers with those of the published norms of the Tennessee Self-Concept Scale (TSCS). The study included administering questionnaires to 23 adolescent mothers between the ages of 13 and 19 years. A t-test for independent samples was used to determine if the mean score derived from the TSCS differed from the norms as presented with this scale. The investigators concluded that the self-concepts of the subjects in this group were significantly lower than the norms of the general population. Toffolo investigated the level of self-esteem among never pregnant and pregnant adolescents ($n = 60$), and found post pregnancy self-esteem was lower than pre-pregnancy self-esteem, and both were lower than that of never pregnant adolescents.

Troutman and Cutrona (1990) explored the extent to which childbearing increased vulnerability to clinical

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depression and depressive symptomatology among primiparous adolescent girls aged 14 to 18 years. The childbearing subjects (n = 128) were assessed during pregnancy, 6 weeks postpartum, and 1 year postpartum. Matched non-childbearing subjects (n = 114) were assessed at corresponding time points. A diagnostic semi-structured interview was conducted, and two measurements of personality were used. The investigators concluded that although there was relatively high prevalence of clinical depression among adolescent mothers, there was no statistically significant differences between the childbearing and non-childbearing samples of either major or minor depression. The investigators concluded that the key finding was the lack of evidence that childbearing places adolescents at increased risk for depression during the early weeks following delivery.

Iheanacho (1988) summarized research findings dating from 1960 to 1988 related to the self-concept of adolescents from minority cultures. The author reported that the main obstacles minority adolescents face in their development of self-concept are environmental factors and their limited access to mainstream society. Iheanacho attributed the obstacles for minorities to their lack of opportunity to penetrate barriers of discrimination.

Phenomena Associated with Adolescent Pregnancy

Several studies were found which identified phenomena associated with adolescent pregnancy. Ryan and Sweeney (1980) interviewed 87 pregnant adolescents, 92% of which

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were black. The investigators reported that almost all the subjects had knowledge of contraceptives and that most were happy about being pregnant.

Swartz and Darabi (1986) interviewed 150 new adolescent patients at a large urban clinic to determine what events or advice led to their decision to approach a family planning clinic for the first time. The investigators concluded that the fear of being pregnant, especially for Hispanic adolescents, was the primary incentive to visit the clinic for birth control.

Harper (1986) conducted interviews and administered questionnaires to 25 ever-pregnant and 25 never-pregnant black adolescents. The method used for data analysis was stepwise discriminant analysis. The investigator concluded that measurable psychological factors are associated with adolescents' contraceptive decision-making. Another issue addressed was the extent to which social forces influence individual motivational structures and behavioral dispositions. Harper suggested that one must understand the reasons for sexual activity, pregnancy, and parenthood to have a significant impact on the phenomena of adolescent sexuality, pregnancy and parenthood.

Namerow, Lawton, and Philliber (1987) sought to determine how teenagers' actual and perceived probabilities of pregnancy are related. The data were collected from interviews with 425 adolescents, aged 13 to 19 years, who were asked to estimate their likelihood of becoming pregnant the last time they had intercourse. Thirty-six percent of

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the sample were black, 36% white, 24% Hispanic, and 4% Oriental. The investigators reported that the perceived probability was not related to the actual probability of pregnancy. The investigators concluded the sex education program should focus on teaching adolescents to apply reproductive knowledge to themselves.

Herr (1988) studied 24 females in a high school program for pregnant or parenting teens. The purpose of the study was to describe and understand the phenomenon of teenage pregnancy. Access to contraception was a minor theme reported, and it appeared the girls did not think they would become pregnant. Nevertheless, they expected to derive benefits from the pregnancy. These anticipated benefits included a re-negotiation of their relationships with significant others.

Phoenix (1989) interviewed 79 pregnant teenagers 16 to 19 years of age to discern influences on their contraceptive use prior to pregnancy. The investigator found that the subjects had knowledge of contraception. Additionally, the investigator identified four orientations to pregnancy that influenced the subjects' contraceptive use at the time of conception: a desire to conceive, did not mind conceiving, had not thought about it, and did not want to conceive.

Theory and Adolescent Development

A conceptual insight into adolescent growth and development is relevant for understanding the adolescents' sexual identity. In the Epigenetic Theory, Erikson proposed that an individual undergoes eight psychosocial crises

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during development. The trait of adolescence is identity versus role diffusion (Erikson, 1963). Erikson described the rapid body growth changes as disturbing to the adolescent, and labeled them the identity crisis, whereas ego identity is manifested as confidence.

The greatest change for adolescents is role diffusion. With role diffusion, adolescents may over identify with cliques and causes; they can temporarily lose their own individuality. They are also intolerant of others outside their clique. In search of self, they often come into conflict with parents, siblings, and others close to them while re-fighting many of the battles of earlier years (Erikson, 1963).

According to Thomas (1979), who described Erikson's theory, youths who solve the problems of the adolescent years come through with a strong sense of their own individuality and a recognition that they are acceptable to their society. Additionally, those who fail to work their way through the identity crisis continue to experience problems associated with immaturity in later life.

Erikson (cited in Makihara, 1983) discussed the application of psychoanalytic theories to clinical practice. Archer (1989) investigated research on identity formation using Erikson's ego identity construct and concluded that, to a substantial degree, diffusion characterizes today's youth. Adolescent development into adulthood and the importance of career and intimacy has been reported by Raskin (1989) and Comerci (1989).

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Summary

In summary, limited reports exist concerning the phenomena associated with adolescent pregnancy. Additionally, most research methods which were limited to one-time interviews and questionnaires, failed to obtain the insight of the true phenomena of pregnancy which must be captured over time.

Black adolescent pregnancies continue to occur at a high rate, and carry a burden of detrimental societal outcomes. However, this population has received little attention from nurse and/or physician researchers as identified in only two of the studies. For example, Ryan and Sweeney (1980) investigated a population that was primarily black, and Harper (1986) reported an investigation in which all subjects were black adolescents. To better understand the phenomena of black adolescents who become pregnant, one must understand the reason(s) or behaviors related to adolescent sexuality and pregnancy as suggested by Harper.

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CHAPTER III

Methodology

The purpose of the study was to describe the perceptions of black adolescents about the phenomena in their lives at the time of conception. The phenomenological perspective was the methodological approach.

Design

Phenomenology first appeared in the writings of the philosopher Franz Brentano during the latter 19th Century (Parse, Coyne, & Smith, 1985). Edmond Husserl, a German philosopher and Brentano's student, refined and logically developed phenomenology in the early 20th Century (Berrios, 1989; Parse et al.; Patton, 1990). Phenomenology then continued as the Phenomenological Movement, and included philosophers, such as Gabriel Marcel, Jean Paul Sartre, and Maurice Merleau-Ponty (Patton).

The phenomenological perspective for the study was characterized by an understanding of the experience of becoming pregnant to that of shared experiences of becoming pregnant. The collection of data was ongoing and resulted in a category of themes of the shared experiences identified by the subjects.

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Instrumentation

The instrument for the study was the researcher. According to Lincoln and Guba (1985), "the instrument of choice in naturalistic inquiry is the human" (p. 236).

The human instrument can provide data almost as reliable as more objective means for data collection. Lincoln and Guba (1985) report some of the characteristics which enhance the reliability of the human instrument: (a) responsiveness of being able to interact with the situation, (b) adaptability, (c) holistic emphasis to grasp conversations in one view, (d) knowledge base expansion by being aware of a situation beyond mere propositional knowledge, (e) processual immediacy to process data as soon as they become available, (f) opportunities for clarification and summarization of data on the spot, and (g) an opportunity to explore atypical or idiosyncratic responses.

The human instrument was used to increase reliability and validity in another way. The researcher, who had over 18 years experience as a labor and delivery nurse, followed the subjects through their labor and delivery experience because of a belief that an intimate bond of trust and respect forms between patients and nurses at the time of delivery. It is through this bond with the subject, that the researcher expected deep, honest, and reliable follow-up interviews from the subjects.

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Sample

Sample size is a reflection of what you want to know, the purpose of the inquiry, and what will have credibility for the study. In-depth focus on a relatively small sample is appropriate for qualitative or naturalistic inquiry. In contrast, quantitative methods depend on larger samples, selected randomly (McCracken, 1988; Patton, 1990). Therefore, 11 subjects comprised the sample for this study. These 11 subjects were purposefully selected. According to Bogdan and Biklen (1982) and Patton, the goal of purposeful sampling is to obtain information-rich cases concerning a particular phenomenon.

The subjects were obtained from the prenatal clinics and observation area of the obstetrical unit, at a large teaching hospital in the South. Criteria for subject selection were : (a) able to speak and understand English, (b) unmarried, black primigravidas 14 to 18 years of age, and (c) in the third trimester (37 to 39 weeks) of pregnancy at the time of the initial interview. The investigator checked charts in the clinic to identify subjects who met the criteria to participate in the study. Additionally, the investigator made frequent visits to the observation area to identify potential subjects who met the criteria for the study.

The subjects' ages were chosen because statistics have shown an increase in birth rates among 15- to 17-year-old adolescents (NCHS, 1990). To be included in the study, subjects had to be 14 to 18 years of age by May 31, 1991.

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Black adolescents were selected because they have: (a) an increased incidence of pregnancies among low income blacks, (b) a higher susceptibility to having low birth weight infants and inadequate prenatal care, and (c) a paucity of formal investigations among the black population. Single primigravidas were selected to maintain a homogeneity of the variables which may be identified by the subjects.

Primigravida adolescents who were 37 to 39 weeks gestation were selected so that the initial audiotaped interview would occur prior to following the subject through her birth experience. Moreover, many patients do not seek prenatal care until the third trimester of pregnancy (Smith, 1990).

Once the subjects were identified, the investigator asked them to participate in the study. Also, the investigator talked with the adolescents' parents or legal guardian and invited them to sign the consent form. The script used to invite subjects to participate is provided in Appendix A.

If the subject declined to participate in the study, the investigator thanked her for her time and ended the conversation. If the subject agreed to participate in the study, the investigator spoke to her mother or legal guardian. The script used to invite parents/legal guardians to allow their daughters to participate in the study is provided in Appendix B. Following signed consent, the subject was interviewed. If the parent/legal guardian declined to allow their daughter to participate in the

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study, the investigator thanked them for their time and ended the conversation.

The investigator also communicated with the staff in labor and delivery at the hospital concerning notification of when subjects were admitted to the labor unit. Several steps were followed to ensure that the investigator attended the labor and birth experience of the subject: (a) the investigator carried a beeper for 24-hour coverage, (b) the investigator asked the adolescent and parent to notify her when they went to the hospital, (c) the investigator flagged the chart of each subject with a name and number to contact the investigator upon the subject's admission to the hospital, (d) the investigator checked with the staff in the observation area frequently to see if the subjects were admitted, (e) the investigator was on the labor unit frequently to monitor admissions and deliveries of subjects, and (f) the investigator had a contact person on the unit to enlist the help of the staff in notifying the investigator when subjects were admitted.

Three interviews were planned for each subject. One interview was scheduled to take place antepartum, and two interviews were scheduled following delivery.

Subjects who completed at least two interviews and were followed during their labor and delivery were included for the complete analysis of their perceptions of their lives at the time they became pregnant. They were offered $20 for completion of the three interviews to ensure their return for their final interview. Because adolescents are

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considered at high risk for pregnancy complication, they must have had normal outcomes of their pregnancy, according to a nursing assessment, for continuation in the study. Continuation in the study was determined mutually by the investigator and subjects. An example was that the interviews were continued on patients who had mild preeclampsia or a Cesarean section for cephalopelvic disproportion.

Setting

For the first interview, the setting was in a conference room at the prenatal clinics, and/or in labor and delivery. The second interview was conducted in a conference room on the postpartum unit, 1 to 3 days after delivery. The conference rooms have thick insulation and people outside the room were not able to hear the conversation. Approximately 3 to 4 weeks following delivery, the third interview was held at a mutually agreed upon place by the subject and investigator.

Procedures

Data Collection

Prior to any data collection, an assurance that human subjects were protected was obtained from the Institutional Review Board (IRB) at The University of Alabama at Birmingham (UAB). Agency approval was provided to invite patients from the hospital to participate in the research.

A consent form for the adolescent (Appendix C), parental consent form (Appendix D), and a child assent form

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was obtained (Appendix E). The consent form stated that the subject could withdraw from the study at any time.

Data were collected by audiotaping three in-depth interviews. According to Marshall and Rossman (1989), in-depth interviewing is "a conversation with a purpose" (p. 82); the purpose is to obtain valid and reliable information. The three interviews consisted of open-ended, unstructured questions concerning perceptions of phenomena around the time of conception and lasted 30 minutes to 2 hours each. An interview guide was developed for the study (Appendix F). At the beginning of the initial interview, the subjects answered brief demographic questions (Appendix G). Interview techniques, which include clarification, reflection, paraphrasing, and probes were employed during the interview. Examples of probes which were used for yes/no questions, or to encourage the subject to continue speaking included: (a) the interviewer would gently nod her head; (b) the interviewer would say "uh-huh" following a statement by the subject; or (c) the interviewer would use who, where, what, when, and how questions, to obtain a complete and detailed picture of the experience. To maintain anonymity of the subjects, the tapes were erased following transcription.

Reliability in qualitative research refers to the accuracy, or the extent to which the investigator records what the informant is actually experiencing (Bogdan & Biklan, 1982). In order to test the reliability and validity in this study, multiple interviews were conducted.

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The final interview was used to clarify any ambiguous meaning with previous interviews.

The primary purpose of being with the subject during labor and birth was to establish trust and rapport. The subject was not interviewed at this time.

Data Analysis

The researcher must be careful not to allow previous experience, personal bias, and knowledge of the literature to influence the interview sessions. Thus, the investigator analyzed data according to methods described by Patton (1990). The first step is called Epoche', in which the researcher becomes aware of personal bias and eliminates personal involvement with the subject material. Essentially, this step requires the setting aside of the researcher's personal viewpoint in order to see the experience for itself (Patton).

The second step is phenomenological reduction, called bracketing. Bracketing involves several steps:

1. Locate within the personal experience, or self-story, key phrases and statements to speak directly to the phenomenon in question.
2. Interpret the meanings of these phrases, as an informed reader.
3. Obtain the subject's interpretations of these phrases, if possible.
4. Inspect these meanings for what they reveal about the essential, recurring features of the phenomenon being studied.
5. Offer a tentative statement, or definition, of the phenomenon in terms of the essential recurrent features identified in step 4. (Patton, 1990, p. 408)

The process of bracketing helps bring together the shared meanings of the phenomena. Once the data are

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grouped, the researcher then identifies and eliminates irrelevant, repetitious, or overlapping data.

The final step in phenomenological analysis is the development of a structural synthesis, in which the true meaning of the experience is described. Structural synthesis included the identification of variables concerning the perception of adolescents around the time of conception.

Assumptions

The assumptions for this study were:

1. The subjects truthfully recollected their perceptions.

2. The researcher was able to eliminate biases from the process of inquiry.

3. The researcher did not allow previous knowledge of the focus of inquiry to affect the methodological approach for the study.

Limitations

Limitations to this study were:

1. The data obtained were retrospective in nature.

2. The possibility exists that the researcher would have difficulty in eliminating complete bias from the data.

3. Racial difference exists in that the interviewer was Caucasian and the subjects were Black. These limitations could have contaminated the data, and, therefore reduce the reliability and validity of the study.

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CHAPTER IV

Results

The purpose of this study was to discover the perceptions of black adolescents about the phenomena in their lives at the time of conception. Included in this chapter is a description of the subjects who participated in the study, and the timing and format of each interview. Data generated from the interviews in the antepartal and postpartal periods are categorized according to factors thought to influence adolescent pregnancy, such as the lifestyle and sex education of adolescents, their feelings about themselves, their relationships with their families, friends, teachers, and the father of their infant. Themes which emerged from the interviews are presented, along with supporting verbatim comments.

The cooperation and support of the staff and physicians at the hospital and clinics were integral to the methodological approach for this study. Because of the enthusiasm and astute observations by the staff, the investigator attended 11 of 11 deliveries. Additionally, both staff and physicians communicated with the investigator to maximize the care administered to the adolescent and her baby. Each subject was given a pseudonym to ensure anonyity.

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Subjects

The 11 subjects ranged in age from 14 to 18 years at the time the first interviews were conducted. Their education ranged from 7 to 12 years. As anticipated, the only ones to have completed high school were the two subjects who were 18 years old. The mothers of eight of the subjects were single parents; seven were unemployed; one worked in a home for the handicapped; one worked in a hospital as a nurse-technician; one worked as a security guard; and one as a school teacher. The ages of the mothers of the subjects when they first became pregnant ranged from 13 to 27 years, with a mean age of 19. Only one of the subjects was an only child; their mothers had an average of 2.8 children. Five of the subjects reported weekly church attendance; one subject attended church monthly; two subjects occasionally attended church service; and three subjects did not attend church.

All antepartal interviews were conducted in a private room; two in the antepartum clinic and nine in an observation area of the hospital. Second interviews were conducted in a private conference room adjacent to the postpartum unit. Third interviews were conducted in a mutually agreed upon place by the investigator and subject.

Abby

When I first met 18-year-old Abby, she was wearing a pink blouse and white pants. She was clean, neatly groomed, and wore no makeup. The first interview lasted approximately 30 minutes, and Abby was quiet and smiled

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infrequently. She is a high school graduate who is interested in a career in the health care field. Abby lives with her parents, who are married, and a younger brother and sister. Abby's mother was 17 years old at the time of her first pregnancy and does not work outside the home. Her father is a truck driver.

I did not see Abby again until she had been admitted to the hospital in early labor. Her membranes had ruptured and there was a slight meconium stain to the amniotic fluid. After approximately 10 hours of active labor, Abby had a healthy male delivered by Cesarean Section due to fetal distress. Her mother was with Abby at intervals during labor, and chose not to be present for the surgery. Abby's father visited once a few hours prior to the Cesarean Section. Abby saw her infant briefly after delivery, was given sedation for discomfort, and was transferred to the recovery room.

I visited Abby four times while she was in the hospital. Prior to the second interview, which was conducted on the second postpartal day, I observed Abby holding her baby close while feeding him. She commented, "I still can't believe he is real." On each visit, Abby was talkative and happy until the day of discharge when she seemed agitated. She cried, "I am ready to go, I've had enough of this hospital."

I talked to Abby three times on the telephone prior to the third interview, and she reported, "I feel better each week." The last interview was conducted in a private room

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in the GYN clinic when Abby returned for her postpartal examination. She talked about her sister who shared a room with her and said, "After being in my room with the baby, my sister don't want any babies." When we left I gave Abby a hug and wished her luck with her family and career.

Bea

When I first met 14-year-old Bea, she wore a bright red shirt and bright blue-jean shorts with a black jacket. She wore no make-up and her hair was neatly combed. The first interview lasted approximately 30 minutes; Bea was quiet and I found it challenging to have a conversation with her; however, she did appear to understand the questions I asked. Bea had just completed the seventh grade. She resided with her mother, an older brother, and two younger sisters. Bea's mother was 18 the first time she became pregnant, and is single and unemployed.

I saw Bea three more times before her admission to the hospital. On one occasion when I saw Bea before admission, she was waiting in the observation area with other patients for a test. She did not appear to be comfortable with my presence, as she was smiling mischievously with her friends and did not appear to want to talk to me.

Bea's labor was interrupted when she developed an elevated temperature. She delivered a healthy boy via Cesarean Section approximately 9 hours after her admission. Her mother remained with Bea throughout labor and the birth. When the pediatrician brought the baby over to show Bea, she turned her head and refused to look at him. Bea's mom

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laughed and said, "She is upset because it is a boy." While Bea was in the recovery room, I met the father of the baby, who did not see Bea until she was on the postpartum unit.

I visited Bea three times in the hospital. During the second interview, 2 days after delivery, Bea was tired and uncomfortable with "gas" pains. The interview lasted approximately 45 minutes.

I was unable to obtain the third interview with Bea because she did not show up for her clinic appointment. Further, I found out that Bea was "hiding out" with her baby to avoid being taken by the state due to her mother's history of alcohol and substance abuse.

Carol

When I first met 16-year-old Carol, she was a petite, pretty girl and wore bright red lipstick, a white blouse, and neon pants. The first interview lasted approximately 45 minutes, and it was difficult to maintain eye contact with Carol because she gazed downward. Carol had completed the seventh grade, she resided with her mother, her older sister, her sister's 1-year-old baby, and two younger brothers. Her mother was 19 when she became pregnant the first time, is single, and unemployed.

I saw Carol two times prior to her admission to the hospital. After approximately 10 hours of active labor, Carol delivered a healthy baby girl vaginally. The father also remained with Carol during delivery. Carol's mother and the father of Carol's baby visited Carol intermittently during labor.

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I visited Carol twice while she was in the hospital. Prior to our second interview, 1 day after delivery, I visited Carol while she was feeding her infant. The interview lasted approximately 1 hour and then I visited with Carol, the baby's father, her mother, sister, and niece in the waiting room.

For the third interview, I picked Carol up at her small shot-gun style apricot house on a major highway. We went to McDonald's for lunch before the third interview which was conducted in the privacy of my car in the parking lot. Following the interview, I left Carol off at her house and wished her luck. She asked if she could see me again, and somehow I knew that I would hear from her again.

Dee

When I met 17-year-old Dee she was wearing a white blouse and black stretch pants. During the first interview, which lasted approximately 20 minutes, Dee was quiet and did not talk much. Dee had completed the ninth grade and resided with her mother, one older and two younger brothers. Dee's mother was 19 years old at the time of her first pregnancy, is single and unemployed.

The next time I saw Dee she was admitted to the hospital in labor. After approximately 12 hours of active labor, Dee had a healthy female by Cesarean Section due to failure to make progress in her labor. Dee's aunt was present as much as possible during Dee's labor. The aunt was concerned because she reported to me that, "Dee has the mind of a 12-year-old." Nevertheless, her aunt was not

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present during the delivery because Dee received a general anesthetic due to an unsuccessful epidural anesthesia. Dee's mother came to the hospital following the delivery, but did not visit Dee until she was in her postpartum room.

I visited Dee four times while she was in the hospital. The second interview was conducted 2 days after delivery, and lasted approximately 50 minutes.

I spoke with Dee four times on the telephone before we met for the third interview in a private conference room in the GYN clinic when Dee returned for an examination. Dee looked very young and attractive. Further she was hugging and kissing her new boyfriend when I approached. Following the interview, Dee told me she was living with her grandfather while her mother was taking care of the baby. She did not mention when she would return to her mother's home. After the interview, I hugged Dee, said goodbye, and wished her luck.

Eve

When I first met 16-year-old Eve, she was wearing a blue striped blouse and white pants with white sandals. Eve told me she was eager to be a subject for this study. During the first interview, which lasted approximately 30 minutes, Eve smiled frequently but did not say much. Eve had completed the ninth grade and resided with her mother. She had one older brother and three older sisters who were not living at home. Eve's mother was 18 years old when she became pregnant for the first time, is single, and employed as an aide in a home for the handicapped.

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The next time I saw Eve, she was admitted to the hospital for her delivery. After approximately 11 hours of active labor, Eve delivered a healthy baby boy via Cesarean Section due to failure to progress in her labor. There were no family members present during Eve's labor or delivery. However, Eve's mother called once to inquire about her.

I visited Eve four times while she was in the hospital. During the second interview, which took place 1 day after delivery, Eve spoke very little and smiled frequently.

I was unable to contact Eve for her third interview. The telephone number that was given to me had been disconnected. Additionally, I was present in the clinic at the time Eve was scheduled for her postpartal visit; however, she did not keep the appointment.

Flo

When I first met 16-year-old Flo, she was neatly groomed and wore brown and red striped pants with white sandals. During the first interview, which lasted approximately 30 minutes, Flo was articulate and clear in her speech. Flo had completed the tenth grade, and she resided at home with her parents. Flo had eight brothers and a sister who were older than she. Flo's mother was 19 years old when she became pregnant for the first time and she is unemployed. Flo reported to me that her father was an anesthesiologist.

I did not see Flo again until she was admitted to the hospital about 2 weeks later. She delivered a healthy baby

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boy vaginally about 4 hours after her admission. Her mother was present for the delivery.

I saw Flo, just prior to our second interview, 1 day after delivery while she was feeding her baby. She would talk softly to him while holding him close. During the interview which lasted approximately 40 minutes, Flo was rather quiet and did not reveal herself in depth.

After Flo was discharged from the hospital, I called her on several occasions. She decided not to meet for the third interview because she was too active in school, and did not have the time to meet again.

Gigi

When I first met 15-year-old Gigi, she was wearing a black tee-shirt and jeans. Her hair was slightly messy and she wore no make-up. During the first interview which lasted approximately 30 minutes, Gigi was friendly and energetic. Gigi completed the eighth grade and had one younger sister. Gigi's mother was 13 years old at the time of her first pregnancy, is single and unemployed.

Gigi was admitted to the hospital one afternoon and delivered a healthy baby girl vaginally about 7 hours later. Gigi asked for her mother, but I was unable to contact her throughout the labor, delivery, and recovery period. An older female friend of Gigi's came to the hospital for the delivery.

I saw Gigi the next evening for her second interview, and she was quite talkative before and during the interview which lasted approximately 1 hour. Gigi told me that she

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had lived in the streets for a while and her family wanted her committed to a psychiatric facility. She had been seeing the social worker for some of her hostility and aggression, but she felt the social worker was too "nosey".

Gigi was waiting for my call after her discharge from the hospital. We talked on the telephone a few more times and met for our third interview at a local Burger King. Gigi's new and older boyfriend brought her and the baby to meet me. Gigi looked very young, bouncy, and vibrant in her blue jeans and tight tee-shirt. I fed the baby during lunch, while Gigi chatted about a program for teenage mothers where she could go to school and build her career. The baby smiled frequently while I was holding her. The interview, which lasted approximately 45 minutes, took place in a secluded area of the parking lot at Burger King in the comfort and privacy of my car. Following the interview, I dropped Gigi off at a small dingy white apartment which did not seem large enough for a family of six. As I let Gigi off at her house, I gave her a hug and she said she wanted to call me. I knew I would hear from Gigi again.

Hattie

When I first met 18-year-old Hattie, she was wearing an old beige top with a blue jacket, black pants, and black flats. She wore no make-up and her hair was pulled back. The first interview lasted approximately 30 minutes. Hattie had completed high school and was interested in a career in criminal justice. Hattie resided with her mother and was an only child. Hattie's mother was 18 years old when she

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became pregnant for the first time, is single, and is a school teacher.

I saw Hattie twice before she was admitted to the hospital. After approximately 6 hours of active labor, Hattie delivered a healthy baby girl vaginally. Her mother attended the delivery.

I saw Hattie again the next evening for our second interview, which lasted approximately 45 minutes and she was quiet, but friendly and smiled frequently. I saw Hattie two more times before discharge from the hospital, once while she was feeding her baby. She held the baby in her lap where she and the baby could establish eye contact.

I made a few telephone calls to Hattie prior to our meeting for the third interview which took place in the privacy of my car in the parking lot at McDonald's and lasted approximately 50 minutes. I picked Hattie up at her small white house in a busy neighborhood. At lunch, the baby slept and Hattie talked about her senior trip to California, and how it hurt to be talked to rudely at the hospital when she delivered. Following the interview, when I dropped Hattie off at her house, we hugged and kissed goodbye, and I wished Hattie luck with her family and career.

Ingrid

When I first met 14-year-old Ingrid, she was well groomed in appearance, wearing a blue striped dress. She wore no make-up but was very attractive. During the first interview, of approximately 25 minutes, Ingrid laughed

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frequently. Ingrid was in the ninth grade and she resided with her parents and one older sister. She has a brother who is married and expecting their first child soon. Ingrid's mother was 21 years old the first time she became pregnant and she is not employed outside the home. Her father is a blue collar worker.

I next saw Ingrid when she was admitted to the hospital. After approximately 7 hours of active labor, Ingrid delivered a healthy girl vaginally. Her mother attended the delivery. Ingrid's family was present for the baby's birth, including her father. They were excited and supportive.

I met Ingrid the next day for our second interview, and she was quiet during the interview of approximately 40 minutes. She was complaining of her stitches and did not elaborate during the interview.

I spoke on the telephone with Ingrid three times before our third interview which took place in her parents' small white home. The house was clean and welcoming. We sat in the living room for privacy, on a beige sofa, and the curtains were drawn to darken the room. During the interview Ingrid was quiet, however, she did talk about the maturity and responsibility of being a parent. After the interview, I said goodbye to Ingrid and her mother and left.

Jane

When I first met 16-year-old Jane, she was wearing a blue Minnie Mouse tee-shirt and floral pants. During the first interview, Jane appeared to be shy and did not speak

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much. Jane lived with her mother and one older brother. Jane's mother was 27 years old when she became pregnant for the first time and is single and employed as a security guard.

I met Jane again when she was in labor. After 14 hours of active labor, she delivered a healthy girl vaginally.

The paternal grandmother was present for the labor and birth. Jane's mother and the father of Jane's baby remained in the family waiting room.

I visited Jane three more times when she was in the hospital. Jane was quiet during the second interview 1 day after delivery. I visited Jane in the nursery as she held the baby on her chest while the baby slept. The baby's father made it clear he wanted the baby to be a boy. Even as Jane was being discharged, she informed me that the baby's father was still disappointed the baby was not a boy.

Jane and I spoke several times on the telephone before we met for our third interview at a health clinic near her home. The interview took place in the privacy of my car in the parking lot at the health clinic. After the interview, we went to McDonald's for breakfast, and I dropped Jane off at her boyfriend's mother's small white house. I hugged Jane and wished her luck, and informed her she could call me if needed.

Kay

When I first met 16-year-old Kay, she was wearing a red sweater blouse and some dark blue pants with black flats. She wore no make-up and her hair was short and curly.

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During the first interview of approximately 40 minutes, Kay was friendly and talkative. Kay resided at home with her mother, grandmother, three older sisters, and a younger brother. Kay's mother was 20 years old when she became pregnant for the first time, is single, and a nurse technician at a hospital.

I arrived at the hospital just prior to Kay's admission. She had a vaginal delivery of a healthy baby girl within 2 hours of being admitted. Her mother attended the delivery.

When I arrived at the hospital for the second interview, 1 day after delivery, Kay was kissing her boyfriend who was leaving shortly. During the interview of approximately 1 hour, Kay was talkative. We spoke on the telephone three times before meeting at Kay's house for the third interview. The interview took place in the privacy of her mother's small, clean kitchen. However, the house was quite hot because Kay said her mother does not like to run the window air conditioner during the day. During the interview which lasted approximately 1 hour, Kay was talkative and strayed from the topic. Our discussion ended abruptly when we heard several gunshots close by (two doors next to Kay's). The police arrived within minutes, and I hugged Kay goodbye and departed.

Experience of Becoming Pregnant

Factors evolved from the interviews which relate to the experience of becoming pregnant. These factors are sex

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education; lifestyle; relationships with family, father of the baby, friends, and teachers; and self feelings.

Factors Related to Becoming Pregnant

Sex Education. The findings have shown some of the problems identified by the adolescents concerning their sex education. Only one subject, Bea, said she had not received any sex education in school. Hattie, Abby, and Gigi felt that sex education did not have an impact on their becoming pregnant. As Hattie said, "You hear about sex everywhere. Even on television they are telling you about sex and say no to sex. I don't think it would have no impact on me."

Several subjects (Ingrid, Jane, Kay, and Hattie) reported that their sex education was included in classes such as physical education and biology; however, they described the courses as too short or too difficult. As Carol stated, "They showed us films on babies and they teached us some about sex, but nobody could understand what they was talking about."

The timing of the sex education courses appeared to be a critical issue with all but three of the subjects. Carol and Gigi said they were too young, while Ingrid said she was in the last months of pregnancy when she received the course. Additionally, when the material was presented to them, they had other thoughts and were not attentive. Dee said, "They were showing us a film about all different things about sex and talking about I can get AIDS and disease and stuff. And how to stop that and what to use and stuff. I didn't think about it. It really wasn't on my

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mind." Kay said, "I wasn't worried about it. I was a basketball freak."

Communicating with family and friends did not seem effective for the subjects. Essentially, they thought their friends did not know any more than they did. According to Ingrid, "They hardly didn't know anything themselves. The things that they say is just the things they hear." Four of the subjects (Abby, Gigi, Hattie, and Ingrid) had discussed sex education with their mother. Nevertheless, communication did not seem to be ongoing. As Ingrid said, "We had a talk 2 years ago. We had a little mother-daughter talk."

Lifestyle. The results showed that the subjects enjoyed shopping, parties, dancing, movies, skating, sports, and activities outside the home, particularly with friends. Three subjects reported they did not go out frequently; only one subject admitted to going out drinking wine, while all others denied using drugs.

All subjects, except Eve and Gigi, said they were in school last year. Gigi gave a dramatic picture of her lifestyle last year. She said, "I was just mainly moving around. I was running away from home and stuff like that."

Relationship With Family. The subjects were either close to their family, or they did not communicate; there appeared to be no middle ground. Abby and Carol said their mother was like a sister. Abby said this about her mother, "But mostly we are like sisters. She's my best friend. I talk to her about anything. She don't like some of the

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things but she'd rather me tell her, come to her, than go to somebody else."

Gigi had a troubled family relationship. She said:

> My mama was the type of person who always felt like she was going to be a teenager for the rest of her life. She was going to be young for the rest of her life. No matter what trials she had to face, or something like that. Because we didn't have too much of a relationship, because we was already on bad terms then, she wanted to turn me, she wanted to put me in, you know, a girl's home. Because she didn't want to be bothered with me. Because she was going to have to stop what she do, and take on her own responsibilities. And she didn't want to do that.

When asked about her family, Dee said, "You know, we have bad times. You always have bad times, and you know, in your family and stuff." None of the subjects talked about their relationship with their father.

All subjects reported that they were closer with their family once they had the baby. Dee said, "Now you know we're fine. We talk on the phone every day. We have a good relationship." Gigi continued to be alienated from most of her family, except her grandfather, with whom she now resides.

<u>Relationship With Father of the Baby</u>. Prior to the pregnancy, all subjects except Gigi described their relationship with the father of their baby as "being close and alright." Gigi reported that she did not know who her baby's father was. She said:

> To tell you the truth, I'm ashamed for this baby because when you don't know who your own baby's daddy is, and you didn't have to do it but you did it anyway. And you can't say who made this with you. You can't take them all and make them take no blood test. People will think you crazy. But the one that I thought it was for, and the one who it looks like, I told him.

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> Which I figured it was who it was for. He told me it wasn't him. I just left it like that. I told him, "You got a lot of babies in the world but it's not the same because you got one on the way." But, he understood that. It's alright with me. At the time when this was happening, I had thought he was older. He stayed across the street from my grandparents so that's how it happened.

Carol, Bea, Jane, Hattie, and Kay continue to have a relationship with their baby's father. The other subjects did not continue their relationship, although Dee said she is still friends with her baby's father.

Abby summed up her relationship with her baby's father, "He was the sweetest. Always bought me things and we always went out to dinner. And now it's a totally different story. It's like another chapter." Carol reported, "When I first met him, he tried to make an impression on me. He was telling me that he stayed by himself and that he had all this and that. And when I found out the truth, and he didn't have all that stuff, so it's hard for me to trust him now." Jane described her relationship with the baby's father by saying, "We wasn't having no problems. Whatever I asked him to do he would do." Kay stated that she and her baby's father argued a lot. Furthermore, she said, "I told him if he didn't get a job, I don't want to talk to him."

Relationships With Friends. Friends were an essential component in the lives of the subjects. Some subjects preferred male friends. Abby said, "My mama always stressed that the less girlfriends you have, there's the less trouble you'll be in." Dee commented that, "Yea, I got friends, you know. I ain't going to call them no friends, because

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friends, you know, you don't want too many friends. Because they turn on you and talk about you and stuff. But I have, you know, people that I talk to and get along with."

Gigi said:

> But if I wanted to have friends, I would prefer to have boys. A lot of boys was my friends. Because with boys, not only do you stay out of a lot of trouble, sometimes, but you like can learn what the male population is and you could see how a boy feels. And it's how these girls, how they miscarry themselves and stuff. And just like they say, when you lose respect for a boy, you lose a respect for, not for yourself, but you lose respect. Because it's better for boys not to disrespect you. It's better for you.

Moreover, Gigi tends to fight with girls. She said:

> I don't know. Girls didn't get along with me. They say it used to be something I did but I never understood why they always wanted to fight me. Because I used to find myself in unnecessary fights, you know. Just unnecessary. But, mainly I think it was to see if you could fight or not. Mainly, if you can beat me, you can fight, I guess. I really don't know what it's all about but I used to wind up fighting.

Jane and Kay also had fights with other girls. As Kay said, "You don't need friends. Not where we stay in a black neighborhood, you don't need friends." In contrast, Hattie and Ingrid had more girl friends, while Carol said she never had too many friends because she was not comfortable around too many people.

Relationship To Teachers. Several of the subjects had at least one teacher in whom they confided. Abby said, "We talked to her about anything. She's real religious. So we talked to her and we were real close to her, all of us." Dee talked about a special teacher and said, "I had a teacher at school. We just go up to the library, like if I was passing some of my grades. If I was failing, if I was

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falling down on some of my grades, she would get my books for me and we would go to the library and we would study."

Ingrid talked about her English teacher last year. Additionally, Jane said this about her Language Arts teacher, "If I had any problems I would just go sit down and talk to her. When they cut my hair, I went and sat down and talked to her the day after. But I told her I wasn't going to be coming back to their school the next semester. I switched schools."

Carol, Dee, and Hattie said their teachers were nice, but their relationship was one of teacher-student. Three of the subjects, Eve, Gigi, and Kay, had conflicting relationships with their teachers. Gigi said, "I don't ever get close to the teachers." Eve declared that she would fuss with the teachers, while Kay said teachers would make comments about her coming to class tardy and "they would holler at me, and I'd get mad."

<u>Self-Feelings</u>. When asked about how they were feeling about themselves before becoming pregnant, the subjects initially answered, "fine." Abby described herself as a typical teenage girl. She said, "I was young, free. I'd be graduating, no worries."

Carol said she liked herself. When asked what she liked about herself, Carol responded, "One thing that I like was that I wouldn't get in trouble a lot. I never did. Didn't like being around the wrong people. I don't like being around loud people." Dee described herself as one who would get mad. She said, "Sometimes I like to have my way.

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And when I don't get my way, I get mad and catch an attitude. Other people tell me and I know I have an attitude because I get mad and saying stuff."

Gigi described herself as being a sad and depressed person. Gigi elaborated on these feelings and said:

> I felt sometimes low and sometimes bad, because what my grandmother was telling me and stuff I thought, if she feels this way about me, how do other people feel about me. So anyway, I started taking things out on myself because I thought that this was my fault, that all of the things going on. And I was feeling bad sometimes. Sometimes I used to lay down and sometimes say I wish I were dead.

Additionally, she was able to vividly describe her emotions. Gigi reported, "I felt depressed most of the time, because you feel that people don't love you no more. It was like nobody loved me." Pain was evident when she said:

> Why did she (Mama) have me if she didn't want me, you know. Because she had an opportunity to have an abortion. That when abortion wasn't illegal, you know. And if she didn't really want this child and she wasn't going to take on the responsibility, why would you bring a child into the world when you know you not going to do for it. You know what I'm saying? But mainly it was depression and stuff like that. Because it wasn't like I was getting her attention that I should have been getting from my mama, and them, and my grandmother wasn't around. And I was going from place to place staying with this one and that one and the other one. And you know, it's 'cause my mama, she couldn't, she never had a stable house or nothin' like that. She had it one time but when she got a house, it turned where she never stayed at home. She never stayed in the house. I used to stay at my cousin's most of the time. When I was home by myself I used to clean up the house and do a lot of little stuff and cooking and cleaning and go to the store. When my mama had money, I used to make groceries and stuff and put it in the house like it was my house. That's how I managed the house. That's mainly what it was because I was alone by myself. Mainly that's what I was.

When asked what it felt like to be in the streets, Gigi said it was very scary. She described it this way:

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> Nothing I want to go through. I was like, when you ain't got no food to eat and you don't know where you are going to sleep at, it's hard. It's scary too because when you're on the streets and stuff you don't know what's going to happen next, and hope that nobody don't mess with you and nothing like that. Especially when you walk up the street by yourself in the morning time, they look at you like you're crazy. What are you doing out here at this time of morning?

The other subjects did not really describe their feelings or emotions. Instead they described things or objects as being correlates of happiness. Bea, Flo, Eve, and Hattie said they were happy because they were doing things. Ingrid liked making good grades in school. Jane said that she was happy because she could accomplish what she wanted, such as having a job and being able to buy her own things. Kay said she was proud of herself. In her words, "I was fine. And everybody used to say I was fine. I used to talk to any boy I wanted, you know." She further elaborated, "I thought I was it. Mama and them used to give me anything I wanted. Especially my grandmother. I used to get all the name brands and all of that, you know. I thought I was it."

Identification of the Phenomena of Becoming Pregnant

The three categories of themes emerged from the interviews. These categories were unthinking, blaming, and mistake.

Unthinking

All subjects used the category of unthinking in their responses. Unthinking is described as not focusing on the occurrence of pregnancy at the time of conception. Unthinking was expressed by phrases such as "the pregnancy

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caught me," and "it just happened," and "I wasn't thinking." Abby verbalized unthinking in the following statements:

> I didn't want a baby at the time but it was, how could you say, caught up and I didn't really think about it. I didn't think about it. Okay, well pregnancy hit me right afterwards. Before then pregnancy was the furtherest thing from my head and a lot of people say that's when it happens to you, when you least expect it.

Unthinking was expressed by Dee in the following way:

> I didn't think I was going to be pregnant. I know the responsibility of having sex and getting pregnant at the time. My girlfriend and some people they say, "You going to get pregnant." And I wasn't using protection or nothing like that and I wind up and I got pregnant. I had other friends pregnant. I see what they did and what they went through and what they going through and all the responsibility they have to do. Take care of their baby and that kind of stuff. At the time I say I don't want no baby, but I wasn't thinking about it.

Unthinking was expressed by the other subjects. Bea stated, "I never thought I'd be pregnant, really." According to Carol, "people say that if I didn't use no protection or not and I like babies. So a lot of people say that I got pregnant on purpose but I didn't. I just wasn't thinking at that time." Eve reported that she ". . . wasn't thinking the right way."

Unthinking was evident when Flow said:

> At the time when I was doing intercourse, I wasn't thinking about pregnancy at all. But afterwards, I was like, you know, what happened? What's going to happen? But during I wasn't thinking about that.

Gigi recalled that, ". . . a baby never really crossed my mind." Hattie stated that she, ". . . wasn't planning to get pregnant . . it just happened."

Ingrid had the following thoughts about the occurrence of pregnancy: "Yes, I knew I could get pregnant. But at

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that time I wasn't thinking about it." She further went on to state, "I guess because I wasn't thinking at the time when I was talking to him, I was so crazy about him, I wasn't thinking. I didn't have my head on straight at the time."

The category of unthinking was also expressed by Kay in the following statement: "I know I could get pregnant, but I just didn't think about it at the time. I never thought I would. I never had before and it was the same person, you know."

Blaming

In the category of blaming, the subject would blame persons or events for the occurrence of pregnancy. Seven of the 11 subjects used blaming to describe the occurrence of pregnancy.

One source of blaming was to name the father of the baby as being responsible for the pregnancy. Abby simply said, "he made me be a mama." Carol commented that, "he got me pregnant on purpose, he told me . . .. That was his way of keeping me." Bea reported: "I asked my boyfriend what he was using for protection and he told me he was." According to Gigi:

> It's not like I wanted to get pregnant because I didn't. In a way when you think you are going to trust the boy. When I used to do it I used to tell them take it out before you shoot off up in me. Don't shoot off in me, take it out. But I found out that they wasn't taking it out of me, they was letting it go ahead on . . ..

Hattie reported that, "he was ready to have a baby. I wanted to wait until I finished college."

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Blaming was also used in avoidance of using birth control. According to Abby, "I made appointments and never went, too lazy to go . . . .. I didn't want to get pregnant. I was just lazy. If you have been to Family Planning you would see. It's kind of like coming here to the clinics, very structured . . . .." Kay told me, "I was supposed to go get my pills right before I got pregnant and it happened. I had got pregnant. My sister was going to take me."

<u>Mistake</u>

That the pregnancy was a mistake is the third category identified by Dee, Flo, Ingrid, and Gigi. Flo simply stated, "it was a mistake." Dee expressed a mistake in the following statement:

> To me, I thought it was a mistake. But you know, nothing is a mistake you know, if you have stuff out there and you don't use it, it's a possibility that you're going to get pregnant.

The next two statements also reflect the mistake which resulted in pregnancy. Gigi stated:

> . . . we all make mistakes. I mean, I'm not the first teenager to make a mistake. It's not like I'm the first 15-year-old that has a baby at a young age. Cause it's happening every day. Every single day it's going on. It's not like I'm the first and I'm the last. We all know this. They have a lot us 15-year-olds . . . .. But mainly, hard as you try, you feel like, man, I just wish they'd leave me alone. I know I done made a mistake, but you ain't got to keep throwing it in my face. I know what I just done, I'm not stupid.

Ingrid commented:

> I really got tired of it. Everybody would say, you're so quiet, and you're so smart. And I got tired of it. They don't, just because you're smart it don't mean anything. Everybody can make mistakes.

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The major theme that emerged from the data is the inevitability that pregnancy would occur. The theme of inevitability was identified a total of 83 times. The categories of unthinking, blaming, and mistake occurred 56, 17, and 10 times, respectfully.

Summary

Inevitability that pregnancy would occur was the dominant theme that emerged from the perceptions of black adolescents about the phenomena in their life at the time of conception. Categories contributing to inevitability were unthinking, blaming, and mistake.

A summary of factors thought to influence adolescent pregnancy was presented. Sex education was primarily evidenced by unthinking. For example, Dee said, "It [sex education] really wasn't on my mind." Most of the subjects were in school. Furthermore, they enjoyed activities away from home. The subjects were either close as a family, or they did not communicate. Prior to the pregnancy, all subjects but one considered their relationship with the father of the baby to be close. Friends were an integral part of the subjects' lives. Also, subjects reported they felt "fine" about themselves. Nevertheless, they described things or objects as correlates of happiness.

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CHAPTER V

Conclusions, Discussion, Implications, and Recommendations

Discussed in this chapter is the significance of the findings compared to previous literature. Additionally, implications for nursing practice and recommendations for research are presented.

Conclusions

Based upon the fact that the subjects were unthinking, blaming, and making a mistake, an interpretation of the findings suggest that the primary phenomenon in the lives of the adolescents at the time of conception is the inevitability that pregnancy will occur. Inevitability of pregnancy was evident in two ways. First, there were statements from subjects such as when Eve said, "every girl gonna get pregnant." Second, the subjects were aware of birth control and did not elect to use preventive measures during sexual activity. Therefore, pregnancy is inevitable for the sexually active adolescent who does not use pregnancy prevention.

Pregnancy is inevitable when the subject is engaging in sexual intercourse without thinking about the occurrence of pregnancy during that time and, therefore, not using proper protection to prevent pregnancy. With blaming, the

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adolescent allows external forces to be a factor in the inevitability that a pregnancy will happen. For these seven subjects, the external forces were the partner, a sister, or family planning clinics. With mistakes, the improper use or lack of use of birth control at the time of intercourse inevitably leads to pregnancy.

The findings suggest that sex education did not have an impact on the adolescents' sexual behavior. Furthermore, family, friends, and teachers did not influence sexual activity of the subjects. The findings also suggest there is not a relationship between attending church and becoming pregnant.

Discussion

As the instrument for this study, the investigator was challenged by the process of natural inquiry. The investigator had initially begun the study because of preconceived ideas about the occurrence of pregnancy for adolescents. The investigator thought stressors occurring in nonpregnant adolescents could be identified by the adolescents. Examples of stressors included peer pressure (Dash, 1989; Dunn, 1987), welfare money (Dunn), loneliness, and low self-esteem (Tauer, 1983). Furthermore, if stressors could be identified, then pregnancy prevention interventions could be developed to prevent adolescent pregnancy.

Therefore, an important component of discovering the adolescents' perceptions about their lives at the time of pregnancy was to develop primary prevention interventions

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based upon Neuman's Systems Model (1989). Primary prevention is to identify stressors occurring in nonpregnant adolescents and to intervene prior to prevent pregnancy or sexually transmitted diseases. Stressors, according to Neuman (1989), are tension-producing stimuli which may cause disequilibrium. This study proposed to identify stressors as perceived by adolescents at the time of conception. However, based upon the inevitability of pregnancy, no stressors as perceived by the adolescents were identified at the time of conception. Therefore, the identification of stressors from Neuman's Systems Model was not found to be useful for pregnancy prevention.

Another challenge for the investigator concerned the interview process. The interview process proved to be a unique experience for the subjects and investigator. As Flo said following her second interview, "this [interview] has made me think about things I haven't thought of before." Furthermore, the investigator believes the subjects were honest and helpful in responding to the questions. Their affect which reflected joy, pain, frustration, anger, and fear illustrated their attempt to speak thoughtfully and honestly. Additionally, during the interview process, the subjects and investigator were able to illuminate the time in which the experience occurred.

An assessment of the interview process revealed the value of conducting more than one interview with each subject. For example, typical responses in the first interviews were "yea," "alright," "fine," and "uh huh."

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However, the subjects were talkative and articulate during the two interviews following delivery. The attendance of the investigator at each delivery facilitated the subsequent interviews.

The data from the last two interviews were more informative than in the interviews prior to delivery. An example is Gigi's response during the first interview to a question about the father of her baby. She said, "he's not around." However, during the second interview, Gigi elaborated in detail how she felt ashamed for her baby because she did not know who the father was. The responses from the second and third interviews were similar, except the third interviews included clarification from the first two interviews.

A third challenge by the investigator concerned feelings and emotions which emerged during interactions with the subjects and their families. The investigator felt concern and love for the young girls who shared an emotional life experience of conception and birth.

The most difficult time shared with the adolescents was during their labor and delivery. The investigator could assist the subjects to breathe during contractions or to apply sacral pressure. However, when Abby felt her operation because of an ineffective epidural anesthesia, the investigator cried and experienced pain in her chest.

Another highlight occurred at the time of the third interview. Some of the subjects were hopeful and planned to continue their lives as before. Other situations, such as

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Bea's, were not so hopeful because of the turmoil in her family brought on by alcohol and substance abuse.

Sex education was an example of how nurses may implement pregnancy prevention at the primary prevention level. However, despite the multitude of sex education curricula that claim to reduce teenage pregnancy, the incidence of teenage pregnancy remains high (Barret & Robinson, 1986; Delatte, Orgegon, & Priest, 1985; Stout & Rivera, 1989). Some problems with sex education, identified in the literature, concerns the quantity and quality of sex education received (Marsiglio & Mott, 1986); the lack of support for teachers of sex education courses (Trudell, 1988); and that neither pregnancy nor contraceptive education has exerted any significant effect on the risk of pregnancy among sexually active adolescents (Dawson, 1986). Additionally, researchers report that there is a universal knowledge of methods to prevent pregnancy (Phoenix, 1989; Ryan & Sweeney, 1980). The findings suggest that the subjects were aware of methods to prevent pregnancy and that sex education courses were insignificant in meeting the needs of the population in this study.

Some researchers suggest religion may increase the likelihood of responsible sexual behaviors (Forste & Heaton, 1988). However, the findings of this study suggest there is no relationship between church attendance and pregnancy.

Limited research exists on lifestyles of adolescents who become pregnant. However, the findings suggest that most of the subjects enjoy activities away from home.

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Herr (1988) conducted a study similar to this investigation to describe and understand the phenomenon of teenage pregnancy. The investigator concluded that the teenagers expected to derive benefits from the pregnancy. The anticipated benefits included a re-negotiation of their relationships with significant others, primarily their parents and male partners. However, the findings of this study suggest that most of the subjects were not anticipating a re-negotiation with their families or partners. Most of the adolescents described being close to their families. Furthermore, none of the subjects identified the need for a relationship with the father of their baby as a factor contributing to their pregnancy.

Implications for Practice

Nursing and other disciplines must continue to respond in greater numbers to the needs of adolescents at all levels of prevention. The findings suggest that sex education had no impact on the adolescents' sexual behavior. Therefore, it is even more imperative to target adolescents through screening clinics and sex education programs. The quantity and quality of sex education curricula must be improved, and support for programs must be provided by parents, communities, government, and society. The value of primary prevention cannot be overlooked; however, the inevitability of pregnancy for black adolescents needs to be realized. The concept of inevitability can only be viewed as challenging for nurses.

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Because of the inevitability of pregnancy among black adolescents, emphasis on healthy outcomes for adolescent mothers and babies is indicated. Although the adolescents purposefully selected for this study had healthy outcomes, risk factors associated with black adolescent pregnancies are identified in the literature (Apte, 1987; Olds et al., 1988; Smith, 1990; Zuckerman et al., 1987). Barriers to care, which often exist, can be overcome by providing opportunities for access to quality supportive care within the community in which the black adolescent resides. Nurses are especially qualified to offer humanistic, quality care to include all levels of prevention. Furthermore, nurses can no longer ignore the special needs and concerns regarding the sexuality issues facing black adolescents.

Recommendations

Based upon the results of this study, the following recommendations are offered:

1. Replicate this study as close as possible with a Black female interviewer.

2. Use grounded theory methodology to develop a theoretical basis for the meaning of pregnancy for Black adolescents.

3. Promote individual counseling for disseminating sex education knowledge to promote prevention at an individual level.

4. Because the findings suggest the inevitability of pregnancy, there should be an increased focus on providing health care at the levels of prevention, with a particular

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interest on healthy mothers and babies. Nurse practitioners can be especially beneficial in the coordination and outcome evlauation for recommendations 3 and 4.

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Appendix A

Script for Prospective Participants

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Script for Prospective Participants

Hello, I am Margaret Tennyson, a registered nurse and a doctoral student at the University of Alabama School of Nursing, The University of Alabama at Birmingham. I am conducting a research study about pregnant teenagers to help nurses better care for teenagers who are pregnant. Because you are at least 37 weeks pregnant and are a teenager pregnant for the first time, you are invited to participate in the study. The answers to some of the questions you might have are:

1. What is the purpose of the study?

The purpose of this study is to help nurses and other health professionals better understand teenage pregnancy as you, the teenager, can describe it.

2. What will be required of me?

You will be asked to participate in three interviews. One will be now. The second interview will be after you have your baby, while you are still in the hospital. The third interview will take place 3 to 4 weeks after you have your baby. Each interview will take from 30 minutes up to as long as 2 hours.

A second requirement will be that I be with you when you are at the hospital to have your baby. I can help you at this time because I have been taking care of women when they are having their babies for a long time.

3. What can I get from doing the study?

You may get some satisfaction from knowing that the information you give will help nurses and other health professionals who work with teenagers concerning sexuality and pregnancy issues. You may also receive some benefits from discussing your experience. If you like, you will be given some information about the findings of the study. Moreover, if you complete the three interviews, you will receive $20.

4. What do I do now?

If you are interested in participating in this study, you can sign a consent form and have the first interview just before you go home.

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Appendix B

Script for Parent/Legal Guardian of Prospective Participants

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Script for Parent/Legal Guardian of
Prospective Participants

Hello, I am Margaret Tennyson, a registered nurse and a doctoral student at The University of Alabama School of Nursing, The University of Alabama at Birmingham. I am conducting a research study about pregnant teenagers to help nurses better care for teenagers who are pregnant. Because your daughter is at least 37 weeks pregnant and a teenager pregnant for the first time, she is invited to participate in the study. The answers to some of the questions you might have are:

1. What is the purpose of the study?

The purpose of this study is to help nurses and other health professionals better understand teenager pregnancy as the teenager can describe it.

2. What will be required of my daughter?

Your daughter will be asked to participate in three interviews. One interview will be now and the second interview will be after she has her baby, while she is still in the hospital. The third interview will take place 3 to 4 weeks after the baby is born. Each interview will take from 30 minutes up to as long as 2 hours.

A second requirement will be that I be with your daughter when she is at the hospital to have her baby. I can help your daughter at this time because I have been taking care of women when they are having their babies for a long time.

3. What can your daughter get from doing the study?

Your daughter may get some satisfaction from knowing that the information she gives will help nurses and other health professionals who work with teenagers concerning sexuality and pregnancy issues. She may also receive some benefits from discussing her experience. If you like, you will be given some information about the findings of the study. Moreover, if your daughter completes the three interviews, she will receive $20.

4. What do I do now?

If your daughter is interested in participating in this study, you can sign a consent form and she will have the first interview just before she goes home.

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Appendix C

Consent Form

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Consent Form

Title of Study

Becoming Pregnant: Perceptions of Black Adolescents

Investigator

Margaret Tennyson, RN, MN

Objectives

By signing this form, I am agreeing to participate in the research project named above which is being conducted by Margaret Tennyson. The purpose of the research is to help nurses better care for teenagers like me who are pregnant.

Patient Inclusion Criteria

I am being asked to participate in this study because I speak English; I am between 14 and 18 years old; I am black; this is my first pregnancy; and I am at least 8 months pregnant.

Patient Exclusion Criteria

I understand that I do not have to participate in this study and that my refusal will in no way jeopardize any care or treatment I may need. I also know that I can withdraw from the study at any time, refuse to answer any questions, and have any further questions about the study answered.

Procedures

I understand that any information collected from me will be kept confidential and will not be used in any way that can identify me. However, I realize that because Mrs. Tennyson works with other health professionals who are also responsible for my care, she may communicate with them about me. She has assured me that virtually anything I tell her is confidential, but that it may be necessary to disclose some information about me to my other caregivers for my safety and well-being. She has promised that she will disclose nothing without discussing it with me first. Overall, I know that what happens between Mrs. Tennyson and me will not be communicated to anyone other than my caregivers in any way that will reveal my identity.

I will be followed by Mrs. Tennyson late in my pregnancy and for several weeks after my delivery. I will be formally interviewed three times: once during my pregnancy, once within 2 days of my delivery, and once 3 to 4 weeks after my delivery. These interviews will be audiotaped. I know that

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I can review the audiotapes. Audiotapes of our discussion will be destroyed after they are transcribed further, to protect my anonymity and the confidential nature of this study. Mrs. Tennyson will try to be with me during the birth of my baby.

Risks

I understand that I will not be exposed to any risks, beyond those of discussing my personal life with someone else, as a result of participating in this study.

Alternatives

The alternative is that I may choose not to participate in the study.

Benefits

I understand that by participating in the study, I may not receive any benefits whatsoever.

Financial Disclaimer

Participation in this study will not result in any extra charges above and beyond those routinely incurred by patients with similar illnesses. The costs of unforeseen complications must be met by me. I know that I will be paid the sum of $20 when I complete my third interview with Ms. Tennyson, 4 to 6 weeks after I have my baby.

Assurance of Right to Privacy

I am being asked to allow Mrs. Tennyson to use the information she collects from me to be used for research purposes, which may include publication or presentation at conferences. However, my privacy will be protected, and my name will not be used in any manner whatsoever.

Assurance That Questions Have Been Answered

All my questions concerning this study have been answered. I understand that I have the right to be provided with answers to questions which may arise during the course of this study. If I have questions about patients' rights or other concerns, I can call Dr. Perry G. Rigby, Chancellor, at ___-____.

Copy of Consent Form Given to the Subject

I understand that I will receive a copy of this consent form. A summary of the results of the study may be obtained upon request.

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Additional Information

I further understand that the nature of the study may require further contact of me for future studies. I agree to allow Mrs. Tennyson to contact me for participation in a follow-up study. I also know that I may refuse to participate in future studies.

______________________________ ____________
Signature Date

______________________________ ____________
Mrs. Tennyson's Signature Date

______________________________ ____________
Witness Date

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Appendix D

Parental Consent Form

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Parental Consent Form

(Parents or legal guardian must sign if your daughter is currently under 18 years of age).

Title of Study

Becoming Pregnant: Perceptions of Black Adolescents

Investigator

Margaret Tennyson, RN, MN

Objectives

By signing this form, I am agreeing to allow my daughter to participate in the research project named above which is being conducted by Margaret Tennyson. The purpose of the research is to help nurses better care for teenagers like my daughter who are pregnant.

Patient Inclusion Criteria

My daughter is being asked to participate in this study because she speaks English, is between 14 and 18 years of age, is black, this is her first pregnancy, and she is at least 8 months pregnant.

Patient Exclusion Criteria

I understand that my daughter does not have to participate in this study and that her refusal will in no way jeopardize any care or treatment she may need. I also know that she can withdraw from the study at any time, refuse to answer any questions, and have any further questions about the study answered.

Procedures

I understand that any information collected form my daughter will be kept confidential and will not be used in any way that can identify her. However, I realize that because Mrs. Tennyson works with other health professionals who are also responsible for my daughter's care, she may communicate with them about my daughter. She has assured me that virtually anything my daughter tells her is confidential, but that it may be necessary to disclose some information about my daughter to her other caregivers for the safety and well-being of my daughter. She has promised that she will disclose nothing without discussing it with me first. Overall, I know that what happens between Mrs. Tennyson and my daughter will not be communicated to anyone other than her caregivers in any way that will reveal her identity.

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My daughter will be followed by Mrs. Tennyson late in her pregnancy and for several weeks after her delivery. My daughter will be formally interviewed three times: once during her pregnancy, once within 2 days of her delivery, and once 3 to 4 weeks after her delivery. These interviews will be audiotaped. Audiotapes of the discussion will be destroyed after they are transcribed to protect my daughter's anonymity and the confidential nature of this study. Further, Mrs. Tennyson will try to be with my daughter during the birth of her baby.

Risks

I understand that my daughter will not be exposed to any risks, beyond those of discussing her personal life with someone else, as a result of participating in this study.

Alternatives

The alternative is that my daughter may choose not to participate in the study.

Benefits

I understand that by participating in the study, my daughter may not receive any benefits whatsoever.

Financial Disclaimer

Participation in this study will not result in any extra charges above and beyond those routinely incurred by patients with similar illnesses. The cost of unforeseen complications must be met by me. I also know that my daughter will be paid the sum of $20 when she has completed three interviews with Mrs. Tennyson, 4 to 6 weeks after she has her baby.

Assurance of Right to Privacy

I am being asked to allow Mrs. Tennyson to use the information she collects from my daughter to be used for research purposes, which may include publication or presentation at conferences. However, my daughter's privacy will be protected and her name will not be used in any manner whatsoever.

Assurance That Questions Have Been Answered

All my questions concerning this study have been answered. I understand that I have the right to be provided with answers to questions which may arise during the course of this study. If I have questions about patients' rights or other concerns, I can call Dr. Perry G. Rigby, Chancellor, at ___-____.

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Copy of Consent Form Given to the Subject

I understand that I will receive a copy of this consent form. A summary of the results of the study may be obtained upon request.

Additional Information

I further understand that the nature of the study may require further contact of my daughter for future studies. I agree to allow Mrs. Tennyson to contact my daughter for participation in a follow-up study. I also know that I may refuse to allow my daughter to participate in future studies.

Parent(s) or Legal Guardian's Signature	Date
Mrs. Tennyson's Signature	Date
Witness	Date

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Appendix E

Child Assent

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Child Assent

Signature, Required if 12 years or older	Age of Subject
Relationship if other than patient	Date
Patient's Name	Witness

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Appendix F

Interview Guide

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Interview Guide

1. Think back to the time before you become pregnant, prior to 2 years ago and tell me about your life at that time.

2. Tell me what was going on in your life around the time you became pregnant (prior to discovering you were pregnant).

3. Describe your relationships with family, close friends, teachers, and the father of your baby at the time you became pregnant. What was school like for you?

4. Tell me about how you were feeling about your life before you became pregnant.

5. What was the response of your family and friends to your pregnancy; baby?

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Appendix G

Demographic Questions

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Demographic Questions

The following demographic questions will be asked at the beginning of the first interview.

1. How old are you now?

2. What is the zip code of the place where you live?

3. What is the highest grade in school that you have completed?

4. What does your parent or legal guardian do for a living?

5. What is the marital status of your mother and father now?

6. How old was your mother when she became pregnant for the first time?

7. How many brothers and sisters do you have?

8. How religious are you?

   A. Strongly
   B. Moderately
   C. Slightly
   D. Not active
   E. Not concerned

9. How often do you worship at church?

   A. Daily
   B. Weekly
   C. Monthly
   D. Several times a year
   E. Yearly
   F. Once every several years

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GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM

Name of Candidate Margaret A. Tennyson

Major Subject Community Mental Health Nursing

Title of Dissertation Becoming Pregnant: Perceptions of Black Adolescents

Dissertation Committee:

_________, Chairman Stephen B. Graves

Director of Graduate Program E. Stullenbarger

Dean, UAB Graduate School Terry L. Hickey

Date ____________

PS-1428

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