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A DESCRIPTIVE STUDY OF FAMILY RELATIONSHIPS, RACE AND ETHNIC ORIGIN, AND SEXUALITY EDUCATION IN PREGNANT ADOLESCENTS

by

JOY MURPHY

A Thesis
Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Science in Nursing
in the Division of Nursing
Mississippi University for Women

COLUMBUS, MISSISSIPPI

AUGUST, 1996

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A Descriptive Study of Family Relationships, Race and Ethnic Origin, and Sexuality Education in Pregnant Adolescents

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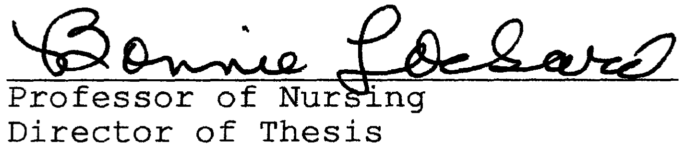
Joy Murphy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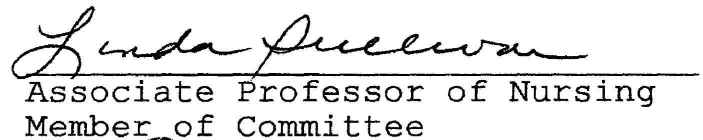
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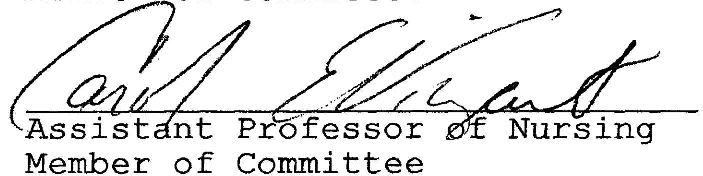
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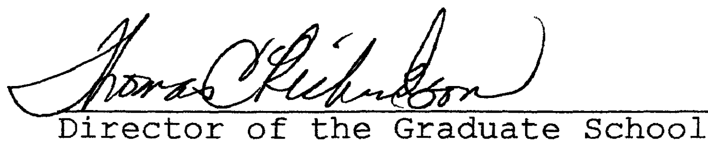
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Abstract

Adolescents are becoming sexually active at increasingly younger ages despite the well-known health risks. The adolescent pregnancy rate in the United States has been considered the highest of any country in the Western world. The purpose of this study was to identify, examine, and describe family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. Pender's Health Promotion Model was used as the theoretical framework to guide this descriptive study. Data were collected from a convenience sample of 30 pregnant adolescents who received prenatal care at three local obstetricians' health care clinics in Northeast Mississippi. Participants were surveyed using the Teenage Pregnancy and Parenting Program Questionnaire. The data were analyzed using descriptive statistics. Data analysis revealed that most of the pregnant adolescents were never married and still lived with their parent(s). Positive relationships were identified with the mother of the pregnant adolescent more often than with the father. Results also revealed that more than half of the pregnant adolescents had received sexuality education prior to becoming pregnant, and

that only 30% utilized some form of contraceptive at the time of conception. Further research is recommended with a larger more diverse sample to also include the male adolescent because they too need to be identified as individuals at increased risk associated with adolescent sexual activity.

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To all the inspiring individuals without whose assistance this research would not have been completion of a long awaited dream. Most importantly I would like to thank God from whom all blessings flow.

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Chapter I

The Research Problem

Adolescence, a normal phase of an individual's life, is a period of adjustment that can result in many positive and negative outcomes on an individual's life. These outcomes are often influenced by relationships between adolescents and their families and particularly mother-daughter relationships.

Erikson identified two important developmental tasks that are crucial as the adolescent faces identity versus role confusion and intimacy versus isolation (Whaley & Wong, 1991). Adolescents are faced with the crisis of identifying with a group to avoid social isolation. Adolescents strive to attain a personal identity as opposed to role confusion. Erikson believed that adolescence should be a time of experimentation as the adolescents try out different roles, identities, personalities, and ways of behaving. Erikson defined intimacy as the capacity to develop an intimate love relationship with another and intimate interpersonal relationships with friends, partners, and significant others. Failure to develop intimacy may lead to feelings of

isolation and loneliness (Whaley & Wong, 1991). Delayed identity development for the adolescent can lead to negative consequences and behaviors such as sexual promiscuity, use of drugs and alcohol, conduct disorders, delinquency, depression, suicide, and adolescent pregnancy.

During this period of adjustment adolescents often encounter stressful events, peer pressure, discover new friendships and relationships with members of the opposite sex. Adolescent pregnancy is a common problem that can further complicate the period of adolescence (Rogers & Lee, 1992).

Establishment of the Problem

The adolescent pregnancy rate in the United States is considered the highest of any country in the Western world. Each year over one million United States adolescents become pregnant by the age of 18, 24% of adolescents have become pregnant at least once. Most adolescent pregnancies are unplanned with less than half (47%) that result in a live birth. Forty percent of adolescent pregnancies are terminated by elective abortion and 13% end in miscarriage. Unplanned pregnancy affects nonwhite adolescents almost twice that of white adolescents (Clinician's Handbook of Preventive Services, 1994).

Adolescents are becoming sexually active at increasingly younger ages. Statistics revealed that in 1982, 19% of unmarried females at age 15 reported sexual activity. By the year 1988, 27% of the fifteen year old females reported sexual activity. The 1990 statistics revealed that 48% of female and 61% of male high school students reported having experienced sexual intercourse. Only about half of adolescents use a contraceptive method during first intercourse. Contraceptive use in adolescents is less effective than in adults because adolescents don't use birth control correctly or consistently (Clinician's Handbook of Preventive Services, 1994).

Adolescent pregnancy is associated with more risks to both mother and baby than adult pregnancy. Two of the factors that contribute to these increased risks include lack of prenatal care and poor nutrition. Adolescents often avoid prenatal care because they are in denial of the pregnancy, they are ignorant of the need for prenatal care, or they are unaware of available services. Poor nutritional status can be associated with late or lack of prenatal care, lower socioeconomic status, and the adolescent's typical eating patterns (McGrew & Shore, 1991).

Adolescent pregnancy is likely to be associated with a higher percentage of premature birthweight infants.

Cephalopelvic disproportion also causes increased risks in girls younger than 15 years of age. These problems associated with adolescent pregnancy often result in poor health and development of infants (McGrew and Shore, 1991). The Center for Population Options estimated the societal costs of adolescent parenthood in 1989 at $21.55 billion (Clinician's Handbook of Preventive Services, 1994).

Pregnancy at any age can generate developmental changes, but in an adolescent it can even create a developmental crisis. Parenting is stressful and adolescent parenting along with other developmental issues can lead to the adolescent's inability to cope with further stress. Compared to other mothers, adolescent mothers lack parenting skills and as a result their children do not progress and develop at optimal levels. Early research defined adolescence as a period of transition from childhood to adulthood, but today it is described simply as a time to renegotiate roles (Rodriquez & Moore, 1995).

Adolescent pregnancy is commonly described as "babies having babies." Factors that contribute to the increased number of adolescent pregnancies or premature sexual decisions made by adolescents include, earlier age of menarche, growing up in a sexually saturated society with less parental supervision, and more peer pressure (Rodriquez

& Moore, 1995).

Research has shown that adolescents have not fully developed their cognitive ability, decision making skills, and a sense of autonomy needed to care for a child. Adolescents also have not developed operational thinking, which according to Piaget is essential for planning for the future. Increased peer pressure and fear of rejection causes adolescents to imitate behaviors and actions of those they perceive as role models, whether they are adults or peers. Adolescents, because of their developmental stage, tend to be more prone than others to emotional outbursts, dramatic mood changes, and acute depression (Rodriquez & Moore, 1995).

The influence of the family relationship plays an important role on the adolescent's sexuality. Furstenberg (1991) found that families which were able to develop and maintain a balance between emotional connectedness and individualization were also able to foster adolescent psychosocial development. Sexual activity in the adolescent can be related to many different factors such as home life, scholastic performance, dating habits and cultural inhibitions. Some of the most common problems identified in parent-child communication concerning sex were embarrassment, lack of knowledge, poorly defined values,

fear of encouraging sexual activity and inability to initiate and maintain a conversation about the subject (Fitzgerald & Fitzgerald, 1987).

Family communication and configuration have an important influence on the adolescent's sexual activity. Communication transmits knowledge, opinions, attitudes and beliefs concerning sexuality. Vance (1985) studied several cases of adolescent pregnancy and discovered that probably the most influential factor related to increased sexual activity in the adolescent was unsatisfactory interpersonal relations with family members. Factors that affect the family configuration, such as living with both biological parents and being reared without fathers, have been indicated as predictors of early sexual intercourse. Adolescent girls reared without fathers were more likely to become sexually active. Increased sexual activity was related to the rapid increase in the number of children being raised without fathers (White & DeBlassie, 1992). The 1990 statistics revealed that 48% of female and 61% of male high school students reported having experienced sexual intercourse.

Appropriate education concerning the consequences of adolescent pregnancy should be a major concern for health care providers. Education should be provided in the homes,

churches, schools, and communities for both adolescents and their parents.

Significance to Nursing

The nurse's role is to provide the best quality care available for the client. Nurses are constantly seeking methods to improve the quality of client care. This study seeks to improve the quality of care given to adolescents by targeting and identifying adolescents who are at increased risk for developing an adolescent pregnancy. It is also important for the nurse practitioner to recognize those adolescents who are at increased risk and provide them with the services that will enable them to avoid unnecessary risks.

Conceptual Framework

Pender's (1987) Health Promotion Model served as the theoretical framework for this study. Pender's model viewed health promotion as behaviors that consist of activities directed toward increasing the level of well being and actualizing the health potential of individuals, families, communities, and society. The goal of the theory is to integrate what is known about health-promoting behavior to achieve optimal health of the individual. According to

Pender, health is seen as a positive high-level state and is viewed from the perspective of medicine, nursing, psychology, and sociology (Marriner-Tomey, 1994). Pender defined health promotion as activities directed toward increasing the level of well being and actualizing the health potential of individuals, families, communities, and society (Pender, 1987).

Pender viewed adolescence as a period in the life span with major developmental significance and a special relevance for health. Adolescence is a period in which individuals experiment with behaviors that can be health-damaging or life-threatening. Anticipatory guidance and peer support for healthy life styles are especially important during this period of development. Pender (1987) noted that positive health behaviors developed during adolescent years are resistant to change and can persist over time. Therefore, adolescents are an important target group for well planned health promotion programs.

Pender's (1987) Health Promotion Model represents interrelationships between cognitive-perceptual factors and modifying factors that may influence the occurrence of health-promoting behaviors. Seven different cognitive-perceptual factors comprise the health promotion model. These factors include: importance of health, perceived

control of health, perceived self-efficacy, definition of health, perceived health status, perceived benefits of health-promoting behaviors, and perceived barriers to health-promoting behaviors.

Pender (1987) noted that individuals who placed a high value on health received results in information seeking behavior and engaged in actions directed toward becoming more knowledgeable on health-related topics. The perceived control of health in individuals appeared to influence their effectiveness for continued practice of health-promoting behaviors. Pender (1987) defined perceived self-efficacy as the individuals' convictions that they can successfully execute the required behavior necessary to produce a desired outcome. Gillis (1994) found that self-efficacy emerged as the strongest predictor of the adolescent's health promoting lifestyle. Adolescents are at an age where they are beginning to assume an increased responsibility for their health and to expect greater mastery of personal and environmental factors that influence health. Adolescents view themselves as being independent, self-reliant, and able to make their own choices rather than relying on others (Gillis, 1994).

Pender (1987) related the definition of health to factors that influence individuals to achieve a high-level

of wellness. An individual's definition of health should primarily reflect self-initiated activities directed toward attaining wellness. Perceived health status was found to be a significant determinant of behavioral intentions for health promotion. Individuals who perceived themselves to be in good health felt physically well and were motivated to increase their personal health status. Pender (1987) found that perception of benefits from health-promoting behaviors appeared to facilitate continued practice and helped strengthen and reinforce beliefs about benefits. Perceived barriers to health promoting behavior should be identified for the individual as well as the family. These barriers may be imagined or real and consist of perceptions concerning the unavailability, inconvenience, or difficulty of a particular health-promoting option (Pender, 1987).

Several modifying factors such as age, gender, education, income, body weight, family patterns of health care behaviors, and expectations of significant others also play important roles in helping to determine health care behaviors. The modifying factors have an indirect influence on behavior while the cognitive-perceptual factors directly influence behavior. Cues to action serve an important function for health promotion. These cues may result from internal or external sources and will depend on the level of

readiness of the individuals or group to engage in health-promoting activity (Marriner-Tomey, 1994).

Several of the cognitive-perceptual and modifying factors of Pender's Health Promotion Model are germane to this research study. The modifying factors of age, gender, education, income, family health care behaviors, and expectations of significant others all greatly influence the adolescent female in her tendency to engage in sexual activity. All of the cognitive perceptual factors to some extent influence the adolescent female and her tendency to engage in sexual activity. The concepts focus directly on the individual's perception of health along with benefits and barriers that affect the degree of health the adolescent is able to achieve (Marriner-Tomey, 1994).

Health promotion involves movement toward a positive state of well being and striving to increase one's state of health. Health promotion is concerned with people, and their quest of health and wellness and can be generalized to all individuals (King, 1994). This research study will seek to identify data on family relationships, race and ethnic origin, and sexuality education in pregnant adolescents.

Assumptions

For the purpose of this study, the assumptions are as follows:

1. Subjects will answer all questions honestly when completing the TAPPS questionnaire.

2. Pregnant adolescents represent a unique population.

3. Adolescence as a period in the life span is of major developmental significance and has special relevance for health.

Purpose of the Study

The purpose of this study is to identify, examine and describe family relationships, race and ethnic origin, and sexuality education in pregnant adolescents.

Statement of the Problem

The problem of this study is to identify and describe factors that are present in pregnant adolescents and to specify the frequency with which these factors exist in pregnant adolescents.

Research Question

What are the family relationships, race and ethnic origin and history of sexuality education of pregnant adolescents?

Definition of Terms

For the purpose of this study, the operational definitions are as follows:

Family relationships: The type of interaction, communication, living arrangements between the adolescent female and the people she lives with (i.e. father, mother, grandmother, sisters, boyfriend) as measured by the Teenage Pregnancy and Parenting Program Questionnaire.

Race and ethnic origin: Race is described as a group of individuals having certain characteristics in common, owing to a common inheritance. Ethnic origin is described beliefs and lifestyles of an individual; characteristics that are common to certain inheritances.

Sexuality education: The level of understanding an individual has concerning the act of sex and the outcomes of engaging in sexual activity as measured by the Teenage Pregnancy and Parenting Program Questionnaire.

Pregnant adolescents: Females ages 12 to 18 who are pregnant, reside in a small southeastern town and seek prenatal care at a physician's office.

Chapter II

Review of the Literature

A review of the literature revealed that the health status of adolescents has declined over the last several years. Adolescents have continued to exhibit many risk-taking behaviors. Adolescent pregnancy, one consequence of risk-taking, has resulted in some of the most far-reaching and long-term social problems in our society today. Record numbers of babies have been born to unmarried mothers over the past decade, most of whom are adolescents. This selected review of the literature focused on the effects of family relationships, race and ethnic origin, and sexuality education in the pregnant adolescent.

Barnett, Papini, and Gbur (1991) conducted a study to detect the differences in demographic characteristics, sexual practices, perceptions of family functioning, and individual developmental factors among sexually active adolescents who were pregnant or were not pregnant. A number of variables in the study were examined which included, demographic data, sexual history, adolescent perceptions of family functioning, and perceived self-

esteem.

The subjects were non-randomly selected from sexually active adolescent females who were attending health clinics and family planning programs in northwest Arkansas. The study consisted of 124 sexually active adolescents aged 13 to 19 (M=17), and 57% of the participants were pregnant at the time of the study. Most of the participants (62.1%) came from disrupted homes where parents were divorced (39.5%), remarried (12.9%), or widowed (9.7%). All of the subjects who participated were Caucasian.

A further investigation of the demographic variables revealed even more significant differences between the pregnant and nonpregnant adolescents. Seventy-two percent of the pregnant adolescents came from disrupted homes. In the total sample of participants 16.9% were high school dropouts with three dropouts (5%) from the nonpregnant participants as opposed to 18 dropouts (28%) from the pregnant participants. Yearly income for the pregnant participant was reported as less than $20,000 for 99% of the participants, whereas only 66% of the nonpregnant participants fell into this category.

Other variables included in the study were sexual history questionnaire which included questions regarding pregnancy status, use of birth control, previous pregnancy

experiences and outcomes, and frequency of sexual activity. The Family Adaptability and Cohesion Evaluation Scale (FACES III) was utilized to measure the adolescents' perceptions of family cohesion, or the degree to which family members felt emotionally connected or separated. The Family Strength Questionnaire was also utilized to measure the adolescents' perceptions of family strengths. The Parent Adolescent Communication Scale (PAC) was utilized to assess adolescent perceptions of the overall quality of communication with parents. Finally, The Adolescent Self-Esteem Scale (ASES) was utilized to assess the adolescents' perception of themselves in regard to self-respect, self worth and self acceptance.

Stepwise logistic regression analysis revealed that adolescent perceptions of family strengths of openness of parent-adolescent communication were significantly related to adolescent pregnancy status. Pregnant adolescents had lower perceptions of family strengths and were more likely than nonpregnant adolescents to see their families as exhibiting less pride and harmony. Results revealed that communication patterns with parents were perceived as being more problematic and closed for the pregnant adolescent when compared to the nonpregnant adolescent. Demographic findings revealed that pregnant adolescents were more likely

than nonpregnant adolescents to be married, live in low-income homes, and come from single parent or no parent families. Birth control surfaced as a significant predictor of whether or not an adolescent was pregnant, and results revealed nonpregnant adolescents were more likely to use some type of birth control than pregnant adolescents.

Barnett et al. (1991) found that pregnant adolescents had lower mean scores (M=33.29) of perceptions of family strengths than did nonpregnant adolescents (M=39.87). Parent-adolescent communication was scored higher in nonpregnant adolescents (M=2.62) than for pregnant adolescents (M=1.22). Pregnant adolescents scored higher on family adaptability (M=27.40) than did nonpregnant adolescents (M=26.82) which indicated that pregnant adolescents perceived their families as flexible. Nonpregnant adolescents scored higher (M=33.01) on perception of families sense of cohesion or togetherness than did the pregnant adolescents (M=28.04).

A lower score on the self-esteem scale indicated higher self-esteem. Results revealed that pregnant adolescents had higher mean scores (M=24.45) as compared to the nonpregnant adolescents (M=28.04).

Barnett et al. (1991) concluded that adolescent pregnancy status was a function of a combination of

demographic and familial variables. The findings revealed several differences between pregnant and nonpregnant adolescents that were capable of predicting adolescent pregnancy. Among these differences were: perceptions of family strength, perceptions of the openness of parent-adolescent communication, adolescent marital status, use of birth control, income level, and family composition.

In a similar study Casper (1990) sought to investigate the effects of family interaction in preventing adolescent pregnancy according to four levels of decision-making as set forth by the National Academy of Sciences (NAS). The four levels set forth included: the initiation of sexual activity; the use of contraceptives once sexually active; the choice, if pregnant, of abortion or adoption; and the well-being of the pregnant adolescent and her baby once a decision has been made to carry to term.

Casper utilized information obtained from the 1982 National Survey of Family Growth (NSFG) which conducted interviews in the homes of 7,969 women. Casper utilized a subset of data on women aged 15 to 19 only (N=1,888). The data set contained a wide variety of topics which included histories of pregnancy, prenatal care and pregnancy outcomes, menarche, sexual experience, contraceptive use, sterility, birth expectations, visits for family planning

services, family background and relationships, and work history.

The sample was comprised of different groups of adolescents because levels of decision making may have been achieved at varying intervals. Each sample contained the population which was considered to be at risk for that particular defined event. The first level of analysis included the whole sample (N=1,888) because every female was considered at risk for becoming sexually active. The second level of analysis focused on the use of contraceptives once the adolescent was sexually active (n=945). The third level of analysis dealt with choosing between alternatives to parenthood and consisted of those adolescents who were once pregnant (n=298). The final analysis focused on the well-being of the adolescent and her baby once a decision had been made to continue the pregnancy to term. This group consisted of those adolescents who had a live birth (n=206).

Two logistic models were performed to evaluate the effectiveness of family interaction on the prevention of early pregnancy and childbearing in adolescents. The models were measured at each level of decision making. The first logistic model measured the effect of family background without regard to family interaction. The second model measured the effect of family background and family

interaction.

Casper (1990) determined that parent-adolescent communication concerning how pregnancy occurred did not relate to the probability of abstinence until the age of 19 years. The researcher did indicate that race, religion, residence, mother's education, age of adolescent and family income were all significantly related to sexual activity during adolescence. Family interaction in the form of communication was found to significantly influence the use of contraceptives ($p<0.001$). Religion and age were found to have an influence on predicting contraceptive use. Adolescents who were found to be living with a parent or parents at the time of conception was significantly related to the probability of choosing adoption over parenthood ($p<0.05$). Race and religion were found to be influencing factors for alternative parenthood choices. No significant relationships were found between family interaction and the probability that an adolescent would have a healthy pregnancy. Age was identified as being related to the fact that an adolescent would receive adequate prenatal care. The older the adolescent the more likely they were to receive adequate prenatal care.

Casper (1990) concluded that family interaction may have had a positive impact in helping to prevent early

adolescent pregnancy and childbearing at certain stages of decision making. Interaction among family members may have been beneficial in assisting the adolescent with alternative methods of parenthood. Family interaction was not however related to the probability that the adolescent would have a healthy pregnancy, or that she would abstain from sexual activity during adolescence. The researcher recommended additional studies to enhance parent-child communication concerning sexual activity, alternatives to early parenthood, and supportive programs involving health promoting practices of adolescents.

Rodriquez and Moore (1995) were interested in determining relationships among the developmental, cognitive, social, and emotional variables in adolescent pregnancy issues. They examined these issues by assessing the perceptions of pregnant adolescents who were currently enrolled in school-based pregnancy and parenting programs. Data were examined to determine if there were any correlations among personal, family, race and ethnicity, and educational background variables and unplanned adolescent pregnancy. While the primary purpose of the study was concerned with intervention and ways to improve current practices for adolescents and their babies, the ultimate goal was prevention.

An anonymous questionnaire was administered to volunteer respondents enrolled in 14 school-based pregnant and parenting adolescent programs. The survey instrument was designed to assess perceptions of pregnant and parenting adolescents. The instrument consisted of 83 items that addressed personal, family, and educational backgrounds as well as peer relations, future plans, and prenatal health.

The sample consisted of 341 pregnant parenting adolescents ages 11 to 19, and of these participants 46% were 16 years of age or younger. Most of the participants were Hispanic, had never been married, and were reared in a one-parent home. The majority were also below grade twelve in school. The majority of the parent(s) of the pregnant and parenting adolescents had less than a high school education: mothers 48% and fathers 52%.

The participants were obtained in a nonrandom manner and the levels of measurement were developed for the collection of data. The Chi-square test was utilized to evaluate any group difference. The significance level was established at $p<.05$.

The study revealed that 35% of the adolescents had initially experienced sexual intercourse before the age of 14 and 60% had experienced sexual intercourse before the age of 14 to 16. The use of contraceptives was also identified

as a risk-taking behavior. Eighty-nine percent of the participants used no form of contraception prior to pregnancy, and 55% of those who were sexually active reported they never thought they would become pregnant. Of the adolescents participating in the study 31% reported they intentionally became pregnant, and 48% reported using alcohol or some form of drugs at the time of conception. Forty-six percent of the adolescents planned to raise their child by themselves, and 50% of them planned to raise it with the father of the baby. Adolescents who participated in the study reported that often conversation about sex came too late. Only 52% reported that their parent(s) had ever talked to them concerning sex.

Rodriquez and Moore (1995) concluded that adolescents perceived a lack of emotional closeness with their parent(s), had a dearth of sex education, and evidenced race and ethnicity differences on key variables. Adolescents from two-parent families were more likely to have positive relationships with their parents and feel good about themselves than those from one-parent families. Black adolescents were more likely to have received sex information from their parents, more likely to feel good about themselves, and more likely to attend religious services than whites or Hispanics. Hispanic adolescents

were more likely to have grown up in two-parent families, and white adolescents were more likely to have divorced parents. Adolescents who had poor communication with their parent(s) or little parental support were more likely to become sexually active.

Rogers and Lee (1992) also conducted a similar study to determine if there was a difference between pregnant and nonpregnant adolescent mother-daughter dyads in their perceptions of their relationship. A predominantly black sample was utilized to test the hypothesis that greater attachment, more intimacy, and stronger feelings of closeness would be perceived by both mothers and daughters where there was not, nor had there ever been, an adolescent pregnancy.

The respondents consisted of unmarried female middle and high school students in grades 7 through 12 and their mothers, and pregnant females enrolled in an in-school program for pregnant adolescents. Participation was anonymous and voluntary for all subjects. A total of 31 mother-daughter dyads for the nonpregnant sample and 21 mother-daughter dyads for the pregnant sample was utilized. Questionnaires designed to measure perceived intimacy, attachment, and strength of feelings of closeness between mother-daughter dyads were distributed at participating

schools. The students were asked to complete their questionnaire at school and to take home the mother's questionnaire along with a stamped preaddressed envelope. A telephone follow-up was also conducted 10 to 14 days later encouraging the nonrespondents to complete their questionnaire.

Demographic results revealed that mothers of pregnant daughters had significantly more children than mothers of the nonpregnant girls ($x2=15.5337$, $p=0.495$). The income for the families in the pregnant adolescent group was significantly lower than the income of the nonpregnant group ($x2=15.978$, $p=.0069$). The grade point average, mothers' marital status, racial composition, mothers' employment status, and mothers' ages were similar for both groups.

A series of _t_ tests were utilized to analyze subgroups of pregnant and nonpregnant adolescents concerning intimacy, attachment, and strength of feeling of closeness scores. These subgroups were: (1) pregnant adolescents compared to nonpregnant adolescents; (2) mothers of pregnant adolescents compared to mothers of nonpregnant adolescents; (3) pregnant adolescents compared to their mothers; and (4) nonpregnant adolescents compared to their mothers. No significant differences were found for intimacy, attachment, and strength of feelings of closeness were identified between

the pregnant and nonpregnant adolescent groups. The scores for attachment and strength of feeling were not significantly different for mothers of the pregnant and nonpregnant adolescents. However, the scores of the mothers of the nonpregnant adolescents perceived intimacy significantly more than did mothers of pregnant adolescents ($p = .0282$). Mothers of nonpregnant adolescents also perceived intimacy more significantly than did their daughters ($p = .0203$). Correlational analysis indicated that intimacy scores of the mothers of the pregnant daughters could predict attachment scores ($r = 0.4765$, $p = .0145$) but that the daughters feelings were not necessarily in harmony with their mothers.

Rogers and Lee (1992) concluded that mothers' perceived intimacy and daughters' attachment in the pregnant group may be reflective of the fact that black families are more supportative of pregnancy and childbearing. These researchers recommended further research concerning adolescent pregnancy and the effects of family relationships to better understand the relationships between families during this stressful period of life.

Records (1993) sought to examine the life events of pregnant and nonpregnant adolescents and how these events compared regarding numbers and types and whether the two

groups had different perceptions of the events. Records (1993) addressed the following five questions to determine the life events: (1) What differences exist in the demographic variables of age, employment, ethnicity, and living arrangements between the two groups? (2) What life events occurred for adolescents in each group during the 12 month period? (3) How many life events occurred for adolescents in each group? (4) What life events, categorized as good and bad, occurred with greatest frequency in each group? (5) Does the perception of total or individual events as good or bad differ between groups?

A retrospective design with a convenience sample was utilized to conduct the study in a southwestern metropolitan high school. The sample was composed of 46 females. There were 23 females in the pregnant group aged 15.3 through 19.2 years (M=17.3, SD=1.1), and 23 females in the nonpregnant group aged 14.5 to 18.9 years (M=17.0, SD=1.6). The pregnant group consisted of 14 (60.9%) Hispanics, 6 (26.1%) Anglos, 2 (8.7%) American Indians, and 1 (4.3%) black. The nonpregnant group consisted of 14 (60.9%) Hispanics, 8 (34.8%) Anglos, and 1 (4.3%) black. Sixteen of the pregnant subjects (69.6%) reported living with parents or other relatives, and 7 (30.4%) reported living with their husbands or boyfriends. All of the nonpregnant subjects reported

living with their parents or other relatives.

Two different instruments were utilized to conduct the study. A demographic questionnaire was obtained which included information regarding age, employment, ethnicity, and living arrangements. The other instrument was the Warrick Life Event Checklist which helped determine which events adolescents had experienced and whether they were perceived as good or bad.

A series of $\underline{t}$ tests were conducted to determine the difference between the pregnant and nonpregnant samples on the demographic variables of age, ethnicity, work status, and living arrangements. Results revealed no statistically significant differences between the groups in terms of age and ethnicity. There was, however, a difference among the subjects in terms of work status and living arrangement. Thirty percent (n=7) of the nonpregnant adolescents were employed on at least a part-time basis, as compared to 4% (n=1) for the pregnant adolescents (p=.02). Results also revealed that 30% (n=7) of the pregnant adolescents reported living with their husband or boyfriend, as compared to 100% of the nonpregnant adolescents who lived with their family of origin (p=.003). The life event that occurred most frequently by the total sample was pregnancy of sister of close friend (56.5%). Other events reported included

arguments between parents, change in parents' financial status, and trouble with brother or sister (50%).

The number of life events reported by the nonpregnant group were 239 or an average of 10.39 events per person. The pregnant group reported a total of 269 life events, or an average of 11.69 events per person. Chi-square analysis revealed that the difference between the two groups was not statistically significant. Regarding the most frequently encountered life events, the pregnant group reported pregnancy of a sister or close friend, moving to a new home, an increased number of arguments between parents, and a change in their parents' financial status. Frequently reported life events for the nonpregnant adolescents included trouble with brother or sister, pregnancy of sister or close friend, increased number of arguments between parents, change in parents' financial status, and celebration of a marriage or religious ceremony. The final question was concerned with the adolescent's perception of events as good or bad. The pregnant sample reported 115 good life events and 154 bad life events. The nonpregnant sample reported 108 good life events and 131 bad life events. No significant difference was found between the two groups.

Records (1993) concluded that loss experienced during

adolescence often precedes pregnancy. Pregnant adolescents were more likely to have experienced a change in schools than nonpregnant adolescents. A greater understanding of factors that affect the life events of adolescents is necessary so that adolescents at risk can be identified and interventions implemented.

Bluestein and Rutledge (1992) conducted a study to establish associations between sociodemographic, clinical, and psychosocial determinants of delayed pregnancy testing among adolescents and to help identify which determinants best predict the duration of delayed testing. The dependent variable was identified as the delay in obtaining a pregnancy test. Independent variables were identified as potential sociodemographic, clinical, and psychosocial predictors. The sociodemographic variables consisted of age, race, education, and the ability to pay for a test. Clinical variables included parity, contraceptive use, menstrual pattern, irregular menses, and number of pregnancy symptoms.

There were 151 pregnant adolescents included in the study with ages which ranged from 14 to 19 years and a mean age of 17.3 years. A total of 123 of the adolescents returned completed surveys to be used for analysis. Sixty four of the adolescents maintained their pregnancies and 59

of them chose abortion. Sixty-one percent of the participants were black, 98% of them were unmarried and 67% were pregnant for the first time. Most of the participants (87%) reported no difficulty in paying for health care services. The participants ranged in level of education completed from the seventh grade to the second year of college with a mean level of eleventh grade.

Two collection sites were utilized for obtaining data, a high school for pregnant adolescents and a pregnancy termination clinic. The participants voluntarily and anonymously completed self-report surveys consisting of a short version of the Center for Epidemiologic Studies-Depression Scale (CES-D), the Family APGAR, and a study-specific questionnaire addressing other sociodemographic, clinical, and attitudinal variables.

Descriptive statistics were utilized to profile the study participants and Pearson correlations were calculated for the study variables to identify associations among the variables. Bluestein and Rutledge (1992) found the mean duration of delay in seeking a pregnancy test was 4.35 weeks. Adolescents were moderately satisfied with the support received from their families (mean Family APGAR score, 6.37). The majority of the adolescents (78.2%) reported they had no trouble talking with their parents. A

moderate degree of emotional distress was reported according to the CES-D score of 15.5. Thirty-nine percent of the adolescents reported they were happy about their pregnancy, and 45% had trouble admitting they were pregnant.

Results revealed a significant correlation between delayed pregnancy testing and young maternal age, black race, lower educational attainment, lack of pregnancy symptoms, continuing the pregnancy, and difficulty acknowledging the pregnancy. Bluestein and Rutledge (1992) also found difficulty acknowledging the pregnancy as being associated with depressive symptoms ($P<.01$), problems talking with partners ($P<.05$), and negative initial reaction to the pregnancy ($P<.01$). Depressive symptoms were also associated with dissatisfaction with family support ($P<.01$) and difficulties in communicating with partners ($P<.001$).

Bluestein and Rutledge (1992) found psychological barriers to be the most common determinant of delayed pregnancy testing among adolescents. Adolescents may often lack emotional readiness to volunteer information about a possible pregnancy. Health care providers can provide needed support and anticipatory guidance for adolescents who face difficult choices concerning adolescent pregnancy.

In another study Thompson, Powell, Patterson, and Ellerbee (1995) utilized quantitative and qualitative

methods to conduct a study to describe the nature of the mothers' pregnancies and parenting experiences and the children's health and development over time. A previous study conducted ten years before had utilized 98 mothers and infants who attended the Teen Obstetrical Perinatal and Parenting Service (TOPPPS). The current study attempted to locate participants from the original sample. Difficulties were encountered locating the original participants which resulted in only 19 participants for the current study. The mothers included in the study were from the urban area near the TOPPS clinic and ages ranged from 17 to 23 years. The children who participated in the study were ages two to five years. Sixty-eight percent of the mothers were black, 32% were white, and 57.8% were unmarried.

Mothers were recruited by telephone contact and all that were contacted agreed to participate. The data were collected in the participants' homes and each participant received a $10.00 cash compensation. Interview schedules, the Developmental Profile II (DPII), and the Adult Adolescent Parenting Inventory (APPI) were utilized for the study. Interviews were used for mothers to describe initial and subsequent pregnancies, school status, reasons for following prenatal advice, family support, being a mother, what they would have done differently, advice they would

offer other adolescents, their children's health care, nutrition, and development, and methods of discipline used. The DPII was utilized to measure each child's development in five areas: physical, self-help, social, academic, and communication. The AAPI was utilized to measure parenting attitudes on four constructs: inappropriate expectations, lack of empathy, belief in corporal punishment, and reversing parent-child family roles.

Descriptive statistics were utilized to calculate results. Two researchers also conducted content analysis of narrative data using constant comparison techniques and identified trends through inductive analysis. Results revealed that 14 mothers had a subsequent pregnancy. Most of the first(15 of 19), second(10 of 14), third(3 of 5), and fourth(1) pregnancies in the sample were unplanned. Thompson et al. (1995) found that regular use of birth control after the first pregnancy increased twofold(from 7 to 15). Among the most common reported reasons for initial pregnancies were lack of knowledge and psychosocial influences.

Educational data revealed that 16 mothers had completed high school or an equivalency program, one was currently in high school, and the other two indicated their intent to complete an equivalency program. All of the mothers except

one had plans for completing a postsecondary education.

Developmental Profile II(DPII) scores indicated that 18 of the children were at or above the norm on physical, self-help, social, and communication development. Seventeen children achieved normal or higher scores on academic performance. One child was not tested because he was in a skilled care facility for persons with muscular dystrophy and one child had a borderline delay.

Only three of the 19 mothers scored average or nurturing on all AAPI constructs. Scores indicated risk for nonnurturing behaviors in varied combinations: three mothers on one construct, eight mothers on two constructs, three mothers on three constructs, and two mothers on all four constructs. Four of the mothers had scores that indicated high risk for child abuse. Other risk behaviors identified were family role reversal and inappropriate expectations.

All of the mothers identified a source of social support from the mother's own mother or other family members being the predominant source of support. Twelve of the mothers reported that the child's father played a significant role in the child's life, but only six identified the child's father or his family as a source of support.

Thompson et al. (1995) concluded that these adolescents became pregnant for a number of reasons, but largely because of not understanding reproduction and birth control. Most of the participants would have chosen to have a child but would have postponed the initial pregnancy. The results suggest the need for more education about abstinence and contraception and for programs aimed at promoting self-esteem, interpersonal skills, and age-appropriate development of adolescent parents and their children.

Ammerman, Perelli, Adler, and Irwin (1992) conducted a study in an inner-city ambulatory adolescent clinic to assess adolescent females' knowledge of certain basic medical and sexual related vocabulary, body functions, and anatomy. Adolescent females were chosen for the study because they have the greatest morbidities from sexual activity, i.e., pregnancy and sexually transmitted disease. The three areas identified as having a direct impact on knowledge attainment were sexual activity status, age, and participation in sex education instruction.

Participation for the study included all female adolescents 13 through 18 years of age who presented for well-care appointments at the adolescent clinic. Reproductive health related reasons such as family planning accounted for approximately 70% of the well-care visits to

the clinic. The remaining 30% were for annual physicals or sports or campus physicals. A total of 160 participants were enrolled in the study and none of the participants had ever been pregnant. Approximately 85% of the participants were on Medicaid, another 10% had no insurance, and the remaining 5% had private forms of insurance.

Self administered questionnaires that were divided into two parts were utilized to collect the data. The first part of the questionnaire consisted of a list of the following nine common medical terms used in discussing reproduction and health: "sexually active," "confidential," "birth control," "sexually transmitted disease," "stool," "sexual intercourse," "condoms," "venereal disease," and "urine." The participants were asked to write down all known meanings and descriptions of the terms and "don't know" boxes could be checked if necessary. The second part of the questionnaire consisted of unlabeled anatomic drawings of the male and female external and internal genitourinary systems. The 15 parts shown were: the "penis," "scrotum," "testicle," "foreskin," "bladder," "vas deferens," "male urethra," "clitoris," "female urethra," "vagina," "anus," "fallopian tube," "uterus," "ovary," and "cervix." The participants were asked to label each picture with all known meanings and terms, and "don't know" boxes could also be

checked if necessary.

Participants were also asked their race, sexual activity status, and specific sources, if any, of sex education. Once the authors had obtained informed consent the participants completed the questionnaire in the privacy of the exam room prior to the visit with the health care provider. After completion of the questionnaire and the visit with the health care provider, the participant was debriefed in a standardized method by one of the first two authors or a trained pediatric resident. Three different statistical tests were utilized to evaluate the significance of the data: Student's two tailed t-test, correlation coefficient, and one-way analysis of variance.

Ammerman et al. (1992) found of the 160 participants 82% were black which was consistent with the general population of the clinic. The mean age of the participants was 15.6 years with a standard deviation of 2.4 years. There were two subjects who were unable to self-administer the questionnaire. Seventy-four percent of the participants were sexually active. Results revealed that sexual activity status increased with age from a low of 42% of the 13-year olds to a high of 95% of the 18 year-olds. There were 95% of the participants who reported having had some form of sex education from one of the following: 77% in a formal school

course, 48% in this or another health clinic, 32% from parents, and 20% from "other."

Results revealed that knowledge was high for some terms and body parts or functions such as anus, penis, testicle, condoms, and vagina. Less than 50% of the participants were able to correctly identify many other body parts or functions, including cervix, clitoris, and urethra, or terms, including "confidential," "sexually active," "sexually transmitted disease," and "stool." The definitions from the first part of the questionnaire revealed many different meanings according to the adolescents. "Confidential" was generally understood as having confidence in oneself. "Sexually active" often meant any type of sexual physical interaction, thought, or feelings. "Birth control" was most often referred to as the pill. "Sexually transmitted disease" and "venereal disease" were unfamiliar terms. "Stool" was often taken literally as a type of seat.

In the second part of the questionnaire, the "anus" and "penis" were the only two anatomic and functional terms known by 100% of the participants. The male external anatomy and function was almost always better known than female external anatomy and function. Many of the anatomical parts were identified incorrectly. The two-

tailed t test revealed there was no significant knowledge difference between girls who were sexually active and those who were not($p=.23$ for part 1 and $p=.84$ for part 2). The Pearson's R correlation revealed no significant difference related to the effect of age on knowledge scores. The correlation for age and knowledge was .055 on part 1 and .107 on part 2. A one-way analysis of variance revealed no significance differences between sex education and knowledge scores ($F=.43$ and $p=.73$ for part 1, and $F=.41$ and $p=.74$ for part 2).

Ammerman et al. (1992) concluded that major areas of lack of knowledge and misinformation about basic reproductive and health knowledge that were independent of age, sexual experience, or sex-education exposure. Results suggested that health care providers cannot assume that clients understand what is being said in a discussion of sexual or genitourinary matters. Health care providers cannot know what their clients understand unless they ask questions or encourage follow-up appointments for reinforcement. Adolescents are often concerned with matters regarding sexual activity but are hesitant to initiate questions regarding the subject. The need to educate adolescent clients is urgent and straightforward communication may be a first step in achieving this

objective.

In a similar study, Hockenberry-Eaton, Richman, Dilorio, Rivero, and Maibach (1996) conducted a study to determine the extent to which adolescents could define a series of basic sexual development terms and whether the adequacy of their definitions varied with age, gender, or level of sexual experience. Another purpose was to determine the extent to which mothers of adolescents could define the same terms and to compare the responses of mothers with those of adolescents.

A descriptive, comparative study was utilized to answer the following research questions: (1) What is the level of knowledge of female and male adolescents and mothers regarding general sexual development terms? (2) Are there differences in the level of knowledge among female adolescents, male adolescents, and mothers regarding general sexual development terms? (3) Does age, gender, and sexual experience influence knowledge of general sexual development terms in adolescent females and males?

The study population consisted of 163 total participants, 90 were adolescents and 73 were mothers of adolescents. The adolescents ranged from 13 to 15 years of age with a mean of 13.9. Slightly more than half of the adolescents were female and 63.3% were African-American.

The mothers ranged in age from 29 to 46 with a mean age of 38. Most of the mothers(64.4%) were African-American and 45.2% were married and had completed a mean of 12 years of education.

The participants were recruited for the study through the cooperation of the Boys and Girls Clubs of Metropolitan Atlanta. Adolescents had to be 13 to 15 years of age, have lived with their mother for at least the past year, and willing to participate in order to qualify for participation in the study. The mothers were required to have an adolescent, age 13 to 15, with whom they had lived with for the past year and also be willing to participate. Informed consents were obtained from all participants before participating.

The interview included a list of seven terms related to sexual development which included: ejaculation, hormones, menstruation, ovulation, puberty, semen, and wet dreams. Interviewers read each item to the mothers and adolescents and asked them to give the meaning of the term in their own words. Two child health experts independently evaluated and scored the responses for each term for each participant. A zero was given for a "don't know" or an incorrect response, a one for a partially correct response, and a two for a correct response. The total scores were achieved by summing

the score for each of the seven terms with the total score representing overall knowledge of sexual development terms.

The responses were considered correct if they contained all essential elements of the correct definition. Responses that lacked some of the essential elements were considered partially correct. Responses were scored incorrect if they lacked all essential elements of the correct definition. Results revealed that participants were most able to correctly define the term menstruation with 63.8% providing a correct definition. Fifty-two percent of the participants gave correct definitions for semen, and 41.7% correctly defined ejaculation. Contrasting results revealed only 17.2% could adequately define wet dreams, 6.7% could define hormones, 29.4% could define ovulation, and 36.8% could define puberty.

Hockenberry-Eaton et al. (1996) found differences in levels of correct definitions of terms when data from mothers, adolescent females, and adolescent males were analyzed. The mothers and adolescent females were most likely to correctly define menstruation and semen and less likely to define ovulation and wet dreams. Eighty-eight percent of the mothers and 66.7% of adolescent females correctly defined menstruation, and 66.4% of the mothers and 52% of the adolescent females correctly defined semen. The

adolescent males, in contrast, were more likely to correctly define semen(31%) and puberty(31%), and least likely to correctly define wet dreams(14.3%) and ovulation(2.4%). The greatest percentage of correct responses came from the mothers except for puberty in which females had a higher percentage of correct responses. Adolescent males had the highest incidences of incorrect responses except for wet dreams.

The analysis of variance (ANOVA) was used to determine if there were significant differences in scores among adolescent males, females, and mothers. Results of the ANOVA revealed that mothers had a significantly higher score than did male or female adolescents on ejaculation, menstruation, ovulation, semen, and total knowledge. The adolescent females scored significantly higher than males on menstruation, ovulation, and total knowledge. A cross-tabulation of age by score classification was used to determine if the age of the adolescent was associated with correctness of definitions. Results revealed that older adolescents were more likely to give correct definitions for the terms wet dreams and ejaculation. There was no age difference in percent of correct definitions for the other terms. In terms of gender, older adolescent females were most likely to correctly define semen, and older males most

likely to correctly define wet dreams.

Hockenberry-Eaton et al. (1996) concluded that adolescent females were more likely than males to correctly define terms of the study. Adolescents generally have a low level of knowledge about reproductive issues. Mothers of adolescents were more likely to correctly define terms when compared to the adolescents but were still unable to adequately define most sexual development terms. Results indicated that mothers are often not prepared to provide adequate instruction to their adolescents. Practical approaches to provide accurate information concerning sexual activity during the adolescent period should be a prime concern to the health care provider.

Patton, Kolasa, West, and Irons (1995) conducted a study of pediatricians and family physicians about behaviors and belief with particular emphasis on physicians' attitudes toward attempts to counsel adolescents about sexuality, including abstinence. Physicians surveyed were residents in pediatrics or family practice at local county hospital and community pediatricians and family practitioners. Surveys were self-administered and distributed in the physicians' hospital mail boxes, or mailed with a stamped return envelope. Non-respondents were mailed a follow-up questionnaire.

The surveys were designed to elicit: demographic data and practice characteristics, clinical practices pertinent to the adolescent(sexual development, contraception, sexual peer pressure, and other sexuality topics), opinions regarding the effectiveness of physician counseling about sexuality and the value of additional training. Questions from the surveys included matters related to abstinence and contraception counseling, sexual habits, sexually transmitted diseases, ways to deal with peer pressure relating to sex, normal sexual development, and sexual abuse.

Data were analyzed for differences, and based on professional status, gender, specialty, political characterization, marital status, and whether there were children in the physician's home. Fifty-three of the physicians completed and returned the questionnaires for an overall response rate of 42.7%.

There were no statistical differences found in the physicians' responses based on gender, professional status, specialty, age, political characterization, marital status, or whether there were children in the home. Topics which were regularly discussed by most physicians included: contraception, menstrual history, HIV and STD prevention, and risk of pregnancy. Among the topics less frequently

discussed included: nocturnal emissions, female sexual responses, sexual fantasies, homosexuality, rape prevention, incest, and description of the female menstrual cycle to males.

Results revealed that physicians regularly discussed contraception with their female clients 86.3% of the time, and counseled male clients 64.7% of the time regarding contraception ($t=-3.71$; $p=.0005$). Counseling was instituted with adolescents who had a mean age of 12.9 years. None of the respondents reported feeling very effective in the methods utilized to counsel adolescents. Forty-nine percent of the respondents felt minimally effective. Only 21.6% reported that with additional training they could be very effective; 19.6% indicated they would still be minimally effective with additional training.

Patton et al. (1995) concluded that adolescents acquire information concerning sexuality mainly from their peers rather than from more knowledgeable sources such as parents, teachers, or physicians. Many physicians felt deficient in adolescent health counseling skill and somewhat pessimistic about the effectiveness of their attempts. Further studies were recommended to explore ways for physicians to be more comfortable and more confident about recommending sexual abstinence in a way that affirms the worth of the adolescent

and may open new avenues of communication.

Summary

The rate of sexual activity has continued to increase among the adolescent population. Sexual activity may have numerous medical, social, and economic consequences, including pregnancy and sexually transmitted diseases. Adolescent pregnancy may be influenced by a variety of factors. Family relationships, race and ethnic origin, and sexuality education are only a few of the factors that were reviewed for this study.

This review of the literature revealed that adolescents from two-parent families were more likely to have positive relationships with their families than those from one-parent families. Nonpregnant adolescents felt a closer relationship with their families than did the pregnant adolescents. Female adolescents reported closer relationships with their mothers than with their fathers.

Black adolescents were more likely to feel good about themselves, more likely to have received communication concerning sexual activity, and reported better acceptance of adolescent pregnancies than the other races. Hispanics were more likely to have grown up in two-parent families, and white adolescents were more likely to come from divorced parents.

Research revealed that sexual education is needed, and that family interaction and communication may have had a positive impact in helping to prevent early adolescent pregnancies. Adolescents who had received sex education were more likely to use contraception or delay sexual activity. Adolescents were more comfortable communicating with their mother concerning sexual activity than with their father. Research also revealed however that adolescents tend to discuss sexual activity among peers rather than with parents or health care providers.

Sexuality education programs are needed to help decrease the number of adolescent pregnancies. Age-appropriate education concerning abstinence and contraception are imperative for the adolescent as well as the adolescent parent in order to help control the problem of adolescent pregnancy. This research study sought to help identify adolescents who were at risk for adolescent pregnancy and to identify measures related to family relationships, race and ethnic origin, and sexuality education that would help to decrease the numbers of adolescent pregnancies.

Chapter III

The Method

The purpose of this study was to identify, examine, and describe family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. This chapter will describe the research methods used to investigate the variables of interest. The design, a descriptive study, will be described. The population, sample, and setting are described. Instrumentation used in the measurement of the variables are discussed. The methods of data collection and data analysis will be described.

Design of the Study

A descriptive study was chosen for this study to identify, examine, and describe the family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. This type of research design attempted to describe or explain naturally occurring phenomena and examine the relationships between variables. Therefore, the aim of this study was to identify, examine, and describe a relationship between the chosen variables (Polit & Hungler,

1991).

The variables of interest in this study were family relationships, race and ethnic origin, and sexuality education. The controlled and intervening variable was adolescent pregnancy.

Research Question

What are the family relationships, race and ethnic origin, and sexuality education of pregnant adolescents?

Limitations

The following limitations were identified for this study:

1. The small sample size utilized in this study made the results ungeneralizable.

2. The use of one rural area for data collection limited generalization to more than one area.

3. The use of only female adolescents for data collection limited generalization to more than one gender.

Setting, Population, and Sample

The setting for this study was three local obstetricians' health care clinics located in Northeast Mississippi. The area population is 33,000 in the city and

64,000 in the surrounding county.

The population being studied was all pregnant female adolescents between the ages of 12 and 19 years of age receiving medical attention in this setting. Approximately 22 pregnant female adolescents between the ages of 12 and 18 years are seen in the obstetrician's office per month. The racial composition of these clinics is approximately 33% white and 67% black, with very few adolescents of other ethnic origins.

The sample consisted of all pregnant female adolescents who gave their consent to participate. Parental consent was obtained if the parent accompanied the adolescent. A sample of convenience was utilized for this study. The target sample size was N=30.

Method of Data Collection

This section describes the methods of data collection. Attention is focused on instrumentation, techniques, and procedures utilized for collecting and recording the data.

Instrumentation. The instrument utilized for collection of data in this study was the Teenage Pregnancy Programs Survey (TAPPS) (Appendix A). The TAPPS survey instrument consisted of 83 items that addressed personal, family, and educational backgrounds as well as peer

relations, future plans, and prenatal health. The TAPPS questionnaire had been pretested in select school districts in Central Texas. The questionnaire packets consisted of a cover letter, survey instrument, a pencil, and return envelope.

Procedures. Following approval from the Committee on Use of Human Subjects in Experimentation at Mississippi University for Women (Appendix C), written permission to conduct this study was obtained from the three obstetricians whose offices were the sites for data collection (Appendix D,E,&F). The purpose of the study was then explained and permission obtained from each pregnant adolescent who met the criteria to participate in the study. Consent was also obtained from the adolescent's parent if the parent was present (Appendix G).

In the obstetrician's office, after the adolescent had completed her appointment, the participant was informed of the purpose of the study, asked to participate in the study, and written consent was obtained. Confidentiality and anonymity were controlled as no names appeared on the questionnaire, nor were the names of the adolescents participating in the study reproduced in any manner. Adolescents were advised orally and in writing that their participation was completely voluntary and they could

withdraw from the study at any time without affecting the health care they received.

Data Analysis

Descriptive statistics were used to describe and summarize data obtained regarding family relationships, race and ethnic origin, and sexuality education in pregnant adolescents.

Summary

In summary, a descriptive research design was utilized to identify, examine, and describe the family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. The sample was comprised of 50 pregnant adolescent females receiving care from three local obstetricians' offices in Northeast Mississippi. The TAPPS questionnaire was used to collect data during a visit to the obstetrician's office. Descriptive statistics were utilized to analyze the data.

Chapter IV

The Findings

The purpose of this study was to identify, examine, and describe family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. A descriptive design was utilized in this study. In this chapter the sample is discussed and data analysis described. Descriptive statistics were used to analyze data. Additional findings are also presented.

Description of the Sample

Data for the study were collected during routine prenatal visits to three obstetricians' health care clinics in a small city in the southeast. The research sample was composed of 30 pregnant adolescents 12 to 18 years of age. The adolescents were divided into four different groups. These four groups were 1) under 11 years (0%), 2) 11 to 13 years (3%), 3) 14 to 16 years (30%), 4) 17 to 19 years (67%). Nineteen subjects (63%) were black and eleven subjects (37%) were white. The majority of the subjects (87%) were never married. Sixty-three percent of the

subjects lived with parent(s), 14% with other family member(s), 13% with husband, and 10% with partner of the opposite sex. None of the subjects indicated that they lived alone. Only three of the subjects (10%) indicated that they were employed while 90% were unemployed. Forty-seven percent of the subjects' mothers were high school graduates and 53% of the fathers were high school graduates. None of the subjects' fathers had a college degree and only 6% of the mothers had a college degree. Demographic characteristics of the subjects are presented in Table 1.

Table 1

Demographic Characteristics of the Sample

Characteristics	n	%
Age		
Under 11	0	0
11-13 years	1	3
14-16 years	9	30
17-19 years	20	67
Race		
White	11	37
Black	19	63

(table continues)

Characteristics	n	%
Marital Status		
Never married	26	87
Married	4	13
Divorced	0	0
Separated	0	0
Widowed	0	0
Current living arrangements		
With my husband	4	13
With partner of opposite sex	3	11
With parent(s)	19	63
With other family member(s)	4	13
With partner of same sex	0	0
Currently employed		
Yes	3	10
No	27	90
Mother's educational level		
8th grade or lower	1	3
9th to 11th grade	8	27
High school graduate	14	37
Some college or technical/vocational	5	17
College degree	2	6
Father's educational level		
8th grade or lower	0	0
9th to 11 grade	8	37
High school graduate	16	53
Some college or technical/vocational	3	10
College degree	0	0

Note. N = 30.

Adolescent Sexual and Personal History

Nineteen of the subjects (63%) first experienced sexual intercourse between 14 and 16 years of age, seven subjects

(24%) between 11 and 13 years, and three subjects (10%) between 17 and 19 years of age. The majority of the subjects (90%) did not plan the pregnancy, and only 30% of the subjects were using contraceptives when they became pregnant. Sixty percent of the subjects indicated that alcohol and drugs were not being used at the time of conception, 24% indicated that one partner was using alcohol or drugs, 13% indicated that they didn't know whether alcohol or drugs were being used, and 3% indicated both were using alcohol or drugs.

The condom was the most frequently reported form of contraceptive used (84%), but only 40% of the subjects indicated having a form of contraception "just-in-case." Slightly more than half (53%) of the subjects never thought they would become pregnant. Four of the subjects (13%) indicated already having one child, and one subject indicated having two children.

Ninety-three percent of the subjects indicated they attended church. Although 57% of the subjects had prior work experience, only 10% of the subjects were currently employed. Previous work experiences included fastfood (24%), childcare (22%), office skills (19%), retail sales (16%), and other (19%). Eleven of the subjects (37%) indicated they always felt good about themselves, 10 of the

subjects (33%) indicated they sometimes felt good about themselves, seven of the subjects (23%) indicated they almost always felt good about themselves, and two of the subjects (7%) never felt good about themselves. Fifty percent of the subjects indicated having many friends before they became pregnant and 50% indicated having a few close friends. Seventy percent of the subjects felt closest to their mother since becoming pregnant, 20% felt closest to others, 7% felt alone and close to no one, and 3% felt closest to other pregnant adolescents. Table 2 presents data related to the subjects' personal and sexual history.

Table 2

Adolescent Sexual and Personal History

Characteristics of History	n	%
Age first sexual intercourse experienced		
Under 11 years	1	3
11-13 years	7	24
14-16 years	19	63
17-19 years	3	10
Since sexually active did you ever think of becoming pregnant		
Yes	14	47
No	16	53
Do you carry a form of contraceptive(s) with you "just-in-case"		
Yes	12	40
No	18	60

(table continues)

Characteristics of History	n	%
Use of contraceptives at the time of conception		
Yes	9	30
No	21	70
Use of alcohol or drugs at the time of conception		
Only I was	0	0
Only partner was	7	24
Both were	1	3
Neither	18	60
I do not know	4	13
Do you have other children		
Yes	4	13
No	26	87
Currently employed		
Yes	3	10
No	27	90
I feel good about myself		
Always	11	37
Almost always	7	23
Sometimes	10	33
Almost never	0	0
Never	2	7
Since pregnant I felt closest to		
No one, I felt alone	2	7
Other pregnant adolescents	1	3
My mother	21	70
Others in general	6	20

Note. N = 30.

Family Relationships

The marital status of the parents of the subjects was varied. Twenty-seven percent of the parents were married, 27% were divorced, 20% were separated, 20% were never married, and 6% were widowed. Slightly more than half of the subjects (64%) indicated living mostly with their mother while growing up, while 30% indicated living with both parents, 3% with their father, and 3% with other family members.

The subjects were asked to rate their relationship with their mother and father, and if they had a problem while growing up if they could talk to their mother or father about it. Fifty percent rated their relationship with their mother as good, 40% as excellent, 7% as fair, and 3% as poor. Forty percent of the subjects indicated that if a problem arose they could sometimes talk about it with their mother, 34% usually could talk about a problem, 13% felt they could always talk about a problem, and 13% felt they could seldom talk about a problem. Thirty-seven percent of the subjects rated their relationship with their father as fair, 24% as good, 16% as excellent, 10% as poor, and 13% indicated no relationship with their father. Fifty-five percent of the adolescents indicated seldom talking to their father about a problem, 40% sometimes, and 5% usually able

to talk to their father about a problem.

Fifty-three percent of the subjects received emotional support from parent(s) during pregnancy, 33% felt they were somewhat supportive, and 14% felt somewhat unsupportive. More than half of the subjects (73%) indicated that their mother did not have an unplanned pregnancy when she was an adolescent. Other family members involved in an unplanned adolescent pregnancy included cousins (33%), sisters (28%), brother's girlfriend (11%), and grandmothers (3%). Only nine of the subjects (25%) had no previous family members involved in an unplanned adolescent pregnancy.

Seventy-seven percent of the subjects indicated they did not have a dating relationship with the father of the baby at the time they became pregnant. Current relationships with the father of the baby varied. Forty-seven percent were friends with the father, 24% were planning to marry, 16% had no relationship, 10% were married, and 3% were living together. Almost half of the subjects (47%) indicated that the baby's father was supportive of the pregnancy, 27% were somewhat supportive, 13% were somewhat unsupportive, and 13% were unsupportive. Half of the fathers (50%) were 17 to 19 years of age, 30% were 20 to 22, 13% were over 23, and 7% were 14 to 16. Table 3 presents data related to family relationships of the

pregnant adolescent.

Table 3

Characteristics of Family Relationships

Family Relationships	n	%
Marital status of parents		
Married	8	27
Separated	6	20
Widowed	2	6
Divorced	8	27
Never married	6	20
Lived mostly with		
Both parents	9	30
Mother	19	64
Father	1	3
Other family member(s)	1	3
Perceived relationship with mother		
Excellent	12	40
Good	15	50
Fair	2	7
Poor	1	3
None	0	0
Perceived relationship with father		
Excellent	5	16
Good	7	24
Fair	11	37
Poor	3	10
None	4	13
Able to talk with mother about problems		
Always	4	13
Usually	10	34
Sometimes	12	40
Seldom	4	13
Never	0	0

(table continues)

Family Relationships	n	%
Able to talk with father about problems		
Always	0	0
Usually	1	3
Sometimes	8	27
Seldom	11	37
Never	10	33
Mother involved in unplanned adolescent pregnancy		
Yes	8	27
No	22	73
Other family members involved with adolescent pregnancy		
No one	9	25
Sister	10	28
Brother's girlfriend	4	11
Cousins	12	33
Grandmother	1	3
Relationship with father of baby		
Married	3	10
Living together	1	3
Planning to marry	7	24
Friends	14	47
No relationship	5	16
Age of father of baby		
11-13 years	0	0
14-16 years	2	7
17-19 years	15	50
20-22 years	9	30
Over 23 years	4	13

Note. N = 30.

Sexuality Education

Prior to pregnancy 60% of the adolescents indicated they had some form of sex education. Forty percent indicated receiving sex education from school, 33% from home, 12% from friends, brothers, or sisters, 9% from church, and 6% from media. Slightly more than half of the subjects (63%) indicated that their parent(s) talked to them about sex. Of those who received sex education from the parent(s) 86% came from mother and 14% from both parents. None of the subjects indicated that fathers only had talked to them about sex. Fifty percent of the subjects indicated that they received sex education from parent(s) between 11 and 13 years of age, 25% between 14 and 16, and 25% were under 11 years of age. Parental focus on sexuality aspects included contraceptives (35%), sexual diseases (35%), and premarital pregnancy (30%). Results of sexuality education data are presented in Table 4.

Table 4

Characteristics of Sexuality Education

Sexuality Education	n	%
Any type of sex education received		
Yes	18	60
No	12	40
From whom did you receive sexuality education		
Home	11	33
School	13	40
Friend(s)	4	12
Media	2	6
Church	3	9
What age did you receive sexuality education		
Under 11 years	5	25
11-13 years	10	50
14-16 years	5	25
17-19 years	0	0

Note. N = 30.

Additional Findings

In addition to the variables addressed in the research question several other variables concerning adolescent pregnancy were examined. These variables included prenatal health, educational characteristics, and future plans of the adolescent.

Fifty percent of the subjects indicated they sought medical attention between four and seven months of

pregnancy, 43% between one and three months, and 7% have not sought medical attention. Slightly more than half of the subjects (53%) saw a doctor or nurse at least once a month, 27% twice a month, 13% more than twice a month, and 7% less than once a month. Sixty-three percent of the subjects indicated they did not smoke at all, 20% indicated smoking less, 7% smoked the same amount, and 10% quit smoking completely. The majority of the subjects (93%) indicated they did not drink at all, and 7% indicated they had quit drinking. Slightly more than half of the subjects (60%) made no plans to take any classes about childbirth, 33% had not even thought about classes, and 7% attended childbirth classes.

Educational backgrounds varied greatly among the subjects. Thirty-seven percent were twelfth grade or over, 24% were tenth to eleventh grade, 12% were eighth to ninth grade, 3% were seventh grade or below, and 24% had dropped out of school. Half of the subjects (50%) indicated their usual grades were B's, 44% were C's, 3% were A's, and 3% were D's. Fifty-one percent of the subjects indicated they planned to complete high school after having their baby, 16% would go to a two year college, 14% to a four college, 8% to a technical or training school, and 11% would drop out of school.

Fifty percent of the subjects indicated they would keep the baby and raise it themselves, 37% would raise the baby with the baby's father, and 13% would allow their parent(s) to raise the baby. Almost all of the subjects (94%) indicated that if they became pregnant again and were unmarried, they would have the baby and raise it themselves.

Summary

Most of the pregnant adolescents were never married and still lived with their parent(s). Only 10% of the pregnant adolescents were employed at the time of the study. Positive relationships were identified with the mother of the pregnant adolescent more often than with the father. More than half of the pregnant adolescents had received sexuality education prior to becoming pregnant yet only 30% utilized some form of contraceptive at the time of conception. Because of the risk factors identified with adolescent sexual activity, we as nurse practitioners should strive to foster relationships with adolescents as well as their parents and identify methods to decrease these risks associated with adolescent sexual activity. We as nurse practitioners will be the primary health care providers for many of these adolescents and their families and we should serve as role models of health promoting behaviors.

Chapter V

The Outcomes

The purpose of this study was to identify, examine, and describe family relationships, race and ethnic origin, and sexuality education in pregnant adolescents. Pender's Health Promotion Model served as the conceptual framework for this descriptive study. The research question for this study was the following: "What are the family relationships, race and ethnic origin, and sexuality education of pregnant adolescents?"

The sample consisted of 30 pregnant adolescents who received health care from three local obstetricians' health care clinics in Northeast Mississippi. The instrument utilized for the collection of data was the Teenage Pregnancy Programs Survey (TAPPS).

A summary and discussion of the findings of this study is presented in this chapter. The conclusions, implications for nursing, and recommendations which emerged from those findings also are discussed.

Summary of Findings

Demographics of the sample. The sample for this study was predominantly black (63%) and 17 to 19 years of age (67%). Eighty-seven percent of the subjects were never married and slightly over half (63%) lived with their parent(s). Most of the subjects (90%) were unemployed at the time of the study. Forty-seven percent of the subjects' mothers were high school graduates as compared to 53% of the fathers. None of the subjects' fathers had a college degree and only 6% of the subjects' mothers had a college degree.

Adolescent and Personal History. Sixty-three percent of the subjects first experienced sexual intercourse between 14 and 16 years of age. The majority of the subjects (90%) did not plan the pregnancy, and only 30% were using contraceptives when they became pregnant. More than half of the subjects (60%) indicated that alcohol and drugs were not being used at the time of conception. Condoms were the most frequently reported form of contraceptive used (84%); however, only 40% indicated having a form of contraceptive "just-in-case." Over half of the subjects (53%) never thought they would become pregnant.

Almost all of the subjects (93%) indicated they attended church. Personal feelings about self varied. Thirty-seven percent always felt good , 33% sometimes felt

good, 23% almost always felt good, and 7% never felt good. Over half of the subjects (70%) felt closest to their mother since becoming pregnant.

Family Relationships. Marital status of the parents of the subjects was varied between married 27%, divorced 27%, separated 20%, never married 20%, and widowed 6%. Fifty percent of the subjects rated their relationship with their mother as good, and 24% rated their relationship with their father as good. Forty percent of the subjects indicated they could usually talk with their mother about a problem as compared to only 5% usually able to talk to their father.

More than half of the subjects (73%) indicated that their mother did not have an unplanned pregnancy when she was an adolescent. There were other family members involved in unplanned adolescent pregnancies. Only 25% of the subjects had no previous family members involved in an unplanned adolescent pregnancy. Fifty-three percent of the subjects received emotional support from parent(s) during pregnancy.

Seventy-seven percent of the subjects indicated they did not have a dating relationship with the father of the baby. Forty-seven percent were friends with the father of the baby, and only 10% were married to the father of the baby.

Sexuality Education. Prior to the pregnancy 60% of the subjects indicated they had some form of sex education. Slightly more than half of the subjects (63%) indicated that their parent(s) talked to them about sex. Eighty-six percent of the subjects who received sex education from the parent(s) indicated that the mother talked to them about sex.

Additional Findings

In addition to the variables addressed in the research question other variables concerning adolescent pregnancy were examined. These variables included prenatal health, educational characteristics, and future plans of the adolescent.

Fifty percent of the subjects sought medical attention between four and seven months of pregnancy, and 7% of the subjects sought no medical attention. Sixty-three percent of the subjects indicated they did not smoke at all and 93% indicated they did not drink at all. More than half of the subjects (60%) made no plans to attend any childbirth classes.

Educational backgrounds of the subjects varied. Twenty-four percent had dropped out of school and 51% indicated they planned to complete high school after having

their baby. Half of the subjects (50%) indicated their usual grades in school were B's.

Fifty percent of the subjects indicated they would keep the baby and raise it themselves and 13% would allow their parent(s) to raise the baby. Almost all of the subjects (94%) indicated that if they were unmarried and were to become pregnant again, they would have the baby and raise it themselves.

Discussion

The findings of this study indicated that the majority of the pregnant adolescents (87%) were never married and that 63% of them lived with their parent(s). The majority of the subjects (90%) did not plan the pregnancy and only 30% were using contraceptives at the time of conception.

The subjects indicated a closer relationship with their mother, as opposed to their father, and found it easier to talk to their mother about a problem. Most of the subjects (77%) did not have a dating relationship with the father of the baby. Over half of the subjects (60%) indicated they had received some form of sex education. Eighty-six percent of those who received sex education indicated it came from their mother.

In a similar study, Barnett et al. (1991) found that

72% of the pregnant adolescents came from disrupted homes with low income status. Pregnant adolescents had lower perceptions of family strengths and were more likely than nonpregnant adolescents to see their families as exhibiting less pride and harmony. Results revealed that communication patterns with parents were perceived as being more problematic and closed for the pregnant adolescent when compared to the nonpregnant adolescent. Barnett et al. (1991) also found that pregnant adolescents were more likely than nonpregnant adolescents to be married and come from single parent or no parent families. Nonpregnant adolescents were more likely to use some type of birth control than pregnant adolescents. Pregnant adolescents were also found to have exhibited a lower self esteem than nonpregnant adolescents. In the present study, over half of the subjects felt closest to their mother since becoming pregnant. Communication with their mother was not perceived as a problem, however, only a few of the adolescents felt they could talk to their father about a problem. In contrast, the adolescents in the current study were not more likely to be married and the majority of the pregnant adolescents exhibited positive feelings about themselves.

Rodriquez and Moore (1995) found that black adolescents were more likely to had received sex information from their

parent(s) than whites or Hispanics. Thirty-five percent of the adolescents had initially experienced sexual intercourse before the age of 14 and 60% had experienced sexual intercourse before the age of 14 and 16. Eighty-nine percent of the participants used no form of contraception prior to pregnancy, and 55% reported they never thought they would become pregnant. Forty-eight percent reported using some form of alcohol or drugs at the time of conception. Only 52% of the participants reported their parent(s) had ever talked to them concerning sex. Likewise, the present study indicated that the majority of the subjects first experienced sexual intercourse between 14 and 16 years of age and only 30% of the subjects were using contraceptives when they became pregnant. In contrast, 60% of the subjects indicated that alcohol and drugs were not being used at the time of conception. Sixty percent of the subjects had also received some form of sex education.

Pender's (1987) Health Promotion Model was the conceptual framework for this study. The goal of the theory is to integrate what is known about health-promoting behavior to achieve optimal health of the individual. Pender noted that positive health behaviors developed during adolescent years are resistant to change and can persist over time. Adolescents are at an age where they are

beginning to assume an increased responsibility for their health and to expect greater mastery of personal and environmental factors that influence health. Adolescents view themselves as being independent, self-reliant, and able to make their own choices rather than relying on others. Therefore, adolescents are an important target group for well planned health promotion programs.

Conclusions

The following conclusions were derived from the findings of this study:

1. The majority of the adolescents were never married.
2. Generally adolescents first engaged in sexual intercourse between 14 and 16 years of age.
3. Adolescents did not plan the pregnancy and very few of them were utilizing contraceptives at the time of conception.
4. Adolescents generally had positive feelings about themselves and perceived a closer relationship with their mother rather than their father.
5. Adolescents predominantly received sex education from their mother.

Implications for Nursing

Adolescents are becoming sexually active at increasingly younger ages. Record numbers of babies have been born to adolescents over the past decade. Each year over one million United States adolescents become pregnant by the age of 18. Most adolescent pregnancies are unplanned with less than half (47%) that result in a live birth (Clinician's Handbook of Preventive Services, 1994).

This study identified the profile of the adolescent most likely to develop an adolescent pregnancy as an adolescent who is unemployed, not married, and still living with their parents. The adolescent has usually received some form of sexuality education, most likely from their mother. Pregnant adolescents are more comfortable talking with their mother about a problem and usually have a closer relationship with their mother as opposed to their father. The majority of adolescent pregnancies are unplanned and only a few of the adolescents utilize some form of contraception.

This study seeks to improve the quality of care given to adolescents by identifying those adolescents who are at increased risk for developing adolescent pregnancies. It is also important for the nurse practitioner to recognize those adolescents who are at increased risk and provide them with

the services that will enable them to avoid unnecessary risks. The need to educate adolescent clients and their families is urgent. The development and improvement of community and school programs are essential in reducing adolescent sexual activity.

Recommendations for Further Study

Based on the findings of this study the following recommendations are made for future research in nursing:

1. Replication of the study with a larger, more diverse sample.

2. Conduction of research to include the male adolescent.

3. Conduction of research to include male and female adolescents who are sexually active but not pregnant.

4. Conduction of research to include a larger geographical area.

REFERENCES

References

American Nurses Association (1994). Clinician's handbook of preventive services. Waldorf: American Nurses Publishing.

Ammerman, S., Perelli, E., Adler, N., & Irwin, C. (1992). Do adolescents understand what physicians say about sexuality and health? Clinical Pediatrics, 31, 590-595.

Barnett, J., Papini, D., & Gbur, E. (1991). Familial correlates of sexually active pregnant and nonpregnant adolescents. Adolescence, 26, 457-471.

Bluestein, D., & Rutledge, C. (1992). Determinants of delayed pregnancy testing among adolescents. The Journal of Family Practice, 35, 406-409.

Casper, L. (1990). Does family interaction prevent adolescent pregnancy? Family Planning Perspectives, 22, 109-114.

Fitzgerald, M., & Fitzgerald, D. (1987). Parents' involvement in the sex education of their children. Volta Review, 89(5), 96-110.

Furstenberg, F. (1991). As the pendulum swings: teenage childbearing and social concern. Family Life Education, 40, 127-138.

Gillis, A. (1994). Determinants of health-promoting lifestyles of adolescent females. Canadian Journal of Nursing Research, 26(2), 13-28.

Hockenberry-Eaton, M., Richman, M., Dilorio, C., Rivero, T., & Maibach, E. (1996). Mother and adolescent knowledge of sexual development: the effects of gender, age, and sexual experience. Adolescence, 31, 35-47.

King, P. (1994). Health promotion: the emerging frontier in nursing. Journal of Advanced Nursing, 20, 209-218.

Marriner-Tomey, A. (1994). Nursing theorists and their work (3rd ed.). St. Louis: Mosby-Year Book, Inc.

McGrew, M., & Shore, W. (1991). The problem of teenage pregnancy. The Journal of Family Practice, 32, 17-21.

Patton, D., Kolasa, K., West, S., & Irons, T. (1995). Sexual abstinence counseling of adolescents by physicians. Adolescence, 30, 963-969.

Pender, N. (1987). Health promotion in nursing practice (2nd ed.). Norwalk: Appleton & Lange.

Polit, D., & Hungler, B. (1991). Nursing research (4th ed.). Philadelphia: J. B. Lippincott Company.

Records, K. (1993). Life events of pregnant and nonpregnant adolescents. Adolescence, 28, 325-337.

Rodriquez, C., & Moore, N. (1995). Perceptions of pregnant/parenting teens: reframing issues for an

integrated approach to pregnancy problems. Adolescence, 30, 685-706.

Rogers, E., & Lee, S. (1992). A comparison of the perceptions of the mother-daughter relationship of black pregnant and nonpregnant teenagers. Adolescence, 27, 555-564.

Thompson, P., Powell, J., Patterson, R., & Ellerbee, S. (1995). Adolescent parenting: outcomes and maternal perceptions. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 24, 713-718.

Vance, P. (1985). Love and sex: can we talk about that in school? Childhood Education, 61, 272-276.

Whaley, L., & Wong, D. (1991). Nursing care of infants and children (4th ed.). St. Louis: Mosby-Year Book, Inc.

White, S., & DeBlassie, R. (1992). Adolescent sexual behavior. Adolescence, 27, 183-191.

APPENDIX A

Teenage Pregnancy and Parenting Questionnaire

Hello. My name is Joy Murphy and I am a graduate student at Mississippi University for Women in Columbus, Mississippi. I am doing a research survey about teenage pregnancy. I hope you will take the time to fill out this survey. It should take no more than 35 minutes. Please be assured of absolute anonymity. Thank you for participating.

Directions: The following questions should have only one response unless otherwise indicated. Please indicate the best response by marking the corresponding space on your answer sheet provided in the packet. In case of an answer change, completely erase the wrong answer. Please use a #2 pencil.

PERSONAL BACKGROUND

1. What is your age?
a. under 11
b. 11-13
c. 14-16
d. 17-19
e. over 19

2. What is your racial or ethnic background?
a. White
b. Black
c. Hispanic
d. Oriental
e. other

3. What is your current marital status?
a. never married
b. married
c. divorced
d. separated
e. widowed

IF YOU HAVE NEVER BEEN MARRIED, GO TO QUESTION 5.

4. If you are married, is it because you were or are pregnant?
a. yes
b. no

5. Are you currently living alone or with another person?
a. alone
b. with another person

IF YOU ARE LIVING ALONE, GO TO QUESTION 7.

6. If you are living with another person, please indicate your current living arrangements. I live:
a. with my husband
b. with partner of opposite sex
c. with parent(s)
d. with other family member(s)
e. with partner of same sex (roommate, etc.)

7. At what age did you first experience sexual intercourse?
a. under 11
b. 11-13
c. 14-16
d. 17-19
e. over 19

8. Did you plan this pregnancy?
a. yes
b. no

9. Were you or your partner using any form of alcohol or other drugs at the time of conception?
a. only I was
b. only partner was
c. both were
d. neither
e. I do not know

10. Were you using any contraceptives when you became pregnant?
a. yes
b. no

IF YOU WERE NOT USING CONTRACEPTIVES, GO TO QUESTION 12.

11. If yes, which form(s)? (you may mark more than one)
a. birth control pills
b. chemical spermicides (sponge, foams, jels, etc.)
c. condom
d. diaphragm
e. natural family planning

12. Do you carry a form of contraceptive(s) with you "just-in-case"?
a. yes
b. no

13. Since becoming sexually active, did you ever think you would become pregnant?
a. yes
b. no

14. Were you or are you in love with the father of your baby?
a. yes
b. no
c. not sure

15. Do you have any other children?
a. yes
b. no

IF YOU DO NOT HAVE OTHER CHILDREN, GO TO QUESTION 20.

16. If yes, how many children do you have?
a. 1
b. 2
c. 3
c. 4

e. more than 4

17. If yes, have other children, were these children fathered by:
a. the same person
b. different person

18. If yes have other children, are they living with you?
a. yes
b. no

19. If your other children do not live with you, where do they live?
a. with my parent(s)
b. with adoptive parent(s)
c. with baby's father
d. with baby's father's parent(s)
e. other family member(s)

20. While you were growing up did you attend church?
a. yes
b. no

IF YOU DID NOT ATTEND CHURCH GO TO QUESTION 22

21. If yes attended church, how often did you usually attend?
a. on major holidays only
b. less than once a month
c. once a month
d. once a week
e. two or more times a week

22. Do you have any work experience?
a. yes
b. no

IF YOU DO NOT HAVE WORK EXPERIENCE, GO TO QUESTION 24.

23. If yes, what type of experience do you have? (Mark all that you have)
a. office skills
b. fastfood
c. retail and sales
d. childcare
e. other

24. Are you currently employed?
a. yes
b. no

25. I feel good about myself:
a. always
b. almost always
c. sometimes
d. almost never
e. never

FAMILY BACKGROUND

26. What is the marital status of your parents?
a. married
b. separated
c. widowed
d. divorced
e. never married

IF YOUR PARENTS ARE MARRIED, GO TO QUESTION 28.

27. If your parents are divorced or widowed, what is their current status?
a. both are remarried to different partners
b. father only is remarried
c. mother only is remarried
d. neither mother or father are remarried

28. Were you born or adopted into your family?
a. born
b. adopted

29. Who did you live with most while growing up?
a. both parent(s)
b. mother
c. father
d. a parent and a step-parent
e. other family member(s)

30. How would you rate your relationship with you mother?
a. excellent
b. good
c. fair
d. poor
e. none

31. How would you rate your relationship with your father?
a. excellent
b. good
c. fair
d. poor
e. none

32. While you were growing up if you had a problem, you would talk with your mother about it:
a. always
b. usually
c. sometimes
d. seldom
e. never

33. While you were growing up if you had a problem, you would talk with your father about it:
a. always
b. usually
c. sometimes
d. seldom

e. never

34. While you were growing up, how much free time do you feel you had?
a. not enough
b. too much
c. just enough

35. While you were growing up, were either of your parents home when you got home from school?
a. yes
b. no

36. While you were growing up, do you feel your parent(s) gave you:
a. too much independence
b. too little independence
c. the right amount of independence

37. What is your mother's educational level?
a. 8th grade or lower
b. 9th to 11th grade
c. high school graduate
d. some college or technical or vocational school
e. college degree

38. What is your father's educational level?
a. 8th grade or lower
b. 9th to 11th grade
c. high school graduate
d. some college or technical or vocational school
e. college degree

39. What is the level of emotional support your parent(s) have offered you during this pregnancy?
a. supportive
b. somewhat supportive
c. somewhat unsupportive
d. unsupportive
e. parent(s) do not know I am pregnant

40. At an early age my family promoted "boyfriends" as a cute part of early childhood?
a. very frequently
b. frequently
c. occasionally
d. rarely
e. never

41. Did your parent(s) ever talk to you about sex?
a. yes
b. no

IF PARENTS DID NOT TALK TO YOU ABOUT SEX GO TO QUESTION 45

42. If yes, at what age did they begin to discuss sex with you?
a. under 11
b. 11-13
c. 14-16

d. 17-19
e. over 19

43. If yes, they did talk to you about sex, which aspects of sexuality did your parent(s) talk to you about? (you may mark more than one)
a. masturbation (self-stimulation of sex organs)
b. contraceptives
c. sexual diseases
d. premarital pregnancy
e. pleasurable aspects of sexuality, including intercourse

44. If yes sex was talked about in your home by your parent(s), who discussed it the most?
a. both parents
b. mother only
c. father only

45. Go to the best of your knowledge, was your mother involved in an unplanned pregnancy as a teenager?
a. yes
b. no

IF MOTHER WAS NOT PREGNANT, AS A TEEN, GO TO GO TO QUESTION 47.

46. If yes mother was involved in an unplanned pregnancy, what was the result(s) of the(se) pregnancy (ies)? (you may mark more than one)
a. abortion
b. had baby and placed for adoption
c. kept the baby and stayed single
d. married the father and kept it
e. let other family member(s) raise it

47. How many sisters do you have?
a. none
b. 1
c. 2
d. 3
3. 4 or more

48. How many brothers do you have?
a. none
b. 1
c. 2
d. 3
e. 4 or more

49. If yes, you have brother(s) or sister(s), you are the:
a. oldest
b. middle
c. somewhere in between the oldest and youngest
d. the youngest

50. Has your mother had a baby in the past five years?
a. yes
b. no
c. I do not know

51. Who else in your family has experienced an unplanned teenage pregnancy? (you may mark more than one)
a. no one
b. sister
c. brother (his girlfriend)
d. cousins
e. grandmother

IF NO ONE HAS EXPERIENCED AN UNWANTED TEEN PREGNANCY IN YOUR FAMILY, GO TO GO TO QUESTION 53.

52. If yes you had other family members involved in a teen pregnancy, were any of these children raised in your home?
a. yes
b. no

53. Of those people close to you who are unmarried, which, if any, are currently pregnant? (you may mark more than one)
a. none
b. friend(s)
c. sister
d. cousin
e. brother's girlfriend

EDUCATIONAL BACKGROUND

54. What grade are you currently in?
a. 7th and under
b. 8th-9th
c. 10th-11th
d. 12th or over
e. dropped out

55. What are your usual grades?
a. A's
b. B's
c. C's
d. D's
e. F's

56. Before you became pregnant, did you have any form of sex education?
a. yes
b. no

IF YOU HAD NO FORM OF SEX EDUCATION, GO TO GO TO QUESTION 58

57. If yes you had sex education, where did it occur? (may mark more than one)
a. home
b. school (class of film)
c. friend(s), brother(s), sister(s)
d. media (T.V., magazines)
e. church

58. Are you or were you before you became pregnant involved in school activities other than class?
a. yes

b. no

FUTURE PLANS

59. What are your personal educational plans after having your baby? (you may mark more than one)
a. drop out of high school
b. complete high school
c. go to technical or training school
d. go go to a two year college
e. go go to four college or university

60. If you plan to continue your education beyond high school, how do you plan to pay for it? (you may mark more than one)
a. my parent(s)
b. myself (totally)
c. combination of myself and parent(s)
d. scholarships
e. college financial aid (grants, loans)

61. After birth what do you plan for your baby?
a. keep it and raise it myself
b. place it for adoption
c. keep it and raise with father of baby
d. let my parent(s) raise it
e. let my baby's father or the father's parent(s) raise it

62. What type of child rearing practices do you plan to use with your child(ren)?
a. same as my parent(s)
b. less strict than my parent(s)
c. more strict than parent(s)
d. have not thought about it

63. How do you plan to educate your children about sex?
a. same as my parent(s) educated me
b. give more information
c. give less information
d. I do not think children should be educated about sex
e. I plan to let someone else educate my child(ren) about sex

64. What is the most important way you plan to prepare yourself to do the best job of rearing your child(ren)? (mark no more than 2)
a. follow advice from parent(s)
b. take class(es)
c. get advice from friend(s)
d. get advice from other family member(s)
e. my personal experience and life

65. Are you enrolled in a parent training program in your school?
a. yes
b. no

66. Which 2 areas of information would you want to learn more about? (mark only two)
a. Child development and child guidance
b. Personal and home management

c. Financial management
d. Effective discipline methods
e. Relationships with others

PEER RELATIONS

67. Before you became pregnant would you consider yourself as:
a. having many friends
b. having a few close friends
c. having no friends, but not by choice
d. a loner by choice

68. Since becoming pregnant, I have felt closet to:(mark only one)
a. no one, I have felt alone
b. other girls in the program
c. adults in the program
d. my mother
e. others outside the program

69. Did you at the time you became pregnant have a dating relationship with other males besides the father of your baby?
a. yes
b. no

70. How old is the father of your baby?
a. 11-13
b. 14-16
c. 17-19
d. 20-22
e. over 23

71. What kind of relationship do you have with the father of your baby now?
a. married
b. living together, not married
c. planning to marry (whether living together or not)
d. friends
e. no relationship

72. What was the reaction of your baby's father to your current pregnancy?
a. supportive
b. somewhat supportive
c. somewhat unsupportive
d. unsupportive
e. he does not know I am pregnant

PRENATAL HEALTH

73. When did you first seek medical attention during your pregnancy?
a. have not sought any medical attention
b. between 1-3 months of pregnancy
c. between 4-7 months
d. after 7 months

IF YOU HAVE NOT SOUGHT MEDICAL ATTENTION, GO TO GO TO QUESTION 76.

74. From whom did you first seek medical attention? (you may mark more than one)
a. family doctor
b. private doctor (not family doctor)
c. school nurse
d. person from family planning clinic (planned parenthood)
e. person at public health clinic

75. How often have you seen a doctor or nurse during this pregnancy?
a. once a month
b. twice a month
c. more than twice a month
d. less than once a month

76. If you smoke, have you continued to smoke during this current pregnancy?
a. Yes, the same amount of cigarettes
b. Yes I have continued, but have cut down
c. No, I have quit
d. I do not smoke at all

77. If you drink, have you continued to drink during this pregnancy?
a. Yes, I have continued to drink the same as before
b. Yes I still drink, but I have cut it down
c. No, I have quit drinking
d. I do not drink at all

78. Did you take or do you plan to take any kind of classes to learn about childbirth? (example: Lamaze)
a. yes
b. no
c. I did not know I could take childbirth classes
d. have not thought about it

IF NOT PLANNING GO TO TAKE A CHILDBIRTH CLASS, GO TO GO TO QUESTION 81

79. If yes you took classes or plan to take a class, did you or will you have a class partner?
a. yes
b. no

80. How is your class partner related to you?
a. baby's father
b. friend of same sex
c. friend of opposite sex
d. a parent
e. a sibling (sister)

81. Have you ever considered allowing someone other than a family member to adopt your baby?
a. yes
b. no

82. If no you have not considered allowing your baby to be adopted, which is the most important reason? (mark only one)
a. My friends would think I am a bad person

b. My family would think I am a bad person
c. The leaders of my church would think I am a bad person
d. I do not know how to place my baby for adoption
e. I would think I am a bad person

83. If you were to become pregnant again and are unmarried, what would you do?
a. have baby and keep it
b. have an abortion
c. marry father of baby and raise baby
d. have baby and place for adoption
e. have baby and let family member(s) raise it

This questionnaire is from the "Perceptions of Pregnant and Parenting Teens" research project, and is being used by permission of the authors, Cleo Rodriquez, Jr. and Nelwyn B. Moore, Southwest Texas State University.

APPENDIX B

Permission to Use Tool

Appendix B

Department of
Family & Consumer Sciences

October 11, 1995

Ms. Joy Murphy
2088 Fernbank Road
Millport, AL 35576

Dear Ms. Murphy:

In response to your request, we herewith grant permission for you to use the survey instrument from the "Perceptions of Pregnant/Parenting Teens" Research Project or selected items from said instrument in your Masters Thesis research on teen pregnancy.

The use of the survey instrument is subject to the following conditions/stipulations:

1. The last page of your questionnaire must include the following statement:

   This questionnaire (or contains selected items) is from the "Perceptions of Pregnant/Parenting Teens" research project, and is being used by permission of the authors, Cleo Rodriguez, Jr. and Nelwyn B. Moore, Southwest Texas State University.

2. Permission to use the questionnaire or selected items is limited to your thesis research project.

3. You must acknowledge permission to use the questionnaire (or selected items) from the survey instrument in the Acknowledgements section of your thesis.

4. You must acknowledge permission to use the questionnaire (or selected items) from the "Perceptions of Pregnant/Parenting Teens" Research Project in any future publications which are based on your thesis data base.

5. We are to receive one unbound copy of your thesis after its acceptance by your Thesis Committee and the Graduate School.

Southwest Texas State University

601 University Drive San Marcos, Texas 78666-4616
512-245-2155
SWT is a member of the Texas State University System.

Ms. Joy Murphy
Page Two
October 11, 1995

If you agree to the conditions/stipulations set forth above, please sign and return two copies of this letter. Upon receipt of your signed letters, you will be sent a copy of the survey instrument.

Best wishes for a successful completion of your research project.

With warm regards,

Nelwyn B. Moore/ho

Nelwyn B. Moore, Ph.D.
Professor of Family Science

Ms. Joy Murphy
Page Three
October 11, 1995

I, **Joy Murphy**, herewith agree to the conditions/stipulations set forth in this letter regarding the use of the survey instrument for "Perceptions of Pregnant/Parenting Teens" Research Project in my thesis research project.

s/ Joy Murphy

Date: 10/17/95

NBM/ks

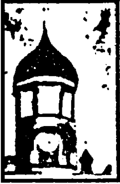
c. Cleo Rodriguez, Jr.

Enclosures (3)

APPENDIX C

Letter of Institutional Approval

Appendix C



MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Office of the Vice President for Academic Affairs
Eudora Welty Hall
P.O. Box W-1603
(601) 329-7142

March 5, 1996

Ms. Joy Murphy
c/o Graduate Program in Nursing
Campus

Dear Ms. Murphy:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research provided the following standards are met:

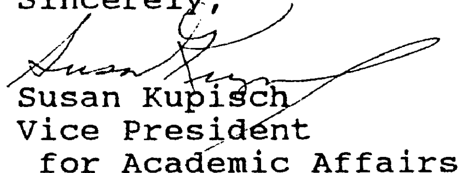
a) Parental consent should be secured whenever possible. This would be particularly true if the parent was attendant with the child.

b) The consent form should contain a statement that the participant may withdraw at anytime.

c) Great care should be taken by the researcher to insure, not only confidentiality of the interview and results, but also the mental well being of the patient.

I wish you much success in your research.

Sincerely,



Susan Kupisch
Vice President
for Academic Affairs

SK:wr

cc: Mr. Jim Davidson
Dr. Mary Pat Curtis

APPENDIX D

Letter of Approval to Use Facility

Consent to Conduct Research Study

Dear Dr. Holzhauer

I Joy Murphy am a nurse practitioner student enrolled at Mississippi University for Women. I am conducting research on adolescent pregnancy. The title of my research study is, A descriptive study of family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The purpose of my research study is to identify, examine, and describe the family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The Teenage Pregnancy/Parenting Program (TAPPS) Questionnaire will be utilized to obtain information from pregnant adolescents ages 12 to 18. The questionnaire which is filled out by the pregnant adolescent is designed to assess perception of pregnant/parenting teens and it consists of 83 items that addresses personal, family, and educational backgrounds as well as peer relations, future plans, and prenatal health.

I hope information obtained from this research study will help to identify adolescents at increased risk for pregnancy and help decrease the number of adolescent pregnancies so prevalent today. I am requesting permission to conduct research in your clinic for the purpose of this study. By signing below you will either be consenting or denying permission for me to utilize your clinic during my research study.

Thank you for your attention to this matter.

Sincerely,

Joy Murphy

Joy Murphy, RNC, Student Family Nurse Practitioner

I, [signature] consent to allow my clinic to participate in this research study

I, ______________________ deny to allow my clinic to participate in this research study.

3-7-96
Date

APPENDIX E

Letter of Approval to Use Facility

Consent to Conduct Research Study

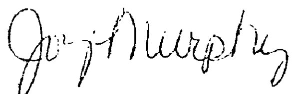
Dear Dr. Trotter

I Joy Murphy am a nurse practitioner student enrolled at Mississippi University for Women. I am conducting research on adolescent pregnancy. The title of my research study is, A descriptive study of family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The purpose of my research study is to identify, examine, and describe the family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The Teenage Pregnancy/Parenting Program (TAPPS) Questionnaire will be utilized to obtain information from pregnant adolescents ages 12 to 18. The questionnaire which is filled out by the pregnant adolescent is designed to assess perception of pregnant/parenting teens and it consists of 83 items that addresses personal, family, and educational backgrounds as well as peer relations, future plans, and prenatal health.

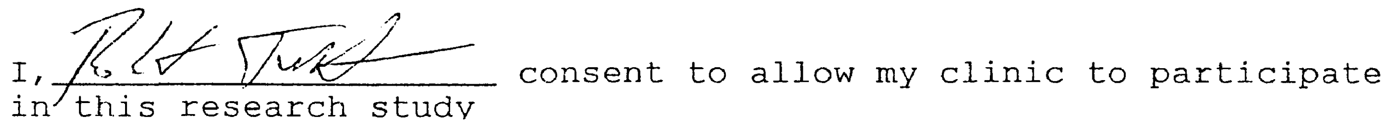
I hope information obtained from this research study will help to identify adolescents at increased risk for pregnancy and help decrease the number of adolescent pregnancies so prevalent today. I am requesting permission to conduct research in your clinic for the purpose of this study. By signing below you will either be consenting or denying permission for me to utilize your clinic during my research study.

Thank you for your attention to this matter.

Sincerely,



Joy Murphy, RNC, Student Family Nurse Practitioner



I, __________ consent to allow my clinic to participate in this research study

I, __________ deny to allow my clinic to participate in this research study.

3-6-96

Date

APPENDIX F

Letter of Approval to Use Facility

Consent to Conduct Research Study

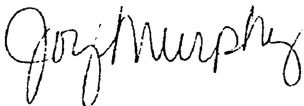
Dear Dr. Witty

I Joy Murphy am a nurse practitioner student enrolled at Mississippi University for Women. I am conducting research on adolescent pregnancy. The title of my research study is, A descriptive study of family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The purpose of my research study is to identify, examine, and describe the family relationships, race/ethnic origin, and sexuality education in pregnant adolescents. The Teenage Pregnancy/Parenting Program (TAPPS) Questionnaire will be utilized to obtain information from pregnant adolescents ages 12 to 18. The questionnaire which is filled out by the pregnant adolescent is designed to assess perception of pregnant/parenting teens and it consists of 83 items that addresses personal, family, and educational backgrounds as well as peer relations, future plans, and prenatal health.

I hope information obtained from this research study will help to identify adolescents at increased risk for pregnancy and help decrease the number of adolescent pregnancies so prevalent today. I am requesting permission to conduct research in your clinic for the purpose of this study. By signing below you will either be consenting or denying permission for me to utilize your clinic during my research study.

Thank you for your attention to this matter.

Sincerely,



Joy Murphy, RNC, Student Family Nurse Practitioner

I, J. B. Witty, Jr., MD consent to allow my clinic to participate in this research study

I, ______________________ deny to allow my clinic to participate in this research study.

3/7/96
Date

APPENDIX G

Consent to Participate

Consent to Participate

Dear Participant:

My name is Joy Murphy. I am a registered nurse and a nurse practitioner student enrolled at Mississippi University for Women. I am conducting a study of pregnant adolescents. Please sign below that you agree to fill out the Teenage Pregnancy and Parenting Program (TAPPS) Questionnaire. There will be no names used in this study. No one will see the questionnaires but me, and I will destroy them after I have analyzed them. A code will be used so that no one will know who fills out the questionnaires. All information will be kept confidential at all times.

Participation in this study is strictly voluntary. You may refuse to participate without fear of penalties or loss of benefits to any kind. Your prenatal care will not be affected in any was.

I have read the above information and agree to participate in this study.

____________	______________________________
Date	Signature of Participant
	______________________________
	Signature of Parent if Present
____________	______________________________
Date	Signature of Researcher