GOAL ASPIRATIONS AMONG NULLIPAROUS AND PAROUS ADOLESCENT GIRLS AGES 16-19: A QUALITATIVE STUDY

By

EVELYN C. KING-MARSHALL

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2013
To my family, my parents, my in-laws, Venette, Desha, and Madelyn aka Bean who have provided support, patience and motivation throughout this process
ACKNOWLEDGMENTS

I'd like to thank my parents Phillip and Maria King for pushing me to follow my dreams and teaching me that persistence is the key to success, and my siblings and grandparents for being supportive every step of the way. I owe my gratitude to my husband, Desha Marshall, and the entire Marshall Family for being a consistent avenue of support, love and understanding and showing me, that it truly takes a village to raise a child. I'd like to thank my daughter, Madelyn, for being the light at the end of the tunnel and a being a constant source of joy and amusement after long days.

I would also like to thank my friends and colleagues who have provided much needed motivation throughout this process. Venette Pierre who has been beside me as a roommate, friend, and now cousin since my first year of college; Isabel Polanco and Melissa Vilaro who were my office mates, confidants, and guides during throughout this journey; and Emmett Martin for providing much needed humor and motivation.

I want to express my keep gratitude and appreciation to my advisor and mentor, Dr. Barbara Curbow, she has helped orientate me academically, professionally, and personally and provided a professional template for the demanding albeit wonderful world of academia. I would also like to thank my committee members Dr. Tracey Barnett, Dr. Peoples -Sheps, Dr. Barbara Lutz, and former member Dr. Bridgette Rahim-Williams. All of which have guided me from conception to conclusion. Dr. Tracey Barnett, whose knowledge and experience helped me anticipate and prepare for the unknown. Dr. Barbara Lutz and the qualitative analysis group who have helped nourish my love and passion for qualitative research. Dr. Peoples-Sheps whose professional experience and knowledge of maternal and child health history, policy and practice have
guided me along the way. Dr. Rahim-Williams, my mentor who has provided advice and support personally and professionally throughout my career.

I want to express gratitude to the Behavioral Science and Community Health Department for support and guidance and the Academic Affairs Committee for their financial support, allowing my research aspirations to become reality.
# TABLE OF CONTENTS

**ACKNOWLEDGMENTS**........................................................................................................... 4

**LIST OF TABLES**.................................................................................................................. 10

**LIST OF FIGURES**................................................................................................................. 11

**ABSTRACT**............................................................................................................................... 12

**CHAPTER**

1  **INTRODUCTION**.................................................................................................................. 14

   Overview ..................................................................................................................................... 14

   Background and Context ........................................................................................................... 15

      Pregnancy ............................................................................................................................... 16

      Teen Birth .............................................................................................................................. 17

      Repeat Birth .......................................................................................................................... 18

   Research Purpose .................................................................................................................... 19

      Research Aims ....................................................................................................................... 20

      Research Questions .............................................................................................................. 20

   Conceptualization of the Problem .......................................................................................... 21

   Methods .................................................................................................................................... 22

   Overview of the Chapters ........................................................................................................ 23

   Chapter 1 Conclusion .............................................................................................................. 24

2  **REVIEW OF THE LITERATURE**......................................................................................... 27

   Adolescent Development ........................................................................................................ 27

   Adolescent Risk Taking ........................................................................................................... 29

   Risk Factors ............................................................................................................................. 34

      Risky Sexual Behavior ......................................................................................................... 34

      Adolescent Pregnancy and Birth .......................................................................................... 37

      Repeat Pregnancy and Birth ................................................................................................. 40

      Unique Circumstances: Adolescent Pregnancy in Foster Care ........................................... 44

   Protective Factors ................................................................................................................... 45

   Implications for Adolescent Pregnancy, Birth, and Repeat Birth ........................................ 47

      Adolescent Birth .................................................................................................................... 47

      Repeat Birth .......................................................................................................................... 48

   Intervention and Prevention Programs .................................................................................. 49

      Successful Programs .............................................................................................................. 49

      Mixed Reviews ....................................................................................................................... 54

      Unsuccessful Programs ......................................................................................................... 55

      Suggested Programs ............................................................................................................. 57

   Adolescent and Repeat Pregnancy Prevention Summary .................................................... 57
Theoretical Framework ......................................................................................................................... 58
  Meaning of Success ............................................................................................................................. 59
  Professional Goal Aspirations ............................................................................................................. 60
  Personal Aspirations ............................................................................................................................. 61
  Perceived Advantages and Disadvantages of Adolescent Parenting ...................................................... 62
  Media Influences ................................................................................................................................. 63
Summary .................................................................................................................................................. 65
Chapter 2 Conclusion ............................................................................................................................. 65

3  RESEARCH DESIGN and METHODS ................................................................................................. 70

Overview .................................................................................................................................................. 70
Approach .................................................................................................................................................. 70
Research Setting ..................................................................................................................................... 72
  Population Estimates ............................................................................................................................ 73
  Socio-Economic Status (SES) ................................................................................................................. 73
  Health Status and Adolescent Risk Behaviors ....................................................................................... 74
  Sexual, Maternal, and Child Health ...................................................................................................... 75
Interviews .................................................................................................................................................. 76
  Sample .................................................................................................................................................. 76
  Inclusion and Exclusion Criteria ............................................................................................................ 76
  Recruitment .......................................................................................................................................... 77
  Recruitment Difficulties ......................................................................................................................... 79
  Procedure ............................................................................................................................................ 80
  Instrument Development ......................................................................................................................... 82
Focus Group ............................................................................................................................................. 83
  Sample .................................................................................................................................................. 83
  Inclusion and Exclusion Criteria ............................................................................................................ 83
  Recruitment .......................................................................................................................................... 83
  Procedure ............................................................................................................................................ 84
  Instrument Development ......................................................................................................................... 85
Quantitative Instrument Development .................................................................................................... 85
  Rosenberg Self-Esteem Scale (RSE) ........................................................................................................ 86
  The Mastery Scale ................................................................................................................................ 88
  Life Orientation Test ............................................................................................................................... 89
  Positive and Negative Affect Schedule .................................................................................................. 90
Data Analysis ............................................................................................................................................ 91
  Quantitative Analysis ............................................................................................................................ 91
  Qualitative Analysis ............................................................................................................................... 92
    Thematic analysis .................................................................................................................................. 93
    Case study analysis ............................................................................................................................... 95
Ethical Considerations ............................................................................................................................ 95
Chapter 3 Conclusion ............................................................................................................................. 97

4  FINDINGS ........................................................................................................................................... 108

Overview .................................................................................................................................................. 108
RQ 1. What are the Similarities and Differences in Demographics, Family Dynamics, Family/Peer History of Teen Pregnancy, Religion, and Psychosocial Constructs Such as Self-Esteem, Mastery, Optimism, and Positive/Negative Affect between Nulliparous and Parous Adolescents? ........ 109
  Background Characteristics ........................................................................ 109
  Family Dynamics ....................................................................................... 110
  Family History of Teen Pregnancy ............................................................... 111
  Sexuality and Teen Parenthood among Peers ................................................ 111
  Psychosocial Constructs ............................................................................. 112

RQ 2. What are the Similarities and Differences in Definitions of What it means to have a Successful Life between the two groups? ........................................ 114
  Meaning of Success ...................................................................................... 114
  Profile of Success ......................................................................................... 116
  Characteristics of Successful and Unsuccessful Members in the Community 117
  Success Rankings ....................................................................................... 118
  Facilitate Success ....................................................................................... 120

RQ 3. What are the similarities and differences in definitions of personal and professional goal aspirations between the two groups? ................................ 122
  Personal Aspirations .................................................................................... 122
  Professional Aspirations ............................................................................. 124

RQ 4. How do Adolescent Girls (Ages 16-19) who have Never Been Pregnant Perceive Pregnant or Parenting Peers? What are their Views on Adolescent Pregnancy/Motherhood in the Media? .................................................. 130
  Sexually Active Peers ................................................................................. 130
  Sex Education aka ‘The Talk’ ..................................................................... 131
  Best Perceived ways of Preventing Pregnancy and Sexually Transmitted Diseases (STDs) ........................................................................ 133
  Media ......................................................................................................... 139
    Effect of 16 and Pregnant ® and Teen Mom on Teen Pregnancy® .......... 139
    Media and Reality ..................................................................................... 140
    Other Media ............................................................................................. 140

  Discovery ..................................................................................................... 141
  Birth ........................................................................................................... 145
  Motherhood ................................................................................................. 146

  Carmella’s Story: Told on April 22, 2012 ..................................................... 150
  Rae’s Story: Told on September 27, 2012 ..................................................... 154
  Tia’s Story: Told on October 16, 2012 ........................................................ 159

Unexpected Findings: Adolescent Mothers in Foster Care .......................... 162
Summary of Findings .................................................................................. 164
Chapter 4 Conclusion .................................................................................. 165
5 DISCUSSION AND CONCLUSIONS................................................................. 175

Overview of the Study.................................................................................. 175

RQ 1. What are the Similarities and Differences in Demographics, Family
Dynamics, Family/Peer History of Teen Pregnancy, Religion, And
Psychosocial Constructs Such As Self-Esteem, Mastery, Optimism, and
Positive/Negative Affect between Nulliparous and Parous Adolescents? ... 175

RQ 2. What are the Similarities and Differences in Definitions of What It
Means to Have a Successful Life between the Two Groups? ................. 176

RQ 3. What Are the Similarities and Differences in Definitions of Personal
and Professional Goal Aspirations between the Two Groups? .............. 179

Pregnant Perceive Pregnant or Parenting Peers? .................................... 181

RQ 5. How Do Primiparous Adolescent Girls (Ages 16-19) Describe The
Context Surrounding Initial Birth? ............................................................ 184

RQ 6. How Do Multiparous Adolescent Girls (Ages 16-19) Describe The
Context Surrounding Subsequent Births? ................................................. 186

Additional Findings: Adolescent Motherhood in Foster Care .............. 187

Strengths and Limitations .......................................................................... 189

Implications for Policy ............................................................................... 190

Implications for Practice ........................................................................... 194

Implications for Theory and Suggestions for Future Research ............. 197

Chapter 5 Conclusion ............................................................................... 200

APPENDIX

A PARTICIPANT INTAKE FORM.................................................................. 201

B NULLIPAROUS ADOLESCENT INTERVIEW GUIDE .............................. 210

C PRIMIPAROUS/ MULTIPAROUS ADOLESCENT INTERVIEW GUIDE...... 217

D FOCUS GROUP SCRIPT AND QUESTION GUIDE................................. 224

REFERENCES ......................................................................................... 230

BIOGRAPHICAL SKETCH........................................................................... 249
<table>
<thead>
<tr>
<th>Table</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1</td>
<td>Risk Factors of Risky Sexual Behavior, Adolescent Pregnancy, and Repeat Pregnancy</td>
<td>68</td>
</tr>
<tr>
<td>2-2</td>
<td>Pregnancy and Repeat Pregnancy Prevention Components of Successful, Mixed, and Unsuccessful Programs</td>
<td>69</td>
</tr>
<tr>
<td>3-1</td>
<td>Data amended from Florida Charts County School-aged Child and Adolescent Profile (2011) and County Health Status</td>
<td>98</td>
</tr>
<tr>
<td>3-2</td>
<td>Inclusion and exclusion criteria for interview participants</td>
<td>100</td>
</tr>
<tr>
<td>3-3</td>
<td>Inclusion and exclusion criteria for focus group participants</td>
<td>100</td>
</tr>
<tr>
<td>3-4</td>
<td>Interview guide themes and corresponding interview questions</td>
<td>101</td>
</tr>
<tr>
<td>3-5</td>
<td>Focus group themes and corresponding questions</td>
<td>102</td>
</tr>
<tr>
<td>3-6</td>
<td>Interview and focus group sample demographic.</td>
<td>103</td>
</tr>
<tr>
<td>3-7</td>
<td>The Mastery Scale (Perlin &amp; Schooler, 1978)</td>
<td>104</td>
</tr>
<tr>
<td>3-8</td>
<td>The Rosenberg Self-Esteem Scale (Rosenberg, 1965)</td>
<td>105</td>
</tr>
<tr>
<td>3-9</td>
<td>The Life Orientation Test (Scheier &amp; Carver, 1985)</td>
<td>106</td>
</tr>
<tr>
<td>4-1</td>
<td>Research aims and research questions</td>
<td>166</td>
</tr>
<tr>
<td>4-2</td>
<td>Population demographics</td>
<td>167</td>
</tr>
<tr>
<td>4-3</td>
<td>Standardized scale means</td>
<td>169</td>
</tr>
<tr>
<td>4-4</td>
<td>Description of participant sample</td>
<td>170</td>
</tr>
<tr>
<td>4-5</td>
<td>Summary of research findings by research question</td>
<td>171</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1</td>
<td>Risk Factors of Risk Factors for Risky Sexual Behavior, Adolescent Pregnancy, Repeat Pregnancy</td>
<td>67</td>
</tr>
<tr>
<td>3-1</td>
<td>Adolescent Birth rate, national distribution. (Birth Rate per 1,000, ages 15-19, 2010.) Original Image (Kaiser Foundation, 2012)</td>
<td>98</td>
</tr>
<tr>
<td>3-2</td>
<td>Alachua and Marion County sited on Florida Map (Florida Counties, 2013)</td>
<td>98</td>
</tr>
<tr>
<td>4-1</td>
<td>Box Plot presentation of PANAS mean difference</td>
<td>172</td>
</tr>
<tr>
<td>4-2</td>
<td>Characteristics of Successful people in the community identified by Nulliparous and Parous participants</td>
<td>173</td>
</tr>
<tr>
<td>4-3</td>
<td>Characteristics of Unsuccessful people in the community identified by Nulliparous and Parous participants</td>
<td>174</td>
</tr>
</tbody>
</table>
GOAL ASPIRATIONS AMONG NULLIPAROUS AND PAROUS ADOLESCENT GIRLS AGES 16-19: A QUALITATIVE STUDY

By

Evelyn C. King-Marshall

August 2013

Chair: Barbara Curbow
Major: Public Health

Risky sexual behavior among adolescents can lead to adolescent pregnancy, and repeat pregnancy. Understanding the context of index and subsequent pregnancies among primiparous and multiparous adolescents is essential to reducing rates of adolescent pregnancy and repeat pregnancy. Research suggests that life goals compatible with motherhood may influence rates of adolescent pregnancy and repeat pregnancy, thus making it imperative to investigate the influence of the meaning of life success and personal and professional goal aspirations on adolescent sexual decision-making and pregnancy.

I used focused ethnography methods to explore the meaning of success and the differences in personal and professional goal aspirations among nulliparous and parous participants. I explored the perceptions of adolescent motherhood among nulliparous participants and the context of single and subsequent births in primiparous and multiparous adolescents.

This research included five research aims and six research questions. I addressed these questions through conducting 30 in-depth interviews with nulliparous, primiparous and multiparous adolescents and two focus groups with parous
adolescents. I collected demographic information, and self-reports of self-esteem, optimism, mastery, and positive/negative affect.

The average age of participants was 17.5 years old. Among the sample, 57% were Black, 25% were White, 12.5% were other, and 6.3% were Hispanic. Findings concluded no statistical difference between nulliparous and parous adolescents on self-esteem, optimism, mastery, or positive/negative affect; however, participant means were consistent with those in the literature. Nulliparous participants placed ‘getting married’ as being significantly more important to reaching personal success than did parous participants. Nulliparous adolescents perceived adolescent motherhood as hard for personal, social, and romantic reasons. Parous participants described being shocked, scared, or excited at pregnancy discovery and characterized adolescent motherhood as ‘not that hard,’ specifically not as hard as they (society) predicted. The easiest part of motherhood was caring for their child, and the hardest part was lack of financial independence.

Overall, participants described success using one of three ideologies: distance traveled, goals achieved, and status achievement. Additionally, personal independence was embedded in each ideology. There were no differences in professional aspirations; however, parous participants described changing goals to include degree programs that took less time since motherhood.
CHAPTER 1
INTRODUCTION

Overview

Compared to adults, adolescents typically have to make decisions regarding risky behavior under time pressures, in a specific context, and with possibly uncertain consequences (Downs & Fischhoff, 2009). One specific consequence of risky sexual behavior is adolescent pregnancy. Despite best efforts, the consequences of adolescent pregnancy are numerous; significant ramifications for society, the community, the adolescent, and the infant have been identified. Identified consequences continue to grow overtime, resulting in a malicious and unyielding cycle. Adolescent pregnancy has been linked to detriments to the individual (adolescent and infant health), the family unit (breakdown in family structure), and society (decreased earning potential and increased system burden).

There are varying definitions of the terms adolescent, teen and teenager. The adolescence period, as described by Lerner (2001, 1980), “is a period in life when a person’s biological, cognitive, psychological, and social characteristics are changing from what is considered childlike to what is considered adultlike” (Lerner, et al., 2001, p. 12). Rivara, Park, and Iwin (2009), concur that adolescence is an age of transition from childhood to adulthood. Although the adolescent age group varies by source and purpose, literature identifies early adolescents (ages 10-13), adolescent (ages 14-18), and late adolescent or young adulthood (ages 19-24) as primary subcategories (Rivara, Park, & Iwin, 2009) or early (10-14), middle (ages 15-17), and late (ages 18-20) (Auslander, Roshenthal, & Blythe, 2006). Due to small sample sizes and inconsistency in data collection, most studies characterizing adolescent childbearing limit the ages to
15-19 (Phipps & Sowers, 2002). National data on childbirth among pre-adolescents and early adolescent (ages 10-14) is substantial, but it is inconsistent at the state level. Adolescent, as used throughout this dissertation, refers to individuals ages 13-19, unless otherwise specified.

Pre-adolescent and adolescent birth (occurring at or before the age of 19); is associated with varying deficits in life achievement such as lower rates of high school graduation, college attendance, marriage, and substantive employment (Fergusson & Woodward, 2000; Rowlands, 2010; The National Campaign to Prevent Pregnancy, 2011). As such, these life course penalties result in increased economic costs, and social consequences.

**Background and Context**

According to the Centers for Disease Control and Prevention’s 2011 Youth Risk Behavior Survey, approximately 47% of high school students reported ever having sexual intercourse and one-third reported not using a condom the last time they had sex (Centers for Disease Control and Prevention (CDC), 2013). About one-third (34%), of participants reported being sexually active, defined as having had sexual intercourse with at least one person during the three months prior to the survey. Among sexually active students, 60% used a condom and 12% used some other type of pregnancy prevention during last sexual intercourse. However, 22% of sexually active adolescents reported drinking alcohol or using drugs before last sexual intercourse (CDC, 2013). Sexually transmitted diseases, HIV/AIDS, unplanned pregnancy and premature death are a few of the many long lasting consequences associated with risky sexual behaviors (Rivara, Park, & Irwin, 2009)
As noted, adolescent (under the age of 19) pregnancy can result in a number of negative outcomes for the teen and the child. Additionally, daughters of adolescent mothers are more likely to become pregnant as teenagers and their sons are more likely to be incarcerated at some point in their lives (NCPP, 2011). In addition to the negative consequences of teenage pregnancy, teens who give birth at an especially young age are more likely to give birth again before the age of 19 (NCPP, 2011). Adolescent mothers are more likely to drop out of high school and subsequently live in poverty. In fact, of all mothers on welfare, 52% had their first child as a teenager (National Campaign to Prevent Pregnancy (NCPP), n.d). Jaffee (2002) found that although individual and family factors accounted for some poor outcomes, such as lower high school graduation, and higher welfare usage, adolescent birth exacerbated the negative outcomes. Social consequences include almost 10.9 billion dollars spent on early pregnancy outcomes in 2008, money paid by taxpayers at the federal, state, and local levels. These economic losses are attributed to lost tax revenue and increased public health care, child welfare, and state prison costs; costs are proportionate to the rates of teen motherhood within these states (NCPP, 2011). Texas taxpayers experienced the highest monetary loss due to teen childbearing, followed by California then Florida; North Dakota, Vermont, and Maine taxpayers experienced the lowest associated loss (NCPP, 2011).

**Pregnancy**

Each year there are approximately 750,000 pregnancies among teenagers ages 15-19 in the United States (Kost, Henshaw, & Carlin, 2010; Ventura, Mathews, Hamilton, Sutton, & Abma, 2011). Historically, the teen pregnancy rate in the US is more than twice as high as in Canada and other industrialized countries (Finer &
Henshaw, 2006). Approximately 82% of adolescent pregnancies are unplanned; they account for about 20% of all unplanned pregnancies in the US each year (Finer & Henshaw, 2006; Ventura, Mathews, Hamilton, Sutton, & Abma, 2011). In 2006, the majority of teen pregnancies (59%) resulted in birth (Figure 1-1) and the teenage abortion rate was 19.3 per 1,000 in the US (Finer, 2006). Overall, teen pregnancy rates have declined over the past decade. Rates for minorities have experienced a more dramatic decline than among their white counterparts. The pregnancy rate for Black females ages 15-19 fell from 223.8 to 126.3 per 1,000 during the period of 1990 to 2006 (Finer, 2006). In 2006, of all unintended pregnancies in Florida, 49% resulted in birth, 40% resulted in induced abortion, and 11% resulted in fetal loss (Finer & Kost, 2011).

**Teen Birth**

In 2009-10, the overall birth rate dropped 9 percent from 37.9 to 34.3 per 1,000 women ages 15-19 (Martin, et al., 2012; Hamilton & Ventura, 2012). Hispanic and Black youth had higher birth rates compared to their White counterparts (Martin, et al., 2012). In 2010, birth rates per 1,000 were 55.7 for Hispanics and 51.5 for Blacks compared to 23.5 for Whites ages 15-19 in the United States (Martin, et al., 2012; Hamilton & Ventura, 2012). Rates were significantly higher among women ages 18-19, but a disparate trend still occurs -- 90.7 per 1,000 for Hispanics, 85.6 for Blacks, and 42.5 for Whites (Martin, et al., 2012). Please see Figure 1-1.

At the state level, in 2010, there were 32 births per 1,000 to Florida teens ages 15-19. Mississippi had the highest rate (55.0 per 1,000), followed closely by New Mexico (53.0), and Arkansas (52.5) (Martin, et al., 2012). States with the lowest rates were New Hampshire (15.7), Massachusetts (17.2), and Vermont (17.9) (Martin, et al.,
States with a higher minority population and those located in the Southern region of the US typically have higher rates of teen birth (Hamilton & Ventura, 2012).

Within Florida counties in 2009-2011, Hardee County had the highest rate of birth among teens ages 15-19 at 81.06 per 1,000; Alachua County had the lowest rate (20.7 per 1,000) (Florida Charts, 2009). Possible reasons for this wide discrepancy may be related to demographic differences. Hardee is a rural county, as defined by Florida Statue, located in the Southern region of Florida; it has less than 100 people per square mile (Legistlature, 2012). In 2010, 26% of Hardee residents lived below 100% poverty, with an average median income approximately $10,000 less than the state average ($37,466 vs. $47.661) (Florida Charts, 2013). Alachua County is a suburban county located in north central Florida with an average yearly income of $40,644; 20% of residents live below 100% poverty (Florida Charts, 2013). For additional information on Alachua County, see Chapter 3, Research Design and Methods.

Repeat Birth

A repeat birth is defined by Florida Charts (2009) as a live birth in which the mother has had at least one previous live birth or births (Schelar, Franzetta, & Jennifer, 2007). The rate of repeat birth in 2010 for all adolescents ages 15-19 was 5.4 per 1,000 (Martin, et al., 2012). Minority adolescents show disparately higher rates of repeat birth when compared to their white counterparts. The rate of repeat birth among Whites ages 15-19 was 4.9 per 1,000 compared to 10.0 among Hispanics, 8.6 among Blacks, and 6.9 among American Indian/ Alaska Natives (Martin, et al., 2012). Rates of repeat birth are also higher among older adolescents (ages 18-19): 11.0 per 1,000 for all races, 10.1 among Whites, 17.2 among Blacks, and 14.4 among American Indian/ Alaska Native (Martin, et al., 2012). Although, the percent of repeat births is typically higher among
Black adolescents, this group experienced the largest decline compared with Hispanic and White adolescents (Martin, et al., 2012). Nationally in 2010, repeat births to females under the age of 20 were the highest in Texas (22%) and the lowest in New Hampshire (11%) (US Department of Health and Human Services (US DHHS), 2013). In 2010, the percent of repeat births in Florida was slightly higher (18%) than in the US overall (17%) (US DHHS, 2013). Repeat births rates among Florida teens ages 15-17 declined from 9.6 per 1,000 in 2006-08 to 8.9 in 2009-11 (Florida Charts: Florida Department of Health, 2013). In 2009-11, the Florida counties of Holmes (24.7%), Gadsden (24.1%), and Hamilton (23.7%), had the highest percentages of repeat births. Gadsden, Holmes, and Hamilton counties are all located in the Florida panhandle, adjacent to Georgia or Alabama and each has a population density of less than 100 people per square mile. In 2010, Gadsden County’s population density (89.8 per square mile) was higher than both Holmes County (41.6) and Hamilton County (28.6) (United States Census Bureau, 2013). They are all defined as rural counties. Additionally, Hamilton and Gadsden counties both have a high (35% and 56%) proportion of Non-White residents (United States Census Bureau, 2013), which may also contribute to higher rates of repeat birth. Alachua County had the 16th highest (19.8%) and Santa Rosa County had the lowest percent (10.9%) of repeated pregnancies (FDOH, 2011).

**Research Purpose**

Although research on the risk and protective factors associated with teen pregnancy and repeat pregnancy is abundant (Raneri & Wiemann, 2007; Rowlands, 2010) our current understanding of the complexities of adolescent childbearing and repeat childbearing is limited. The purpose of this research project was to investigate the definition of life success and personal and professional life aspirations among
nulliparous, primiparous and multiparous adolescents. Current literature provides a detailed account of the epidemiology of teen pregnancy and repeat pregnancy and the risk and protective factors (Chapter 2: Review of Literature), while this research provides a contextual framework for understanding adolescent birth and repeat birth, there is still much that is unknown.

The goal of this research was to provide a preliminary investigation of life success definitions and personal and professional goal aspirations of nulliparous, primiparous and multiparous adolescent girls ages 16-19. Results from this study and follow up studies can lead to the development of specialized repeat pregnancy interventions utilizing goal development and achievement strategies to reduce rates of repeat pregnancy.

Research Aims

The research aims for the project were the following:

1. To explore the role of factors such as demographics, family dynamics, family/ peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect on single and subsequent adolescent births among girls 16-19;

2. To explore the themes associated with what it means to have a successful life between nulliparous and parous adolescent girls (ages 16-19);

3. To explore the themes associated with personal and professional aspirations between nulliparous and parous adolescent girls (ages 16-19);

4. To investigate the explanatory models of nulliparous adolescent girls (ages 16-19) associated with parous peers, and their views on adolescent motherhood in the media; and

5. To explore the described context of conception, delivery, and motherhood (for single and subsequent pregnancies) among parous adolescent girls (ages 16-19)

Research Questions

The research questions for the project were the following:
1. What are the similarities and differences in demographics, family dynamics, family/peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect among nulliparous and parous adolescents?

2. What are the similarities and differences in definitions of what it means to have a successful life between the two groups?

3. What are the similarities and differences in definitions of personal and professional goal aspirations between the two groups?

4. How do adolescent girls (ages 16-19) who have never been pregnant perceive pregnant or parenting peers? What are their views on adolescent pregnancy/motherhood in the media?

5. How do primiparous adolescent girls (ages 16-19) describe the context surrounding initial birth?

6. How do multiparous adolescent girls (ages 16-19) describe the context surrounding subsequent births?

**Conceptualization of the Problem**

Herman (2006) investigated girls regarding how they thought teen pregnancy and birth affected their relationships, vocation, and self. Never pregnant teens reported pregnancy and birth would have a negative effect on friendship and peers, while parenting/pregnant teens reported both negative and positive effects. Parenting teens reported a positive impact on vocation, describing an increase in motivation towards school, while non-parenting teens believed it would cause an increase in difficulties associated with being a parent and a student (Herman, 2006). Arai (2007) found limited effects of peer influence on parenting adolescents. Using qualitative methods, the author investigated the effect of neighborhood and peer influences on pregnancy and fertility. From the mothers’ perspective, there was no evidence that peers influenced their behavior; however early childbearing may be normative in some communities (Arai, 2007, p. 87). Although these mothers sought advice from peers and some
recognized negative local attitudes towards their pregnancy from the community, none reported a long-term impact (Arai, 2007).

Camerena (1998) found that adolescent mothers reported varying degrees of change in life aspirations after giving birth. Some participants described feelings of resilience, some described no change, and some described resignation. Among participants who reported resignation (tone reflected more struggle than hope) the reality of their new life was a source of frustration (Camerena, 1998 pg 132). However, those who reported resilience or adjustment described a renewed focus due to giving birth (Camerena, 1998). Similar to Herman (2010) and Camerena (1998), SmithBattle (2007) reported a renewed sense of focus on education and success among some parenting adolescents while others were victim to family, financial and school difficulties that compelled school withdrawal. Goals that are compatible with motherhood and an ambivalent disposition towards pregnancy have also been linked to repeat pregnancy (Sheeder, 2009; Sheeder, 2010; Rosengard, 2009).

Considering goals compatible with motherhood as a link to repeat pregnancy, I sought to highlight the differences in both personal and professional goal aspirations among primiparous and multiparous adolescents. In addition, I compared these findings with nulliparous adolescents.

**Methods**

I conducted an explorative qualitative research project grounded in ethnographic methodology. Ethnography allows for exploration based on culture (Richards & Morse, 2007). Ethnographic research explores themes within cultural contexts from the perspectives of the members of the group; during data collection, it is essential to reflect on the cultural values, beliefs, and behaviors of the group (Richards & Morse, 2007, pg.
Observational data, field notes, surveys, and interviews (unstructured, semi-structured and structured) are classic ethnographic methods. Ethnographic methods address observational questions, descriptive questions about values, beliefs and practices of cultural groups, and what is happening within the culture (Richards & Morse, 2007). Using key informants and snowball sampling methods, I conducted thirty interviews among nulliparous, primiparous and multiparous adolescent girls ages 16-18. I also conducted two focus groups among pregnant or parenting adolescents ages 16-19.

The interviews and focus groups covered general information about life for girls their age, the meaning of success, and adolescent sexuality and pregnancy. Specific questions investigated their current and previous goal aspirations, perceived benefits and consequences of adolescent pregnancy and the media’s perception and portrayal of adolescent pregnancy. The quantitative strategy included collecting demographic information and self-reported responses to the Positive and Negative Affect Scale (PANAS) (Watson, Clark, & Tellegen, 1988), The Rosenberg Self-Esteem Scale (Rosenberg, 1965), The Mastery Scale (Perlin & Schooler, 1978), and the Life Orientation Test (Scheier & Carver, 1985). I conducted a statistical analysis using SPSS® 22.

**Overview of the Chapters**

In Chapter 1, I have provided a brief introduction into the topic of adolescent pregnancy and repeat pregnancy as well as an overview of the current epidemiologic data. In Chapter 2, I provide a detailed examination of the literature surrounding adolescent pregnancy and contributing theories or factors. Additionally, I present a review of the risk and protective factors associated with teen pregnancy, teen birth, and
repeat birth. Reviews of the literature on success and goal aspirations among adolescents, at risk adolescents and pregnant or parenting adolescents are also included. In Chapter 3, I provide a detailed description of the research methods and design. Information on the research setting, recruitment strategy, participant sample, and the development and varying components of the qualitative and quantitative instruments are located in Chapter 3. I conclude Chapter 3 with a guide of the qualitative and quantitative methods employed in this dissertation. In Chapter 4, I discuss the results of the dissertation. I present the quantitative and qualitative findings as they relate to each research question. Quantitative results related to specific measures such as the PANAS (Watson, Clark, & Tellegen, 1988), The Mastery Scale (Perlin & Schooler, 1978), The Rosenberg Self-esteem Scale (Rosenberg, 1965), and the Life Orientation Test (Scheier & Carver, 1985) are highlighted. In the conclusion, Chapter 5, I provide a summary and a discussion of the findings and their implications for theory, policy, and practice.

Chapter 1 Conclusion

Adolescent pregnancy, birth, and repeat birth have numerous and long lasting adverse effects on the adolescent and the child (NCPP, 2011; Jafee, 2002). Although rates are improving, adolescent birth and repeat birth continue to be issues in the United States as compared to other industrialized countries (Singh & Darroch, 2000; Kost, Henshaw, & Carlin, 2010). This study explored the contextual factors related to adolescent birth and subsequent birth, the meaning of success, and personal and professional goal aspirations among a select sample of primiparous, nulliparous, and multiparous adolescents. The overall aim was to assess differences and similarities on select constructs, success and goal aspirations, and the effect of premature
childbearing among the three groups (nulliparous, primiparous, multiparous girls). This was produced with the use of qualitative methods, specifically focused ethnography, and supported by quantitative methods including the use of validated scales.
Adolescent pregnancy and repeat pregnancy occur within biological, psychological, and social contexts. In Chapter 2, Review of the Literature, I will review adolescent development, adolescent risk taking, and risk taking theory. Following risk taking theory I will discuss the risk and protective factors related to risky sexual behavior, adolescent pregnancy and repeat pregnancy (summarized in Table 2-1, and Figure 2-1), followed by implications of adolescent pregnancy, and a review of intervention and prevention programs (summarized in Table 2-2). I conclude Chapter 2 with the theoretical framework applied to this research, which considers goal aspirations, the meaning of success, and the context of motherhood among adolescents.

**Adolescent Development**

Normal adolescent development encompasses increasing independence, autonomy, peer affiliation, sexual awareness, and cognitive maturation (Igra & Irwin, 1996, p. 36). Developmental tasks of adolescence derived from Erikson’s psychosocial theory are 1) developing an identity or gaining autonomy and independence; 2) developing intimacy in relationship; 3) developing comforts with one’s sexuality; and 4) developing a sense of achievement (Erickson, 1963). Strickland et al. (2006) summarized similar goals of adolescence including 1) achievement of autonomy and independence; 2) establishment of self-identity; 3) development of social competence; and 4) acquisition of cognitive abilities. Adolescence is generally defined as the period between 10-20 and split into three phases. Although the terms, early, middle, and late adolescence are often used, the age distribution differs among researchers. Auslander
et al. (2006) defined adolescence by early (10-14), middle (ages 15-17), and late (ages 18-20). However, Rivara, Park, and Irwin (2009), defined early adolescents (ages 10-13), adolescents (ages 14-18), and late adolescents or young adulthoods (ages 19-24).

During the adolescent period, individuals transform via a period of biological, cognitive, social, and behavioral development (Adams, 2005), with long-term consequences. Adolescent biological development is most often noted for the preparation and onset of puberty. Changes in hormones, increased body hair, and other changes in physical appearance may initiate risk behaviors, especially in early or late maturing adolescents. Adolescent cognitive development includes fluctuation in intelligence quotient (IQ) often a steady increase, and the transformation from concrete thinking to more abstract thinking (Adams, 2005). During adolescence emotional development, tasks include learning 1) to regulate intense emotions; 2) self-soothing techniques; 3) to be aware of their own emotions; 4) to understand the consequences of emotions for others; 5) to distinguish feelings from facts; 6) to manage emotional arousal; and 7) to manage feelings of love, hate or indifference in romantic relationships (Adams, 2005, p. 12). Adolescent social development consists of a greater attachment to peers and earning autonomy and independence from parents (Adams, 2005). During early adolescence, there is strong conformity to peer pressure and the need to belong. During middle adolescence, there are typically larger peer groups, resulting in less confirmatory and increased tolerance of differences. During late adolescence, peer groups typically consist of groups of couples, which provide an environment of intimacy, and dyadic relationships (Adams, 2005).
Adolescent sexual development often occurs within the context of romantic relationships (Auslander, Roshenthal, & Blythe, 2006). In early adolescence, typical sexual development includes understanding how to feel in romantic relationships (Connolly & Goldberg, 1999; Auslander, Roshenthal, & Blythe, 2006). During middle and late adolescence, teens become more sexually experienced and the qualities of intimate relationships become more important (Connolly & Goldberg, 1999; Auslander, Roshenthal, & Blythe, 2006).

These changes in biological, cognitive, social, and sexual development contribute to the precariousness of this stage in the adolescent’s life, which can lead to risk taking and deviant activities. Behavioral development for most adolescents, an estimated 80% per generation, is uneventful and consists of age appropriate actions such as active compliance with school, sports, homework, and religious requirements (Adams, 2005). However, an estimated 20% participate in serious risky behaviors, drug use/abuse, sexual, criminal, or delinquent (Adams, 2005, pp. 13-14), also known as risk taking behaviors.

**Adolescent Risk Taking**

Risky behavior is a leading contributor to premature death; up to an estimated 70% of morbidity among adolescents can be attributed to risk taking behaviors (Adams, 2005; Rivara, Park, & Irwin, 2009). Risk behaviors, defined and measured by the Youth Risk Behavior Surveillance System (YBSS), are behaviors that contribute to the leading causes of death and disability among youth and adults (Youth Risk Behavior Surveillance System (YRBSS), 2013). Risky behaviors include those that contribute to unintentional injury and violence, alcohol and other drug use, tobacco use, unhealthy dietary behaviors and inadequate physical activity (YRBSS, 2013). Risky sexual
behaviors are defined as those that contribute to unintended pregnancy and sexually transmitted diseases such as HIV/AIDS (YRBSS, 2013). The term ‘risk-taking behaviors’ has often been used to link potentially health damaging behaviors such as substance use, precocious sexual behavior, reckless vehicle use, homicidal and suicidal behaviors, eating disorders, and delinquency (Igra & Irwin, 1996, p. 35).

Tobacco, drug and alcohol use, as well as the rate of sexually transmitted diseases, peak in the late teens and early twenties (Rivara, Park, & Irwin, 2009). Excess death attributable to these risky behaviors is especially troublesome because the behaviors are modifiable. Risky sexual behavior, including but not limited to having unprotected sex and numerous sexual partners, although declining, is still common among adolescents in the United States (Kost, Henshaw, & Carlin, 2010). There was no significant decrease in the percent of high school students reporting sexual intercourse before age 13 from 2009 (5.9%) to 2011 (over 6.0%) (Youth Risk Behavior Surveillance- United States, 2011; 2012). In 2011, rates of adolescents reporting sexual intercourse before age 13 were higher among Blacks (14%), than Hispanics (7%), and Whites (4%) (Youth Risk Behavior Surveillance-- United States, 2011, 2012). The prevalence of having four or more sexual partners did not change significantly from 2001 (14.2%), to 2009 (13.8%), to 2011 (15.3%) (Youth Risk Behavior Surveillance-- United States, 2011; 2012). Epidemiological reports indicate that almost half of all new STD cases were among young people ages 15-24 in 2009 and young people ages 13-29 accounted for 39% of all HIV infections (CDC, 2013).

**Decision-Making:** Decision-making can occur in multiple steps. The first step to decision making is to identify options, the second is to begin evaluation of these options
(Downs & Fischhoff, 2009). For example, adolescents might make the decision to have sex or not to have sex, based on potential consequences of each option. However, these steps falsely assume that people, specifically adolescents know what they want and the steps lack the influential impact of the context (Downs & Fischhoff, 2009). Singer and colleagues (2006) explored social and cultural contexts to understand sexually transmitted disease rates in inner city minority women. Context driven decision-making related to sexual risk behaviors included information about the partner (attractiveness, social standing, family background, and personal history), personal relationship status, and availability of condoms (Singer, et al., 2006). Nelson and colleagues (2011), found that among African-American adolescent mothers, condom-use decision making varied by partner type and emotional and relationship factors. Type of sexual partners, such as being steady versus a casual relationship, influenced the adolescents’ perception of risk, thus tipping the decision-making schema (Nelson, Morrison-Beedy, Kearney, & Dozier, 2011). Participants reported always using a condom with a one-night stand, perceived as someone they did not know or trust and never using a condom with their baby’s father with whom they had an existing prior relationship and prior unprotected sex (Nelson, Morrison-Beedy, Kearney, & Dozier, 2011). Not using a condom, not using birth control, or having multiple sexual partners, are all poor health decisions and risky sexual behaviors; risky behaviors have been investigated via many avenues including theories of risk taking.

**Risk-Taking Theories:** Risk-taking literature has explored several explanations for adolescent behavior. Among the most widespread are views that risk-taking has biological, psychological, and social and environmental explanations or the
combinations of all factors, the bio-psychosocial model of risk taking (Sales & Irwin, 2009).

Biologically based theories for risk taking suggest that risk taking results from genetic predispositions, hormonal influences, asynchronous pubertal timing, and brain and central nervous system development (Sales & Irwin 2009 p 33). Family studies have suggested that certain risky behaviors such as alcohol use and misuse have genetic links (Bierut, et al., 1998). Others have stipulated that hormonal influences and that early and late onset of puberty is related to risky sexual behavior (Adams, 2005). Ariely and Loewenstien (2006) investigated contextual factors related to sexual risk taking. Specifically, researchers investigated the effect of sexual arousal on judgment, and hypothetical decision making among male college students (Ariely & Loewenstein, 2006). Results indicated that responses to hypothetical questions about risk taking and sexual responsibility (condom use) were significantly influenced by sexual arousal; sexually aroused men were less likely to anticipate behaving in sexually responsible ways (Ariely & Loewenstein, 2006). As such, sexual decision making among adolescents can be especially complex due to multiple developmental changes, biological conditions and the context of the decision.

Psychologically based theories of risk taking examine the role of cognition, personality, and dispositional characteristics on adolescent risk taking (Sales & Irwin, 2009). Some theories stipulate that risk taking is a normal and essential part of growing up (Adams, 2005; Jessor, 1982;), others address the role of personal fable on decision-making and risk taking (Steinberg, 2002). Jessor’s problem behavior theory hypothesizes that problem behavior is a normal part of adolescent development; as
such it is instrumental in establishing autonomy, gaining peer acceptance, and coping with anxiety and frustration (Jessor, 1982). Research by Greene and colleagues indicated that risk seeking predicted delinquent behavior such as alcohol use and delinquency, but not drug use, drinking and driving, or risky driving. Researchers’ concluded that adolescents that experience high personal fable and high sensation seeking participated in the most risk-taking behavior (Greene, Krcmar, Walters, Rubin, & Hale, 2000). Elkinds (1967) ‘personal fable’ is defined as the belief that the individual is unique, indestructible, and invulnerable to risk (Quadrel, Fischoff, & Davis, 1993).

Social and environmental theories of risk taking look at the roles of peers, family structure, function, and institutions (i.e. schools or churches) on risk taking (Sales & Irwin, 2009). Social and environmental theories examine the role of nature, such as social learning on risk taking. These theories suggest that risk-taking behaviors may be a direct or indirect result of parental, peer or school influences (Sales & Irwin, 2009). Adolescents may learn risk-taking behaviors such as alcohol use by mimicking parents or risky sexual behaviors by mimicking peers. Societal influences such as media and community norms have been linked to risk taking among adolescents. Research indicates that media outlets such as television and music may serve as a sexual super peer (Brown, Halpern, & L'Engle, 2005).

The bio-psychosocial model of risk taking integrates the relationship of biological development and the relationship of risk taking behaviors to psychosocial associations of behavior (Sales & Irwin, 2009). According to this model, biological, psychological, and social or environmental variables mediated by perceptions of risk and peer-group characteristics predict adolescent risk taking (Sales & Irwin, 2009, p. 42). Variables
specific to adolescent risk taking are biological variables such as the timing of puberty (Dunbar, Sheeder, Lezotte, Dabelea, & Stevens-Simons, 2008), psychosocial variables such as self-esteem and optimism (Paul, Fitzjohh, Herbison, & Dickson, 2000; Whitbeck, Yoder, Hoyt, & Conger, 1999), and social influences such as having peers who are sexually active (Adams, 2005; Dogan-Ates & Carrion-Basham, 2007). These variables differ slightly depending on the specific risk behavior; however, research provides consistent support for this model for understanding adolescent risk taking (Sales & Irwin, 2009). Despite the complexities of adolescent development, risk-taking, and decision-making, researchers have identified risk and protective factors associated with risky sexual behavior, adolescent pregnancy and repeat pregnancy.

**Risk Factors**

Numerous studies have investigated the risk and protective factors associated with adolescent sexual behaviors, specifically early sexual intercourse, teen pregnancy, and repeat pregnancy. These risk factors can be placed on a continuum of biological, socio-demographical, and psychosocial factors. Please see Table 2-1 for an outline of risk factors organized by the categories of the socio-ecological model.

**Risky Sexual Behavior**

Family influences, adolescent characteristics and behaviors, and peer influences have all been hypothesized to be predictors of early sexual intercourse (Whitbeck, Yoder, Hoyt, & Conger, 1999). Individual factors, as found by Whitbeck et al. (1999), include self-ratings of low self-esteem and low mastery as statistically significant predictors of early sexual intercourse. Other factors include participation in deviant behaviors and average IQ. Deviant behaviors such as smoking and alcohol and drug use were found to have main effects on early sexual intercourse (Whitbeck, Yoder,
Hoyt, & Conger, 1999). Cigarette smoking and IQ in the middle range were both found to be statistically significant for sexual initiation before age 16 among females (Paul, Fitzjohh, Herbison, & Dickson, 2000). Furthermore, contradictory to Whitbeck et al. (1999), having a higher self-esteem score was associated with sexual initiation prior to age 16 (Paul, Fitzjohh, Herbison, & Dickson, 2000). For males, low reading scores and a diagnosis of conduct disorder in early adolescence predicted sexual initiation before age 16 (Paul, Fitzjohh, Herbison, & Dickson, 2000). Personal factors that influence sexual initiation among Mexican-American women include being foreign born and preferring to speak Spanish (Gilliam, Berlin, Kozloski, Hernandez, & Grundy, 2007).

Family and relationship factors that influence early sexual intercourse are contextual parental and partner factors. Having a mother who had her first child before age 20 was significantly associated with sexual initiation before age 16 among females but not among males (Paul, Fitzjohh, Herbison, & Dickson, 2000). Having a boyfriend or girlfriend who was greater than or equal 2 years older was found to be associated with early sexual initiation when investigated in an urban sample of 6th graders (Marin, Coyle, Gomez, Carvajal, & Kirby, 2000). Furthermore, participants with a current or previous older boy/girlfriend were more likely to be Hispanic, to report more unwanted sexual advances, to have more friends who were sexually active, and the girls were more likely to have reached menarche (Marin, Coyle, Gomez, Carvajal, & Kirby, 2000). These factors, Hispanic ethnicity, sexually active peers, and early menarche, are associated with risky sexual behavior, adolescent pregnancy and repeat pregnancy (Adams, 2005; Coard, Nitz, & Felice, 2000; Dogan-Ates & Carrion-Basham, 2007; Woodward, Fergusson, & Horwood, 2001). Moreover, women who acknowledged a
strong role for partners in their sexual decision-making were more likely to have sex at a younger age (Gilliam, Berlin, Kozloski, Hernandez, & Grundy, 2007). Gilliam et al. (2007) found that girls whose family believed in education over marriage and abstinence until marriage were more likely to be older at sexual debut. Mothers’ age at pregnancy was positively associated with early sexual initiation; that is younger mother’s age was related to early sexual initiation (Gilliam, Berlin, Kozloski, Hernandez, & Grundy, 2007).

Another family and relationship factor is family instability. Fomby et al. (2007) found that family stability or instability, defined by multiple transitions in family structure was correlated with cognitive achievement within white adolescents; but not among Black adolescents. Cognitive achievement was measured with the math ability, reading recognition and reading comprehension subscales of Peabody Individual Achievement Test (Fomby & Cherlin, 2007). Cognitive achievement has been linked to sexual risk behavior (Paul, Fitzjohh, Herbison, & Dickson, 2000; Woodward, Fergusson, & Horwood, 2001). Wu and Thompson (2001) found that for White women, but not for Black, changes in family situations were positively related to the risk of early sexual intercourse. However, for Black women, but not White, there was an increased risk of having lived in a mother-only, father-only, or mother-stepfather household versus an intact nuclear family during adolescent years (family transition) (Wu & Thomson, 2001).

Whitbeck and colleagues (1999) used logistic regression to analyze factors that predict sexual intercourse as a discrete occurrence among adolescents from 8th to 10th grades. School activities and homework completion were negatively associated with early sexual intercourse (Whitbeck, Yoder, Hoyt, & Conger, 1999). Alcohol use, permissive sexual attitudes, delinquent friends, and steady dating were positively
associated with early sexual intercourse each increasing the likelihood of early sexual intercourse (Whitbeck, Yoder, Hoyt, & Conger, 1999). Factors such as not having outside home interests at age 13, no religious activity at age 11, and not being attached to school at age 15 predicted sexual initiation before the age of 16 among males (Paul, Fitzjohh, Herbison, & Dickson, 2000). Predictors for females included not being attached to school, being in trouble at school, and planning to leave school early (Paul, Fitzjohh, Herbison, & Dickson, 2000). Low socio-economic status was an identified social system factor predicting sexual initiation before the age of 16 for females, but not for males (Paul, Fitzjohh, Herbison, & Dickson, 2000).

Factors such as multiple sexual partners, forcing or having been forced to have sex, and intercourse while drunk or high (O'Donnell, O'Donnell, & Stueve, 2001) increase the probability of experiencing an adolescent pregnancy or repeat pregnancy. As such, risk factors for adolescent birth and repeat birth are similar to those identified for risky sexual behavior. See Table 2-1 for a comparison of the risk factors for risky sexual behavior, adolescent pregnancy, and repeat pregnancy.

**Adolescent Pregnancy and Birth**

Individual factors associated with adolescent pregnancy include low self-esteem, minority race/ethnic identity, low educational achievement, and history of sexual abuse. Studies suggest that females who have higher self-esteem are less likely to engage in risky sexual activity. Women who have higher self-esteem are also better equipped to negotiate safe sex practices with their sexual partners (Etheir, et al. 2006). Woodward and Fergusson (1999) and Woodward, Fergusson, and Horwood (2001) concluded that girls with aggressive and antisocial tendencies, measured by documented conduct problems from parents and teachers, were at an increased risk for teen pregnancy,
along with those with a history of illicit drug use. Other individual risk factors include race and ethnicity; prevalence data illustrates that African American and Hispanic teens are more likely to become pregnant than their White counterparts (Florida Charts, 2009). Biological factors associated with teen pregnancy include pubertal changes, such as early menarche (Dunbar, et al., 2008) and early sexual development (Woodward et al., 2001). Additionally, women with no educational qualifications were more likely to have had a child before age 20 than women with higher education; this association was stronger for women than men (Wellings, Wadsworth, Johnson, Field, & Macdowall, 1999). Early sexual experience and poor educational attainment were both independently associated with teenage pregnancy (Wellings, Wadsworth, Johnson, Field, & Macdowall, 1999).

Adolescents who had experienced sexual abuse were also more likely to become adolescent mothers (Erdmans & Black, 2008). Erdmans and Black (2008) found that victims of sexual abuse were more likely to be victims of statutory rape, to have abusive partners, to have behavioral problems, and to be less integrated in high school, all of which have been linked to adolescent pregnancy (Dogan-Ates & Carrion-Basham, 2007; Marin, Coyle, Gomez, Carvajal, & Kirby, 2000; Woodward, Fergusson, & Horwood, 2001).

Researchers speculate that future aspirations factor into adolescent pregnancy. Wolfe et al. (2007) used a two stage econometric model to determine whether the perceptions of adverse income and marital or cohabitation relationship consequences attributed to non-marital adolescent birth. Findings suggest that teens placed greater
weight on potential relationship consequences than income consequences but that both
influenced non-marital birth choices (Wolfe, Haveman, Pence, & J, 2007).

Familial factors associated with teen pregnancy include family disruption, family
dynamics, and maternal and sibling history of teen pregnancy. Adolescents who
reported a high level of parental conflict were significantly more likely to have a teen
pregnancy in a longitudinal study based in New Zealand (Woodward et al, 2001).
Maternal characteristics that are associated with teen pregnancy are low educational
achievement (Woodward et al., 2001) and having a mother who was a teen mother
(National Campaign to Prevent Pregnancy n.d). Wellings et al. (1999) found that the
prevalence of teenage parenthood was higher for both men and women who lived in
one versus two parent households. Furthermore, Molborn( 2010) found that married or
cohabiting adolescent parents who lived with no or one parent had a 73% lower odds of
graduating high school than those living with two parents.

Peer and community risk factors associated with adolescent pregnancy include
having friends who are pregnant, low academic achievement, and high school
disengagement (Scales & Leffert, 1999). Young et al. (2004) investigated the effect of
internal poverty factors, including locus of control, future expectations, and high school
graduation confidence and external poverty factors such as parent’s occupation,
parent’s education, actual socio-economic status (SES), and perceptions of parental
educational expectations. The internal poverty factors of low locus of control, low
educational expectations, and low confidence in graduating from high school and the
external poverty factor of low parental education were most predictive of teen
pregnancy (Young, Turner, Denny, & Young, 2004). Researchers have investigated the
effect of peer relationships on adolescent pregnancy. Arai (2007) found that from the adolescent mother’s perspective, peers did not influence behavior. However, adolescent childbearing may be normative in some geographic communities, thus affecting social and cultural influences of teen pregnancy (Arai, 2007). Young et al., (2004) found that one of the greatest predictors of adolescent pregnancy was decreased confidence in graduating from high school. Furthermore, studies suggest that those teens who participated in comprehensive sex education programs were less likely to become pregnant compared to abstinence only or not participating in sex education (Kohler, 2008). However, there was no significant delay in sexual contact between the two groups (Kohler et al., 2008). Social system risk factors included low school involvement, low socioeconomic status and low community involvement (Scales & Leffert, 1999).

**Repeat Pregnancy and Birth**

The risk factors associated with repeat adolescent pregnancy and birth are similar to initial pregnancy. Individual risk factors are early age at first pregnancy, low educational achievement, and having a planned first pregnancy (Dunbar, 2008; Rowlands, 2010; Sheeder, 2009). Teens who have positive attitudes towards early childbearing, want to have a baby, and select oral contraception over long-term contraception have also been found to have higher rates of repeat teen pregnancy (Rowlands et al., 2010). Individual factors identified by Raneri and Wiemann (2007) are planning to have another baby within five years and not using long acting contraception within 3 months post index delivery. Lack of contraception use before and after index pregnancy has been linked to repeat pregnancy (Lemay, Cashman, Elfenbein, & Felice, 2007). Analysis of focus group data from adolescent mothers found that prior to first pregnancy the beliefs that pregnancy could not or would not happen and a lack of focus
on steps to prevent pregnancy were associated with repeat pregnancy (Lemay, Cashman, Elfenbein, & Felice, 2007). Adolescents were also likely to report switching or planning to switch birth control methods, thus putting them at a greater probability for a repeat pregnancy during a gap in contraceptive use. Common reasons for changing or selecting contraception after initial pregnancy were convenience, perceived effectiveness, familiarity, and side effects (Lemay, Cashman, Elfenbein, & Felice, 2007). Wolfe (2007) found that when modeling the long-term relationship expectations and income expectations, teens who predicted higher incomes and a long-term relationship with the father of their child were more likely to experience repeat adolescent pregnancy.

Relationship level risk factors include marriage before or after the index pregnancy, a partner who is three or more years older, and having a partner who wants a child (Rowlands, et al., 2010). Rowlands et al. (2010) also found that intimate partner violence and a discontinued relationship with the father of the index child were associated with repeat pregnancy. Similarly, Raneri and Wiemann (2007) concluded that not being in a relationship with father of the index child three months after delivery, being more than three years younger than the index child’s father, and experiencing intimate partner violence within three months after delivery were associated with higher rates of repeat pregnancy. Boardman et al. (2006) investigated risk factors for unintended versus intended repeat pregnancy. The authors concluded that intended first pregnancy, prior poor birth outcome, and intended pregnancy by the partner were associated with intended repeat pregnancy; however, marriage was associated with decreased risk for unintended pregnancy (Boardman, Allsworth, Phipps, & Lappane,
2006). Kelly, et al. (2005), found that primiparous adolescents ages 13-21 who lived with their boyfriend and those who delivered prematurely were more likely to participate in postpartum sexual intercourse but there was no relation to contraception use.

Similar to teen pregnancy, family level risk factors for repeat pregnancy, as found by Rowlands and colleagues (2010), are poor mother daughter relationships, lack of family support, and having a mother who was a teen parent.

Community risk factors include having friends who have experienced pregnancy (Raneri & Wiemann, 2007), dropping out of school prior to index pregnancy, not going to school after delivery, low educational aspirations, low socioeconomic status, and low educational status (Rowlands, 2010).

**Rapid Repeat Pregnancy**: Rapid repeat pregnancy is defined as a repeat pregnancy within 24 months of the index pregnancy, and it is a growing concern (Boardman et al., 2006; Crittenden, 2009; El-Kamary, et al., 2004).

Individual risk factors associated with rapid repeat pregnancy, as found by Crittenden (2009), include failure to initiate use of long-acting contraceptives after initial delivery and a discontinued relationship with the father of the first child. High risk adolescents were also less likely to have taken steps to accomplish personal goals (Crittenden, 2009) or to have identified goals that were compatible with childbearing (Sheeder, Tocce, Stevens-Simon, 2009).

Coard et al. (2000) concluded that among an urban sample of first-time adolescent mothers, type of contraceptive method (birth control pills versus IUD) was associated with repeat pregnancy at year one. Low contraceptive use, young maternal age, history of previous miscarriages, and the use of birth control pills instead of the IUD
postpartum, were associated with repeat pregnancy at year two (Coard, Nitz, & Felice, 2000). Steven-Simon et al. (2001) found that long acting contraception was the greatest protective factor for rapid repeat pregnancy. However, there are significant differences associated with those who initiate long acting birth control and those who do not.

Factors correlated with for RRP were desire for a child within two years of first birth and not using birth control in the year following the index pregnancy (El-Kamary, et al., 2004).

Family and relationship factors include poor parent-child relations, conflicting support for the teen mother role such as perceived lack of support by the adolescent versus perceived complete responsibility by the mother/grandmother, and limited social pressures for effective fathering (Bull & Hogue, 1998). Other factors are significant age difference between mother and father of first pregnancy, the male three or more years older, and experiencing intimate partner violence soon after delivery (Crittenden et al., 2009).

Peer and community level factors, also identified by Crittenden et al. (2009), are not returning to school quickly postpartum and having many friends who are adolescent parents. Gray (2006) found that primiparous adolescents who became pregnant within 6 months of delivery were less likely to be in school or to be high school graduates.

Social system factors are limited access to social services for the household, according to focus group data from adolescent parents and their mothers (Bull & Hogue, 1998) and lack of access to prenatal services in the second year, post index child (El-Kamary, et al., 2004). An overview of the risk factors associated with teen pregnancy and repeat pregnancy are detailed in Table 2-1.
Unique Circumstances: Adolescent Pregnancy in Foster Care

Studies suggest that adolescents in foster care have increased risk for participating in risky sexual behaviors and experiencing adolescent pregnancy. One reason for increased risk for sexual behavior and pregnancy is the reported low access to high quality sexual education. Inconsistent adult relationships, placement changes, mental health problems, and developmental needs are identified barriers to pregnancy preventative services including sex education (Svoboda, Shaw, Barth, & Bright, 2012). Knight and colleagues (2006), found that emotional vulnerability as illustrated by distrust, loneliness and rejection, lead to adolescent pregnancy. Adolescents reported multiple and abrupt foster placements making it difficult to learn about sex, relationships, and contraception (Knight, Chase, & Aggelton, 2006). Findings also indicate that infants may fill feelings of loneliness and isolation from being removed from their birth families and having to adapt to several foster care placements in short periods (Knight, Chase, & Aggelton, 2006), a contributing factor to pregnancy among adolescents in foster care.

Coleman-Cowger, Green, and Clark (2011) found that when compared with a non-foster care sample, adolescents in foster care reported higher internal mental distress, behavior complexities, and general victimization. Researchers also found that within the foster group sample, internal mental distress predicated past pregnancy (Coleman-Cowger, Green, & Clark, 2011). Connolly et al. (2012) conducted a meta-synthesis of pregnancy and motherhood within child protective services and identified several overarching themes. They concluded: 1) an infant is used to fill an emotional void; 2) there is a lack of consistent education and a lack of sexual education; 3) there are multiple adversities in motherhood; 4) there was a mistrust of others and a social
stigma associated with being a mother; 5) there is a perception of motherhood as positive and stabilizing; 6) teens experience internal strengths and wanting to do better; and 7) support contributes to a positive motherhood experience (Connoly, Heifetz, & Bohr, 2012). As such, these identified themes pertaining to adolescent pregnancy in foster care, can serve as an explanatory model to reduce adolescent pregnancy within foster care and nurture increase access of and utilization of sexual health series. Barth et al. (1990) found that 40% of adolescents (mean age 17.6) recently aged or emancipated from foster care experienced sexually related difficulties such as unplanned pregnancy, sexually transmitted disease, and inconsistent or never use of birth control. He also found that 57% reported not using social service family planning services (Barth, 1990).

**Protective Factors**

Given what we know about adolescent risk-taking and sexual decision-making, it makes sense that certain groups have been found to be at a higher risk for participating in risky behaviors. Excessive adolescent anxiety, extreme family conflict, unsupervised or over supervised socialization, early and late onset puberty, and delayed identity formation, have all been linked to risk-taking in adolescents (Adams, 2005, p. 15). Vulnerability is the increased likelihood of a negative outcome when exposed to identified risk (Fergus & Zimmerman, 2005). However, resilience, as defined by Masten, Best, and Garmezy, 1990, is the capacity for the outcome of successful adaption despite challenging or threatening circumstance (as cited in Blinn--Pike, 1999). Resilience can be in the form of assets, internal positive factors and resources, or external positive factors; they both help youth avoid negative outcomes in the face of risk (Fergus &
Zimmerman, 2005). Positive or protective factors against risky sexual activity, adolescent pregnancy, and repeat pregnancy are consistent.

Religious influences and affiliations are often noted as protective factors for refraining from sexual intercourse (Fergus & Zimmerman, 2005; Sinha, Curtis, Jayakody, Viner, & Roberts, 2007). In a qualitative study based in England, more young women than men (ages 15-18) mentioned religion as a reason for limiting sexual activities (Sinha, Curtis, Jayakody, Viner, & Roberts, 2007). House and colleagues (2010), found that adolescent pregnancy programs that fostered the development and encouragement of spirituality was protective against initiation of sex, ever having sex, and frequency of sex, and it was associated with increased contraceptive use. Family connectedness has also been found to be protective factor for risky sexual behavior. Aronowitz and Morrison-Beedy (2004), found that among African-American adolescent females ages 11-15, girls with feelings of connectedness to their mothers were more likely to have an extended time perspective and fewer risk behaviors. Findings indicated that future time perspective was a mediator between maternal connectedness and resilience (Aronowitz & Morrison-Beedy, 2004). Future time perspective was measured with a combination of scales that assessed the participant’s attitudes about the future (I feel hopeful about the future), and future aspirations (I will live beyond age 35) (Aronowitz & Morrison-Beedy, 2004). Mother connectedness was measured by scales that assess maternal caring, mother-daughter activities, and mother presence, and it was analyzed against multiple risk behaviors such as violence, sexual behaviors and substance abuse (Aronowitz & Morrison-Beedy, 2004). Among self-reported abstinent youth the top reason for remaining sexually abstinent was fear-- fear of AIDS, fear of
becoming pregnant or getting someone pregnant, and fear of getting a disease (Blinn-Pike, 1999). The next most frequent reasons were conservative values, believing it was wrong to have sex before marriage, and wanting to wait until marriage to have sex (Blinn-Pike, 1999). The least frequent reasons were emotionality and confusion, being embarrassed to use birth control or protection, and not knowing where to get birth control and protection (Blinn-Pike, 1999).

Sources of information have been linked to foster adolescent resiliency. Bleakley, Hennsey, Fishbein, and Jordan (2009) found that certain sources of sexual information could influence sexual decision-making. Learning about sex from parents, grandparents, and religious leaders was associated with beliefs likely to delay early sex (Bleakley, Hennessy, Fishbein, & Jordan, 2009). However, information about sex from friends, cousins, and the media were associated with beliefs that increased the likelihood of having sex (Bleakley, Hennessy, Fishbein, & Jordan, 2009). Additional protective factors against risky sexual behaviors in adolescents include higher self-esteem, more school achievement and attachment, higher participation in extracurricular activities, increased safer sex intention, residing with both parents, positive peer norms for sexual behavior, and higher family socioeconomic status (Fergus & Zimmerman, 2005).

Implications for Adolescent Pregnancy, Birth, and Repeat Birth

Adolescent Birth

Adolescent birth has negative implications for the extended family, the adolescent, and the infant. Siblings living in the house with an adolescent mother have an increased risk of becoming an adolescent mother (East, 1998). Daughters of adolescent mothers are more likely to become adolescent mothers, and sons are more
likely be incarnated (The National Campaign to Prevent Pregnancy, 2011). Nelson and O'Brien (2012), found that mothers of an unplanned pregnancy were more likely to experience maternal depressive symptoms when experiencing high parental stress over the first three years. Outcomes for the infant include preterm birth, being small for gestational age, and having low birth weight at birth (Chan, Dekker, & Keane, 2002).

Furthermore, while there have been several noted biological and health implications for adolescent pregnancy, especially among early adolescents, the disadvantages for society (economic responsibilities) are plentiful (Wellings, Wadsworth, Johnson, Field, & Macdowall, 1999). Adolescent fathers who were working at least half time were less likely than non-working fathers to graduate from high school, however, fathers who were the primary caregivers had elevated odds of graduating (Molborn, 2010). Decreased education, decreased earning power, and increased cost to social services (52% of mothers on welfare had their first child as adolescents) result in monetary losses (The National Campaign to Prevent Pregnancy, 2011).

**Repeat Birth**

The implications of adolescent pregnancy are exasperated by repeat pregnancy. Blankson et al. (1993) found that among multiparous Black and White adolescents there was a decreased utility of prenatal care such as entering care later and attending fewer visits, an increase in pre-pregnancy BMI, and an increase in preterm births. Research also suggests that compared to first teenage birth, second birth almost triples the risk of pre-term delivery and stillbirth (Smith & Pell, 2001). Furthermore, rapid repeat pregnancy compounds social inequality due to less participation in education and work/training (Gray, Sheeder, O'Brien, & Stevens-Simon, 2006). In a sample of American Indian primiparous adolescents, intimate partner violence was reported in 61% of adolescent
mothers, 37% reported abuse during pregnancy, and 22% reported sexual violence (Mylant & Mann, 2008).

**Intervention and Prevention Programs**

There are reporting biases associated with the determination of successful teen pregnancy and repeat pregnancy programs. Pregnancy prevention programs often include and measure erratic factors such as actual behavior change versus intent to change. Furthermore, study design can have a significant impact on the perceived and actual program efficacy. Guyatt et al. (2000) compared randomized trials versus observational studies in adolescent pregnancy prevention and determined that observational trials reported a significantly higher impact. Study outcomes of adolescent pregnancy prevention programs such as initiation of intercourse, pregnancy, responsible sexual behavior, and birth control use within observational studies suggested a statically significant results; however, randomized control studies suggested results equal to non-intervention groups (Guyatt, DiCenso, Farewell, Willan, & Griffith, 2000). Based on published research findings I have highlighted successful, unsuccessful, and mixed review programs that prevent/reduce adolescent pregnancy and repeat pregnancy below, please see Table 2-2 for a succinct summary of program components.

**Successful Programs**

Specific characteristics of adolescent prevention programs are known to enhance protective factors against risky sexual behavior. Adolescent prevention programs that foster the development and encouragement of prosocial norms, prosocial involvement and commitment to avoid specific risk behaviors, have been found to be protective against initiation to have sex, ever having sex, less frequency of sex, and increased
contraceptive use (Fergus & Zimmerman, 2005; House, Mueller, Reininger, Brown, & Markham, 2010). Furthermore, programs that foster self-efficacy to refuse drugs and to use condoms, positive attitudes towards condoms, HIV and reproductive health knowledge and seeing sex as non-normative, which are all known protective factors (Fergus & Zimmerman, 2005), have decreased risky behavior.

**Adolescent Pregnancy:** A simulation intervention evaluation revealed that adolescents 2 to 3 years post participation were able to recall and describe insight and feelings about parental responsibility and consequences of teen pregnancy (Didion & Gatzke, 2004). Study findings suggest success was attributed to the simulated experience as an effective learning strategy (Didion & Gatzke, 2004). A review of abstinence-only programs, abstinence as the sole approach to prevent pregnancy and STDs, and abstinence plus programs, abstinence and other prevention methods, found the two abstinence plus programs and one of six abstinence-only programs to be successful in that they showed measurable behavior change (Thomas, 2000). Components of successful programs included, strong evidence on abstinence, a firm grounding in health behavior theories, and parental participation and addressed social and media influences on adolescent sexual behavior (Thomas, 2000).

Frost and Forrest (1995) concluded in a meta-analysis of five adolescent pregnancy prevention programs that four were successful in reducing the proportion of adolescents who initiated in sexual activity; this was especially true when the programs targeted younger adolescents. Three of those programs, the most successful, also increased rates of contraceptive use among participants and two programs significantly decreased the proportion of adolescents who became pregnant (Frost & Forrest, 1995).
Successful programs were the most active in providing access to contraceptive services (Frost & Forrest, 1995).

**Repeat Pregnancy**: Intervention programs to reduce rates of repeat pregnancy have had mixed success. Some programs have been successful in reducing rates of repeat pregnancy in year one, but have had limited success in year two. Other programs have been successful in improving health outcomes of the infants but unsuccessful in delaying repeat pregnancy. Furthermore, feasibility and attrition are documented logistical issues in sustaining repeat pregnancy programs. Comprehensive programs that include goal setting and case management services typically show higher rates of success when compared to usual care.

The Family Support Center provided comprehensive support in the form of home visits, parenting classes, school advocacy, and case management services in order to reduce repeat pregnancy and school dropout rates (Solomon & Liefeld, 1998). The Family Growth Center was effective in reducing repeat pregnancy (10% versus 38%) and dropping out of school (9% versus 42%) compared to the control group (Solomon & Liefeld, 1998). A randomized control trial comparing a specialized program, including follow up, discussion of school, health teaching, family planning, and usual care found significant results (12% versus 28%) in preventing repeat pregnancy but not for returning to school (O'Sullivan & Jacobsen, 1992). Program components included daily presence of public health nurses, monthly pregnancy tests and surveys, health counseling and referral, and group health-education classes (Schaffer, Jost, Pederson, & Lair, 2008). This comprehensive strategy is attributed to the program’s success.
The Second Chance Club, a school-based repeat pregnancy prevention program, revealed significant success in preventing repeat pregnancy (6%) when compared to the control sample (37%) (Key, Barbosa, & Owens, 2001). Program components included weekly group meetings focused on parenting, career planning, and group support, participation in school events, social work services such as case management and home visits, and medical care for mothers that included contraception services well baby visits for the infants via linked services (Key, Barbosa, & Owens, 2001; Key, O’Rourke, Judy, & McKinnon, 2005-2006). A secondary analysis of the program’s effectiveness, revealed significant success when compared to state data with a total rebound after the completion of the program, four years later (Key, O’Rourke, Judy, & McKinnon, 2005-2006). Key et al. (2005-2006) speculated some limitations in the analysis might be due to rural versus urban community distribution throughout the state and the intervention area. Adolescents in rural communities generally have higher rates of teen pregnancy and repeat pregnancy, as well as decreased access to prevention and intervention services (Key, O’Rourke, Judy, & McKinnon, 2005-2006). Koniak-Griffin et al. (2003) found that when compared to traditional public health nursing, postpartum adolescent mothers who participated in an early intervention of nurse home visits fared better. Intervention group infants were hospitalized less and seen less in the emergency room and the adolescent mothers experienced 15% fewer repeat pregnancies (Koniak-Griffin, et al., 2003).

Colorado Adolescent Maternity Program (CAMP) was a comprehensive, multidisciplinary, prenatal, delivery, and postnatal care program located in a large urban teaching hospital (Stevens-Simon, Kelly, & Kulick, 2001). Results of CAMP included a
repeat pregnancy rate of 14% at year one, and 35% at year two. The results indicated that a failure to use a long-acting birth control six weeks after birth was the strongest predictor of repeat pregnancy in year two (Stevens-Simon, Kelly, & Kulick, 2001). Program evaluation for the Paquin School Program, a School-Based Comprehensive program for pregnant teens based in Baltimore City found promising results (Amin & Sato, 2004). When compared to a comparison sample, Paquin School Program participants enrolled from 1999 to 2001 were more likely to be using contraception or to have expressed intention to use contraception in the future were more likely to use Depo-Provera, a higher report their desire for not having more children (Amin & Sato, 2004). A follow-up qualitative analysis including participants enrolled between 2000 and 2001 concluded participants were more likely to have higher educational aspiration, better reproductive health outcomes, higher contraceptive use, and more breastfeeding practice and intention than a comparison sample (Amin, Browne, Ahmed, & Sato, 2006).

A randomized control trial of routine contraceptive care compared to an advanced supply of emergency contraception determined program success (Schreiber, Ratcliffe, & Barnhart, 2010). Providing emergency contraception resulted in decreased incidence of repeat pregnancy (Schreiber, Ratcliffe, & Barnhart, 2010). Fifty postpartum teens were randomly assigned to routine postpartum contraceptive care or a one week supply of emergency contraception and unlimited supply upon request; the intervention group experienced three (13%) repeat pregnancies compared to eight (30%) in routine care (Schreiber, Ratcliffe, & Barnhart, 2010).
Overall, repeat pregnancy programs that encourage long-term contraceptive use soon after index birth are more successful in reducing repeat pregnancy. Comprehensive programs that include parent education, home visits, peer mentoring, and career counseling are more effecting in improving return to high school rates and reducing negative health impact to the infants.

Mixed Reviews

Adolescent Pregnancy: An abstinence only intervention among middle school teens was shown to be successful in increasing knowledge and abstinence beliefs but unsuccessful in decreasing intention to have sex and increasing condom use (Borawaski, Trapl, Lovegreen, Colabianchi, & Block, 2005).

Corcoran et al. (2007) conducted three separate meta-analyses of pregnancy prevention programs investigating sexual activity, contraceptive use, pregnancy rates, and childbirths as outcomes. Results suggest that of those programs included, there were no effects on sexual activity, significant effects on increasing contraceptive use, and moderate effects on reducing pregnancy (Corcoran & Pillai, 2007; Franklin, Grant, Corcoran, Miller, & Bultman, 1997).

Repeat Pregnancy: The Dollar-A-Day Program in Greensboro, North Carolina was established in 1990 to prevent repeat pregnancies among adolescents under the age of 16 (Brown, Saunders, & Dick, 1999). The program components included a weekly meeting, goal setting and reporting, and a reward of one dollar a day for each day the teen remained non-pregnant (Brown, Saunders, & Dick, 1999). Program results at 5 years revealed 15% of the total sample (N=65) experienced subsequent pregnancies, compared to 30% and 35% reported in similar programs, indicating success in reducing repeat births (Brown, Saunders, & Dick, 1999). Project Redirection
was implemented from 1980-1983, program components directly or indirectly offered services such as employment training, peer group sessions, goal development (Polit & Kahn, 1985). This program was shown to be effective at year one but not at year two (Polit & Kahn, 1985).

A Home Visiting Program revealed mixed results at the 6, 12, and 24-month follow-ups; they found that lack of consistent contraceptive use was highly associated with repeat pregnancy and that discussion and interventions related to lapses in contraceptive use were only documented in 30% of the home visits (Gray, Sheeder, O'Brien, & Stevens-Simon, 2006).

A repeat pregnancy prevention program designed for Hispanic adolescent mothers had limited success due to high attrition (up to 40%). Reasons for attrition were attributed to the lack economic stability and high mobility of the participant population (Erickson, 1994). The repeat pregnancy rate for participants who were followed for one year was 17%, and it was 35% for those followed for two years (Erickson, 1994). The Teen Parents as Teacher program, implemented in the Salinas Valley of California, had similar issues with attrition (57%), despite a monetary incentive for participants (unknown amount). Reasons for attrition were attributed to the instability of the teen population (Wagner & Clayton, 1999).

Unsuccessful Programs

Adolescent Pregnancy: Programs that targeted older adolescents and those that did not provide access to contraceptive services were less successful than other programs (Frost & Forrest, 1995). Chin and colleagues (2012) conducted a meta-analysis on the effectiveness of group based comprehensive and abstinence education interventions to prevent adolescent pregnancy, HIV, and sexually transmitted diseases.
Authors concluded that group based comprehensive risk reduction interventions were successful on all of the measured outcomes, current sexual activity, use of protection, pregnancy, and sexually transmitted diseases (Chin, et al., 2012). However, the meta-analysis on abstinence-only education showed inconsistent findings, study designs, and follow-up times resulting in inclusive effect estimates (Chin, et al., 2012). Components of unsuccessful pregnancy prevention programs as found by Thomas (2000), include those with high attrition, not based in health behavior theory, included non-generalizable homogenous sample, and were inconsistent.

**Repeat and Rapid Repeat Pregnancy**: El-Kamary et al. (2004) found no effects for a home visiting program based in Hawaii. Study results revealed no program impact for the Healthy Start home visiting program and there were several factors were associated with a rapid repeat pregnancy, such as mothers with desire for a child within 2 years and women who had never used birth control (RRR) (El-Kamary, et al., 2004). A RRR was defined as a birth occurring within 24 months after a previous birth (El-Kamary, et al., 2004).

Using a randomized design, Stevens-Simons et al. (1997) found that although monetary incentives promoted peer-support group participation, exclusive peer-support group participation was not effective in reducing repeat pregnancies. Monetary incentive was successful in enticing participation (58% vs. 9%); however repeat pregnancy rates at 6-months (9%), 12-months (20%), 18-months (29%), and 24-months (39%) did not statistically differ from the control group (Stevens-Simons, Dolgan, Kelly, & Singer, 1997).
Suggested Programs:

There have been several wide ranging intervention suggestions for reducing rates of repeat pregnancy including phototherapy (Blinn, 1987) and Computer Assisted Motivational Intervention (Barnet, Rapp, DeVoe, & Mullins, 2010). Blinn (1987) suggested phototherapy as an intervention for reducing repeat pregnancy by directly affecting (increasing) adolescent self-concept. Phototherapy is a process of interacting with photographic image as well as the image of self as a strategy of improving self-concept (Blinn, 1987). Computer-Assisted Motivational Intervention (CAMI) was shown to significantly reduce repeat births when compared to usual care (Barnet, Rapp, DeVoe, & Mullins, 2010). CAMI utilized a computer software program to assess the participant’s stage of change (for contraceptive and condom use), based on the adolescent’s responses to questions about current sexual relationships and behaviors (Barnet, et al., 2009).

Increasing access to emergency contraception has been hypothesized to reduce rates of unplanned pregnancy in adolescents. Belzer et al. (2003) found that among adolescents who reported unprotected sex, top reasons for not using emergency contraception (EC) were not having access to EC at home, forgetting there was EC, and not knowing where to get EC (Belzer, et al., 2003). A meta-analysis of repeat pregnancy prevention programs concluded that although repeat pregnancy programs are effective at least 19 months follow-up, there is little evidence that supports comprehensive programs over others (Corcoran & Pillai, 2007).

Adolescent and Repeat Pregnancy Prevention Summary

The United States has several initiatives in place to reduce the rate of teen pregnancy. Although states develop or tailor specific youth programs, most center on
one of two principles—abstinence only or comprehensive sex education. Abstinence only advocates the absence of sex until marriage (Kohler et al., 2008). Comprehensive curriculums provide abstinence messages in addition to information on birth control and barrier protection for STD prevention (Kohler et al., 2008). Teens who receive comprehensive sex education coupled with risk and consequence identification are at a decreased risk for teen pregnancy (Ponton, 2001). Such programs include information on self-esteem self-efficacy and other constructs related to self and are tailored to the target population.

Repeat pregnancy or rapid repeat pregnancy can be reduced using comprehensive prevention programs; Corcoran et al. (2007) found that among sixteen secondary pregnancy prevention studies there was a 50% reduction in the odds of repeat pregnancy compared to the control group. Comprehensive programs include health care for both the adolescent and infant, sex education, contraception education, parenting training, and social support (Corcoran & Pillai, 2007).

**Theoretical Framework**

Based on the risk and protective factor literature the theoretical framework for this research aimed at assessing the influence of socio-demographic variables, goal aspirations, media, and perceived benefits and disadvantages of adolescent pregnancy on adolescent pregnancy and repeat pregnancy by nulliparous, primiparous and multiparous adolescents. Merrick (1995) postulated that childbearing among African American youth should be evaluated as a career choice; she stipulated several explanations from the ecological framework. That said, an understanding of professional and personal goal aspirations, as a context for and a potential preventative strategy for adolescent childbearing, is essential.
Aspirations provide a standard for adolescents to measure the weight of their decisions; furthermore, they provide a motivational force for achievement (Camerena, Minor, Melmer, & Ferrie, 1998). Adolescents who have recently transitioned to motherhood reported that parenting resulted in an adjustment but not a dramatic change in expectations; however, few reported adequate support for achieving life goals (Camerena, Minor, Melmer, & Ferrie, 1998).

**Meaning of Success**

The meaning of success among adolescents may influence decision-making as they transition into roles that require greater independence. Research suggests that the meaning of success may be routed in class, gender, and ethnic trends (Bradford & Hey, 2007). Varying ethnic groups in England described versions of success. Staying focused, building educational capital and human capital, was identified by Sikh adolescent males, and building psychological capital was identified by Hindu adolescent females (Bradford & Hey, 2007). The meaning of success among Australian adolescents ages 14-19 consisted of wealth and possessions (reported most frequently), occupational or educational status, attributes of personality, secure job, and family of procreation (Katz, 1964). Adolescent females were significantly more likely to report attributes of personality as a definition of success (Katz, 1964).

Academic achievement may be used as a current measure of success among adolescents. Zhang and colleagues (2010) found that among Chinese adolescents low academic achievers were more likely to tailor their behavior based on situational cues, compared to non-low academic achievers. Implications include adolescent females with low academic achievement and greater potential to engage in impression management may experience decreased self-efficacy to make safe sex decisions.
Professional Goal Aspirations

Career or work goals have been hypothesized to influence personal identity; youth with carefully reasoned work goals may have a more coherent personal identity and may be better able to demonstrate the ability to maximize their potential than those without (Yeager & Bundick, 2009). Waterman (2007) concluded that people are more likely to experience an enhanced well-being when they have realized self-generated goals and satisfied personal needs (Waterman, 2007, p. 239). Research suggests that there are more gender differences than ethnic and racial differences in aspirations and career goals (Arbona & Novy, 1991). Kenny et al. (2007) utilized qualitative interview methods to investigate post-high school goals among 16 low-to-high academic achievers attending an urban high school. Academic achievement level was outlined via school reported GPA. Barriers to success, as expressed by research participants, included antisocial values and lack of social attachment, as well as lack of self-discipline, and family issues such as family misfortune and neglect or lack of care (Kenny, et al., 2007). While investigating the gap between vocational aspirations and expectations, Hellenga, Aber, & Rhodes (2002) determined that adolescent mothers with depression and anxiety symptoms and childcare provided by relatives were more likely to experience a gap in vocational aspirations and expectations. Those with higher grade point averages, who lived with biological parents, and had a career mentor, were more likely to experience congruency between expectation and aspiration (Hellenga, Aber, & Rhodes, 2002).

Research suggests that adolescents who have purposeful work goals report more meaning in life and schoolwork (Yeager & Bundick, 2009). Adolescents who think
about what they want to accomplish may be inspired to learn and to create a life purpose (Yeager & Bundick, 2009).

Achievement goal theory, often utilized to conceptualize achievement motivation and school motivation, is now known as the primary framework for conceptualizing student motivation and framing the development of educational interventions (Kaplan & Flum, 2010). Kaplan et al. (2010) sought to identify the theoretical links between achievement motivation theory and adolescent identity formation; their findings suggest that both theories emphasize the differences in mental frames of self-development and self-validation.

**Personal Aspirations**

Studies suggest adolescent pregnancy can result in personal implications such as decreased rates of marriage, increased divorce among those married young, and increased welfare usage (Lichter & Graefe, 2001; The National Campaign to Prevent Pregnancy, 2011). Salmivalli, et al. (2009) investigated the amount of variance in social goals, and self and peer perceptions, which was due to the context of relationships. Study findings concluded social goals, as well as self and peer perceptions, are to a great extent relationship-specific; therefore, they need to be studied in context (Salmivalli & Peets, 2009).

Low-income women who choose motherhood before marriage often describe several reasons for their priority. Theorists have explored the decline in marriage over the decades, especially prevalent among low income and ethnic minority populations (Edin, 2003). Four theories of non-marriage are currently mainstream. Theory one is economic independence; women who can earn a living on their own will find marriage less attractive. This theory does not hold true for low-income women when marriage
will, in-fact, increase earnings, and as partner income rises so does their probability of marriage (Becker, 1974). Theory two involves the decline in male economic positions, as the rate of men in consistent employment declines so will marriage rates (Edin, 2003). Theory three decline in male economic positions, as the rate of men in consistent employment declines so will marriage rates. This theory states that since the 1960’s women have traded dependence on males to dependence on support from welfare or government assistance (Edin, 2003). Theory four highlights cultural influences; as women move into the paid labor force, traditional gender roles have evolved, therefore creating a mismatch in sex roles in poor men and women and decreasing marriage rates (Edin, 2003).

**Perceived Advantages and Disadvantages of Adolescent Parenting**

Although few may argue the extent for which a teen mom can provide for her child, there are discrepancies within the parenting community. Bull and Hogue (1998) analyzed focus group responses of adolescent parents and their mothers and found that young mothers and grandmothers often disagree on the burden of childcare. Adolescent mothers described bearing full responsibility for the infant, while the grandmothers, in a separate focus group, described a discrepant situation (Bull & Hogue, 1998). This raises questions about the meaning of motherhood and infant responsibility among adolescent mothers and their mothers.

Rosengard, Pollock, Weitzen, Meers, and Phipps (2006) investigated the perceived advantages and disadvantages of teen pregnancy among a group of pregnant adolescents ages 12-17. Described advantages included no advantages, connections such as enhancing relationships, family building, having someone to love, closer in age to child, positive changes such as forcing them to grow up, take
responsibility, provide them with a purpose in life and practical considerations such as still looking young, eliminating concerns about future fertility (Ronsengard, Pollock, Weitzen, Meers, & Phipps, 2006). Disadvantages included no disadvantages, lack of preparedness, being too young, not being ready, not having a job or resources, changes such as having to revise life goals, making daily life more difficult, requiring them to miss out on teenage experiences and others’ views such as fellow students looking at them differently (Ronsengard, Pollock, Weitzen, Meers, & Phipps, 2006).

Spear et al. (2004) found among a sample of pregnant mothers, that while knowledge on how to prevent pregnancy was prevalent, inconsistent contraception use and indifferent sexual behaviors resulted in pregnancy. Future expectations from participants consistently included support from the father of their un-born child and often-times resiliency, “I know I can make it and it’s going to be harder, but I’m still going to try” (Spear, 2004, p. 341). SmithBattle (2007), found that motherhood led adolescents to reevaluate priorities, and motivated them to remain in or return to school, thus indicating that motherhood may provide foster resiliency in some otherwise at risk youth.

**Media Influences**

Bleakley et al. (2009) examined how sources of sexual information are associated with adolescent’s behavioral, normative, and control beliefs about having sexual intercourse. Their findings suggest that most frequent sources of sexual information were friends, teachers, mothers, and the media (Bleakley, Hennessy, Fishbein, & Jordan, 2009). Brown et al. (2006) concluded that exposure to sexual content in music, movies, television, and magazines, may accelerate teens’ sexual activity, especially in White adolescents. However, Black teens seem to be more
influenced by perceptions of their parent’s expectations (Brown, et al., 2006). In adolescents ages 12-17, results of a regression analysis indicated that those who viewed more sexual content at baseline were more likely to initiate intercourse and to progress to advanced sexual activities during the subsequent year (Collins, et al., 2004). Braun-Courville and Rojas (2009) found that teens who were exposed to sexually explicit websites were more likely to have multiple sexual partners, have more than one sexual partner in the last three months, and to have engaged in anal sex. Results from a longitudinal study determined that exposure to sexual content predicted teen pregnancy when adjusting for the covariates age, race, and SES (Chandra, et al., 2008). Teens who were exposed to higher levels of sexual content (90th percentile) were twice as likely to experience pregnancy in the subsequent three years than those who were exposed to lower levels (10th percentile) (Chandra, et al., 2008).

Potential explanations for the media’s effect on adolescent sexuality include social comparison theory or modeling. Research suggests that unrealistic images in the media of females confound the pressures adolescent girls feel to maintain a certain body image (Morrison, Kalin, & Morrison, 2004). Zhang et al. (2000) found that viewing videos with heavy sexual imagery is related to more sexually permissive attitudes among adolescents and young adults (Zhang, Miller, & Harrison, 2008). Although we have confirmed that sexuality in the media is common and usually shown in a positive light (Gruber, 2000), and that adolescents use media sources of information to learn about sex and relationships (Gruber, 2000; Bleakley, Hennessy, Fishbein, & Jordan, 2009) the direction of the relationship between media and sexuality remains unclear (Gruber, 2000). According to Brown, Halpern, and L’Engle (2005), earlier maturing girls
reported more interest in seeing sexual content in movies, television, and magazines and in listening to sexual content in music, regardless of age or race. Earlier maturing girls were also more likely to report listening to music, reading magazines watching TV with sexual content, and interpreting the messages as approving of teens having sexual intercourse (Brown, Halpern, & L'Engle, 2005).

**Summary**

Although there is an abundance on literature of adolescent pregnancy and repeat pregnancy, the efficacy of prevention programs’ best practices varies by perceived risk factors and demographics of the target population. As indicated by our current teen pregnancy and birth rates, one-size programs do not prove effective. Strengths in the literature include program evaluation studies, assessment of risk and protective factors, and meta-analysis of current research. Although authors have speculated on the effect of pregnancy and repeat pregnancy on personal and professional outcomes, using cross sectional studies there is only limited data on the effect of pregnancy on personal and professional aspirations. Furthermore, my literature search did not result in any studies on success or the meaning of success among American adolescents. As such, meaning of success and adolescent pregnancy seems to be under-investigated. Further investigation on goal development, assessment, and success and risk avoidance is needed.

**Chapter 2 Conclusion**

In Chapter 2, I have described the multifaceted factors related to adolescent pregnancy and repeat pregnancy. There are both risk and protective factors for pregnancy and repeat pregnancy in the literature; the effects of some factors depend on contextual variables. Following the risk factors, and implications of adolescent
pregnancy and repeat pregnancy I provided an overview of the most effective adolescent pregnancy and repeat pregnancy prevention programs, as well as those that were deemed unsuccessful, or concluded mixed reviews. Although abstinence education is important providing contraceptive education and information on access to services is essential to reducing teen pregnancy. Programs that utilized home visits, peer counseling opportunities, and access to long-acting contraception were most effective in reducing teen pregnancy.

To conclude Chapter 2, I outlined the literature surrounding my theoretical background. Contributing factors to both adolescent pregnancy and repeat pregnancy are adolescent development, goal aspirations, the perceived advantages, and disadvantages of motherhood, and media influences. Considering these factors in the development and evaluation of public health programs is essential.
Figure 2-1. Risk Factors of Risk Factors for Risky Sexual Behavior, Adolescent Pregnancy, Repeat Pregnancy
Table 2-1. Risk Factors of Risky Sexual Behavior, Adolescent Pregnancy, and Repeat Pregnancy

<table>
<thead>
<tr>
<th>Ecological Model</th>
<th>Risky Sexual Behavior</th>
<th>Adolescent Pregnancy</th>
<th>Repeat Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social system</strong></td>
<td>Middle to low SES</td>
<td>Low SES</td>
<td>Low SES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urban or suburban neighborhood</td>
</tr>
<tr>
<td><strong>Peer/ community</strong></td>
<td>Negative attitudes</td>
<td>Having friends who</td>
<td>Having friends who are parents</td>
</tr>
<tr>
<td></td>
<td>towards school</td>
<td>are parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trouble in school</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer influences</td>
<td>Dropped out of school before index pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friends that are</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family/ Relationship</strong></td>
<td>Mother having first</td>
<td>Mother who was a</td>
<td>Poor mother-daughter relationship</td>
</tr>
<tr>
<td></td>
<td>child before age 20</td>
<td>teen parent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family instability</td>
<td>Sibling who is a</td>
<td>Cohabiting with father of the index child</td>
</tr>
<tr>
<td></td>
<td>Boyfriend that was ≥ 2</td>
<td>teen parent</td>
<td>Married before or after index pregnancy</td>
</tr>
<tr>
<td></td>
<td>years older</td>
<td>From a single parent household</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partner wanting a</td>
<td>Partner wants a child</td>
</tr>
<tr>
<td></td>
<td></td>
<td>child</td>
<td>Experience intimate partner violence</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>Deviant behaviors</td>
<td>Early menarche</td>
<td>Age at first birth</td>
</tr>
<tr>
<td></td>
<td>(tobacco, alcohol, drug use)</td>
<td>Early pubertal changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self esteem</td>
<td>Minority status</td>
<td>Minority status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low self-esteem</td>
<td>Intended first pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aggression</td>
<td>Prior poor pregnancy outcome</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not starting long acting contraception soon after index birth</td>
</tr>
<tr>
<td></td>
<td>Pregnancy Prevention Strategies</td>
<td>Repeat Pregnancy Intervention Strategies</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Successful</strong></td>
<td>• Target younger adolescents</td>
<td>• Comprehensive (home visits, service referral, peer groups)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Comprehensive (abstinence and contraception information)</td>
<td>• Provide and encourage long-acting contraception use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide access to contraception services</td>
<td>• Access to emergency contraceptive</td>
<td></td>
</tr>
<tr>
<td><strong>Unsuccessful</strong></td>
<td>• One-size programs</td>
<td>• Monetary incentives increase enrollment but not effectiveness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Those with little to no information on contraception</td>
<td>• Exclusive or abbreviated programs</td>
<td></td>
</tr>
<tr>
<td><strong>Mixed Reviews</strong></td>
<td>• May Influence Knowledge</td>
<td>• May influence rates in year 1, diminished results in year 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Limited effect on behavior</td>
<td>• May reduce teen pregnancy but not school attendance and vice a versa.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase condom use, but have no effect on sexual activity</td>
<td>• Results of the program may rebound after program completion.</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 3
RESEARCH DESIGN and METHODS

Overview

This research study was conducted primarily in Alachua County and Marion County, Florida. I used explorative research methods to investigate the similarities and differences in the meanings of life success and personal and professional goal aspirations among nulliparous, primiparous and multiparous adolescents. Qualitative research methods, supported by quantitative data including demographic and psychosocial variables, formed the basis of the findings. Adolescent girls ages 16-19 who met specified inclusion criteria participated in a research interview and/or a focus group. Each interview and focus group was digitally recorded, transcribed, and analyzed with thematic coding. In this section, I describe the steps for instrument development, participant recruitment, data collection, and data analysis.

Approach

Qualitative research is best when the research question and or data necessitate exploratory methods (Richards & Morse, 2007). According to Creswell (2009), qualitative research seeks to explore and understand how individuals or groups assign meaning to social or human problems. Qualitative methods work well when there is little known about the subject, to make sense of complex situations, to learn from participants about the way they experience reality, to construct a theory or theoretical framework, or to understand phenomena deeply and in detail (Richards & Morse, 2007, pp. 29-30).

This research project utilized explorative qualitative research grounded in ethnographic methodology. Ethnography allows for exploration based on culture
Ethnographic research explores themes within cultural contexts from the perspectives of the members of the group; during data collection, it is essential to reflect on the cultural values, beliefs, and behaviors of the group (Richards & Morse, 2007, p. 55). Typically, ethnography is conducted in the natural setting of the lives of the members of the participant group. The researchers often become integrated in the lives of the people they are studying (Richards & Morse, 2007). Observational data, field notes, surveys, and interviews (unstructured, semi-structured, and structured) are classic ethnographic methods. Ethnographic methods address observational questions; descriptive questions about values, beliefs, and practices of a cultural group as well as what is happening within a culture (Richards & Morse, 2007).

There are four different types of ethnography. The first type is traditional ethnography, which is usually conducted in an unknown culture that is unfamiliar to the researcher and requires prolonged residence and engagement within the culture (Richards & Morse, 2007). The second is focused ethnography, which is used to evaluate or elicit information on a special topic or shared experience. The topic is identified before the researcher commences the study and research can be conducted in a sub-cultural group. The third type is participatory action research, (PAR), which uses the ethnographic method of conducting field research using interviews and observations (Richards & Morse, 2007). The fourth type is action research (AR); in this method a team of professional action researchers and stakeholders conduct research together (Richards & Morse, 2007). For this research, focused ethnography served as the theoretical guide, to investigate the shared experience of adolescent pregnancy among parous participants and special topic of adolescent pregnancy among nuliparous
participants. In-depth interview questions were utilized to investigate the meaning and experience of adolescent pregnancy among nulliparous and parous participants. Weiss (1997) used similar strategies termed Explanatory Model Interview Catalogue (EMIC) to understand illness experience. EMIC sought to investigate the distress, perceived causes, preference for help seeking, and general illness beliefs among participants with general or specified health conditions (Weiss, 1997). Kleinman et al. (1978) determined that explanatory models of disease may determine how individuals understand and respond to disease/illness diagnoses. Research strategies used for this project are similar to explanatory model investigation (Kleinman, Eisenberg, & Good, 1978) and explanatory model interview catalogue (Weiss, 1997).

**Research Setting**

This research was conducted in North Central Florida, in the Southern Region of the United States. Although in 2010 Florida had moderate rates of teen birth, disproportionately higher rates of teen birth and repeat birth typically occur in the southern United States (Schelar, Franzetta, & Jennifer, 2007). As depicted in Figure 3-2, the highest rates of teen birth in 2010 were located in the Southern states (Kasier Family Foundation, 2012). 1 Throughout this section, I present the most current data related to population characteristics, the socio-economic profile, general health status, risk behaviors, and sexual, maternal and child health statistics. All of these factors help provide a framework for understanding adolescent pregnancy within the specified

---

location. This information is outlined for the State of Florida and Alachua and Marion counties. Table 3-1 provides a side-by-side comparison of key statistics.

**Population Estimates**

The population of Florida in 2010 was 18,820; there were approximately 1,650,274 adolescents’ ages 12-18, of which 71% were White, 22% were Black and 27% were Hispanic (Florida Department of Health (FDOH), 2013). Located in North Central Florida (Figure 3-2), the population of Alachua County in 2010 was approximately 247,669. Gainesville serves as the county seat. Alachua County’s population in 2010 was estimated to include 25,850 adolescents ages 12-18. Of these, 65% were White, 25% Black, and 11% Hispanic (Florida Charts, 2013). The US Census Data uses ‘resident’ data to determine population characteristics. Students (above college age) who have resided in the housing unit for more than two months are counted in these data (US Census Data). The University of Florida and Sante Fe College (two large college systems) are both housed in Alachua County and thus influence the US census data. Located just south of Alachua County (Figure 3-1), Marion County had a population of 331,314 in 2010 (Florida Charts, 2013). The county seat is Ocala. In 2010 there were approximately 25,774 adolescents ages 12-18, in Marion County. Seventy-five percent of the adolescent population was White, 19% was Black, and 16% was Hispanic (FDOH, 2011). Among Marion County adolescents, 5.1 per 1,000 lived in foster care, compared to 4.8 in Alachua County and 4.5 in the State (FDOH, 2011).

**Socio-Economic Status (SES)**

The median family household income for Florida was $47,661 in 2010, compared to $40,644 in Alachua County and $40,339 in Marion County (Median Household
Income, Florida Charts 2013). Approximately 14% of Florida residents lived below 100% poverty, similar to the 13.1% in Marion County, but much lower than then 24% in Alachua County (Median Household Income, Florida Charts 2013). The state unemployment rate in 2011 was 10.5%, lower than Marion County (13.8%), but higher than Alachua County (7.7%) (FDOH, 2013). The high school graduation rate in 2009-10 was 81% in Florida, slightly higher than Alachua (77%) and Marion counties (80%) (FDOH, 2013). In 2010, similar to Marion County (15%), but higher than Alachua county (10.3%), approximately 15% of the state’s population over the age of 25 did not have a high school diploma or its equivalency (FDOH, 2013). In 2011, almost 60% of Florida middle school youth qualified for the free or reduced lunch program, compared to 66% in Marion County and 47% in Alachua County (FDOH, 2011). Among Alachua County adolescents ages 12-17 in 2011, 4.8 per 1,000 were in foster care, similar to the state rate (4.5) and the rate for Marion County (5.1) (FDOH, 2011). Review summary Table 3-1 for a side-by-side comparison of SES at the state and county levels.

Health Status and Adolescent Risk Behaviors

Approximately 83% of Florida adults reported having some type of health insurance in 2010, compared to 80% in Marion County and 86% in Alachua County (FDOH, 2013). The age adjusted 3-year death rate in 2009-11 was 676.2 per 100,000 in Florida, lower than in Alachua County (758.8) and Marion County 756.9 (FDOH, 2013). In 2009-11, the total infant mortality in Florida was 6.6, lower than in Marion County (7.7) and Alachua County (8.7) (Florida Charts: FDOH, 2013).

In 2010, rates of risk behaviors among Florida, Alachua, and Marion counties were similar. Thirty-eight percent of Florida high school youth, compared to 37% of Alachua County and 37% in Marion County reported using alcohol in the past 30 days
Rates of binge drinking among high school youth were 19% in Marion County, 22% in Alachua County and 20% in Florida (FDOH, 2011). Marijuana use in the past 30 days among high school youth was higher in Alachua County (23%), than Marion County (15%) and Florida (19%) (FDOH, 2011). Fifteen percent of high school youth in Marion County reported smoking cigarettes in the past 30 days compared to 10% in Alachua County and 10% in Florida (FDOH, 2011).

Sexual, Maternal, and Child Health

The 3-year rate of sexually transmitted diseases (STDs)\(^2\), in 2009-11, among Florida youth ages 15-19 was 2,473.9 per 100,000, lower than both Marion County (2,943.4) and Alachua County (3,197.5) (FDOH, 2011). The rate of new HIV/AIDS cases among youth ages 13-19 was 14.2 per 100,000 in Florida, however the count in both Alachua and Marion County was less than 10 (FDOH, 2011).

The percent of Florida women who began prenatal care in the first trimester was 79%, slightly higher than Alachua County (77%) and Marion County (66%) (FDOH, 2013). Almost 9% of Alachua County babies were low birth weight (under 2,500 grams) in 2009-11, compared to 8.7% in Florida and 7.8% in Marion County (Florida Charts, 2013). The three-year non-white Alachua County infant death rate was 10.9 per 1,000 live births in 2009-11, compared to 13.5 in Marion County and 11.3 in Florida (FDOH, 2013).

From 2009-11 the three-year rate of births to youth 15-17 was 22.3 per 1,000 in Marion County, higher than Alachua County (11.8) and Florida (15.4) (FDOH, 2011). Also during 2009-11, the birth rate to mothers ages 18-19 was 59.3 per 1,000 in

---

\(^2\) Data includes STD data for Chancroid, Chlamydia, Gonorrhea, Granuloma inguinale, LGV, Syphilis
Florida, higher than Alachua (30.1), but lower than Marion County (85.4) (FDOH, 2011). The percent of repeat births to Florida mothers ages 15-19 during the same period (2009-11) was 18%, slightly lower than both Marion County (21%) and Alachua County (20%) (FDOH, 2011). See Table 3-1 for a side-by-side comparison of maternal and child health characteristics at the state and county levels.

**Interviews**

**Sample**

Participants’ age ranged from 16 to 18. The average age was 17.5 years. Almost 27% percent were White, 53% were Black, 6.7% were Hispanic, and 20% were other. Forty percent of participants had never been pregnant, 50% had one child, and 10% had two or more children. Fifty-three percent resided in Marion County, 43% in Alachua County, and 4% in Union County.

**Inclusion and Exclusion Criteria**

Primary inclusion criteria for the research interviews were: adolescent girls between the ages of 16 and 18 who resided in Gainesville or the surrounding areas. Participants under the age of 18 required the consent of a parent or guardian before they could participate. Research participants were required to meet one of three specific criteria: (1) has had no known pregnancies; (2) has had one child or, (3) has had two or more children. Primiparous and multiparous adolescents were required to have given birth to one or more children but were not required to be currently parenting. Additional criteria required participants to be unmarried and to speak, read and understand English. Please see Table 3-2 a summary of the inclusion and exclusion criteria of interview participants.
Recruitment

This research study utilized a variety of methods to recruit participants, all of which focused on a purposive sampling strategy. Purposeful sampling requires participant selection that will best help answer the specified research question (Creswell, 2009). I selected participants who met specific research criteria, thereby providing insight into each of the research questions. I utilized snowball sampling, key informants and research flyers to recruit participants who met the eligibility criteria.

The first step was to conduct a preliminary analysis of the extant teen pregnancy, birth and repeat birth rates in Gainesville and surrounding cities. This analysis was conducted with the use of State and county statistics available via Florida Charts. Florida Charts is sponsored by the Florida Department of Health Division of Public Health Statistics & Performance Management (FDOH, 2013). I also contacted agencies within Alachua and Marion counties who work with or serve adolescent mothers. I identified doctors’ offices (obstetricians, gynecologists, and pediatricians), schools, the Woman Infant and Child (WIC) program, and Healthy Start as potential points of contact for research recruitment. During research recruitment, I posted research flyers at each of these sites.

The second step included meeting with the director and or student educator of the adolescent pregnant and parenting programs in Alachua and Marion counties. During these meetings (average two meetings per site), I assessed the population demographics, strengths and weaknesses of research recruitment, and the steps necessary to conduct research recruitment. I gathered and analyzed information such as race, ethnicity, and age distribution of each program’s clientele. Based on this analysis, I proceeded with research recruitment at both locations; however, due to
considerable barriers to participant access at Alachua County Continuing Education Program for Pregnant/Parenting Teens (ACCEPT), this recruiting avenue was unsuccessful (recruitment difficulties).

The third step was the use of key informant interviews to gather information on recruitment and data collection strategies. I met with an African American, 17-year-old mother of one and an 18-year-old never pregnant African American female both of whom resided in Gainesville, Florida. I asked the primiparous participant about key recruitment strategies of adolescent mothers and repeat mothers. I also asked both participants about interview question formatting and their suggestions for revisions.

A formal cognitive interview was conducted with the nulliparous participant prior to Institutional Review Board (IRB) submission. Cognitive interviews allow for understanding the meaning of the questionnaire from the participants’ perspective (Drennan, 2003). This is especially useful in instances when questions may be considered sensitive or intrusive (adolescent sexuality and pregnancy) and for specific groups for which the questionnaire completion may be an issue (Drennan, 2003). The participant and I went through each interview question and reflected on the participant’s initial response to the question, the meaning of the question, and potential adjustments to the question. Based on the cognitive interview, several questions were revised or added to ensure congruence with the research questions, and participants’ understanding of the topic.

Upon IRB approval, the original key informants were contacted for assistance with participant access and recruitment. The primiparous adolescent was lost for follow-

3 Data from the cognitive interview was not intended for report or publishing, therefore IRB approval was not obtained beforehand, per personal conversation with IRB-01 Summer, 2011.
up and unable to be contacted for formal participation or participant referral. Gatekeepers at key agencies proved the most effective in participant recruitment. Key personnel at Healthy Start, Youth Parenting Program (YPP) - a parenting program for adolescents in Marion County, and Hands of Mercy Everywhere (HOME) - a foster home for parenting adolescents, provided essential access to participant recruitment.

In addition to key personnel, snowball sampling served as the primary recruitment strategy. Snowball sampling is often used for hard to reach or hidden populations. Hidden populations, defined by Heckathorn (1997), are populations for which there are privacy concerns due to stigmatized or illegal behavior and for which there is no sampling frame. Snowball sampling was used in this project due to the stigma associated with teen pregnancy and the difficulty associated with gaining access to the population. Following completion of the interview, each participant was given three project contact cards to distribute to friends or relatives who met the research criteria.

**Recruitment Difficulties**

Alachua County School District maintains a program for pregnant and parenting teens; Alachua County Continuing Education Program for Pregnant/Parenting Teens (ACCEPT) is a voluntary program designed to address the needs of pregnant and parenting teens. It provides prenatal and parenting courses to participants as well as an onsite day care center (Alachua County Public Schools, 2013). ACCEPT is housed at Loften High School (located in East Gainesville), which also serves as the county’s magnet program for vocational careers. ACCEPT is available to adolescents enrolled in the Alachua County School District and provides school bus transportation (with car seats) for participants (Alachua County Public Schools, 2013). Although ACCEPT is
open to all pregnant and parenting adolescents, adolescents who do not need the available daycare often choose to remain at their base school.

The Alachua County School Board research office and the individual school principal must first approve potential research before recruitment can be conducted on school premises. Upon, University of Florida IRB approval, and approval from the Alachua County School Board, the research project and recruitment flyers were submitted to Loften High School (the ACCEPT program), Gainesville High School, and Eastside High School principals for approval. Personal, phone and email attempts with each school principal were unsuccessful and it is unknown if the research flyers were approved or distributed.

**Procedure**

Data collection occurred in several steps: assess interest and eligibility, schedule interview, conduct interview, and complete the post interview procedure. Interested participants made contact with me via email or phone. During a phone conversation (initial or follow-up), I introduced the study, the purpose, and research requirements. Study eligibility, age, and parent/guardian availability were assessed prior to scheduling the interview. Research interviews were scheduled over the phone at a time/place that was convenient to both the researcher and participant. Typical research locations consisted of the participants’ home, school, or a neutral location such as a community park or library.

The participant/parent dyad was consented/assented simultaneously. Participants under the age of 18 were unable to consent to participation and thus provided her assent per IRB-01 regulations. In these cases, the participants’ legal guardian, often a parent, was present during the informed consent process and
provided legal consent. Immediately following consent, the researcher and participant relocated to a private area. Immediately prior to the research interview participants completed the participant intake form (quantitative instrument). This typically took 10-20 minutes to complete. During this time, I answered questions regarding the intake questionnaire as needed. Representative questions consisted of terminology clarification e.g. what does jittery mean, referencing the Positive Affect Negative Affect Schedule (PANAS) item “Over the past 2 weeks how much have you felt Jittery.” Please see Table 3-10 for a complete list of the PANAS (Watson, Clark, & Tellegen, 1988).

The intake form was reviewed for completion and clarification before starting the interview. Subsequently, I reviewed the interview procedure and reminded participants of the confidentially policy and its exceptions, the digital recorder, and participant responses to sensitive issues. Each interview was recorded with an Olympus® digital recorder and lasted an average of 47 minutes. At the conclusion of the interview, participants were asked to complete a worksheet that assessed their perception of their individual placement on a life success ladder and characteristics of successful and unsuccessful members in their community.

At the conclusion of the worksheet, each participant was given a $25.00 gift card to Wal-Mart (originally $20, revised and approved by IRB on 8/4/12), and three research invitations to distribute to friends who might be interested in participation.

On the following workday, each interview was uploaded to the UF encrypted file server, and erased from the digital recorder. Quantitative data were subsequently entered into the SPSS data file and the interview was submitted for transcription.
I conducted 29/30 research interviews and both focus groups. A second researcher was consulted to conduct interviews when necessary. This researcher was a recent graduate of the UF Master of Public Health program and consulted on cases when there was a potential for conflict of interest between the participant and the researcher.

**Instrument Development**

The qualitative interview consisted of several overarching themes: success, future aspirations, professional future, personal future, relationships, sexuality, pregnancy, motherhood, media, and hopes for the future. Each construct consisted of one or two interview questions and several probes that were used as needed. See Table 3.4 for a complete list of each interview theme and the corresponding interview questions.

The meaning of success was assessed by the interview question “Think about someone you consider successful, tell me about that person” and a follow-up worksheet that required a list of characteristics describing successful and unsuccessful people in the participant’s community.

Future aspirations were assessed by interview questions, “Tell me about your life 3 years from now,” and “Tell me about your career plans and hopes for the future.” Both questions included multiple probes to investigate adjustments in aspirations and the reason behind these adjustments.

Nulliparous adolescents were asked to think about a peer who was an adolescent mother and reflect on the positive and negative things about adolescent childbearing. Primiparous and multiparous adolescents were asked to reflect on the
easiest and hardest things about being a mom as well as motherhood’s effect on their educational, personal, and romantic plans.

All participants (nulliparous, primiparous and multiparous) were also asked to reflect on MTV shows *16 and Pregnant®* and *Teen Mom®* and their comparison to the reality of teen pregnancy and motherhood.

**Focus Group**

**Sample**

Participants’ ages ranged from 16 to 19 years. The average age was 17.8 years. Race/ethnicity was reported as Black (54%), White (18%), Hispanic (18%), and other (10%). The majority of the sample had one child (82%) and 18% had two or more children. All of the focus group participants resided in Marion County.

**Inclusion and Exclusion Criteria**

The focus group participants were required to be between the ages of 14-19. Participants under the age of 18 required the consent of a parent or guardian before they could partake. Other inclusion criteria required participants to be unmarried, and able to speak, understand, and read English. See Table 3-3 for a complete list of the inclusion and exclusion criteria for focus group participants.

**Recruitment**

One focus group was conducted at each of the major recruiting facilities, YPP, and HOME, in Marion County. The first step was to contact and meet with the agency’s director. During these meetings (an average of one meeting per site), I explained the study, eligibility criteria, and data collection procedure, and scheduled a follow up meet-and-greet with potential participants.
The second step was to conduct the meet-and-greet session with potential participants. The purpose of these sessions was to inform, assess interest, and schedule the focus group. To inform the participants, I introduced myself and the study, and explained eligibility and the study procedure. After answering preliminary questions and concerns, I assessed participant interest. Prior to scheduling a tentative time, date, and location for the focus group, I gave interested participants a study face sheet. Each participant was asked to complete a study face sheet that included the participant’s name, age, and contact information. Participants returned the face sheet on the day of the session and received an Informed Consent Form (ICF). I reviewed the ICF and consented participants. A completed ICF was required prior to focus group participation.

**Procedure**

Each focus group lasted between 1.5 to 2 hours. At the beginning of each focus group, I reminded the participants about the nature of the study. During this time, I emphasized that participation was voluntary and could be withdrawn at any time. I also collected completed informed consent forms and reminded participants that information shared in the group must remain confidential. Immediately following the introduction to the group, each participant completed an intake form. Intake forms were completed individually and took approximately 20 minutes. I addressed questions about the intake form as needed; the majority of questions concerned vocabulary terms in the Positive and Negative Affect Schedule (Watson, Clark, & Tellegen, 1988), The Mastery Scale (Perlin & Schooler, 1978), The Rosenberg Self-Esteem Scale (Rosenberg M., 1965), and the Life Orientation Test (Scheier & Carver, 1985). See Tables 3-7, 3-8, 3-9, and 3-10 for a complete description of each scale. Following completion of the intake form, I began the focus group. Each focus group was audio recorded with the use of two digital
recorders. Participants were asked to refrain from using names whenever possible, but each transcript was de-identified during data clean up.

At the conclusion of the focus group, each participant received a $5.00 gift card to Wal-Mart and a goody bag. Each goody bag contained a variety of items for the participants or their children. Sample items included a picture frame, Chap Stick, infant washcloths, infant sun-block lotion, pens, pencils, or highlighters. The value of each goody-bag was $5.00.

**Instrument Development**

The focus group guide imitated the components of the individual interview; however, it allowed for group reflection on sexuality and media and excluded questions about personal relationships. Please see Table 3-5, for a complete list of focus group questions and their corresponding constructs.

**Quantitative Instrument Development**

The intake form consisted of demographic information, pregnancy and parenting status, living arrangement and environment, relationship status, family and peer history of teen pregnancy, the Mastery Scale (Perlin & Schooler, 1978), Rosenberg Self-Esteem Scale (Rosenberg, 1965), Life Orientation Test (Scheier & Carver, 1985), and the PANAS (Watson, Clark, & Tellegen, 1988). Please see Table 3-9, and 3-10 for a list of each scale and the corresponding participant means and standard deviations.

Research has highlighted several risk factors for adolescent pregnancy and repeat pregnancy such as race, family history of teen pregnancy, poor family dynamics, and low self-esteem (Boardman, Allsworth, Phipps, & Lappane, 2006; East, 1998; Etheir, Kershaw, Lewis, Milan, & Ickovics, 2006). In order to investigate these risk factors as they relate to the sample, each participant completed an intake form prior to
completing the interview or focus group. The intake form assessed demographic variables such as age, race and ethnicity, family dynamics (such as current living environment), family history of teen pregnancy, and psychosocial variables, perception of control (The Mastery Scale, Perlin & Schooler, 1978), self-esteem (Rosenberg Self-Esteem Scale Rosenberg, 1965), optimism deposition (LOT, Scheier & Carver, 1985) and mood/ affect (PANAS, Watson, Clark, & Tellegen, 1988).

**Rosenberg Self-Esteem Scale (RSE)**

The RSE is a widely used self-report measurement for individual self-esteem (Gray- Little, Williams, & Hancock, 1997). The original RSE was a 10-item Guttman scale guided by ease of administration, time considerations, dimensionality, and face validity (Rosenberg, 1965). Self-esteem defined by Rosenberg is a “positive or negative attitude toward a particular object, namely self” (Rosenberg, 1965, p. 30). Typically high self-esteem implies the individual thinks he or she is “very good”, however high self-esteem reflected in the RSE reflects that the individual thinks he/she is are “good enough” (Rosenberg, 1965). Low self-esteem implies self-rejection, self-dissatisfaction, or self-contempt (Rosenberg, 1965).

Robins et al. (2001) analyzed the construct validity of the Rosenberg Self-Esteem Scale (RSE) and a Single–Item Self-Esteem Scale (SISE) across four studies. Their findings conclude that the RSE and SISE have nearly identical correlations with several constructs; however, the RSE had improved convergent validity in child population samples (Robins, Hendin, & Trzesniewski, 2001).

Various studies have investigated self-esteem related to adolescent health, and sexual behavior. Donnellan, et al. (2005) found that low self-esteem among an international and national sample (comparative sample of New Zealand and the US) of
adolescents and young adults was related to aggression, antisocial behavior, and delinquency. This relationship held true after controlling for parent-child relationships, peer relationships, and socioeconomic status (Donnellan, Trzensniwski, Robins, Mofitt, & Capsi, 2005). Rosenberg and Perlin (1978) also found that when compared to adults adolescent self-esteem showed a lower association to social class (defined using the Hollingshead Index of Social Position). The authors proposed that the fundamental meaning of social class differed in the two groups (achieved versus assigned) thus creating a different effect on self-esteem (Rosenberg & Pearlin, 1978). Whitbeck et al. (1999) found that higher levels of self-esteem were negatively associated with early sexual intercourse.

Lower participant scores (under 15) suggest lower levels of perceived self-esteem. The scale mean was for this study $32.5^4$ (SD 5.0); and the Cronbach’s alpha was .81; slightly lower than those reported in Pallant (2002) whose mean was 33.5 and reported Cronbach’s alpha was .85 among a diverse group of young adults (college age). However, among a small group (N=21) of parenting adolescents (ages 15-19), the mean score for RSE was 14.72, and the reported alpha coefficient was 86 (Hudson, Elek, & Campbell-Grossman, 2000). These participants also scored high levels of depression (Center for Epidemiologic Studies Depression Scale for Children), however the two scores were not significantly related (Hudson, Elek, & Campbell-Grossman, 2000) Hockaday, Crase, Shelley, and Stockdale (2000) analyzed adolescent pregnancy prospectively and its association with self-esteem, aspirations, and expectations. The

---

4 Mean based after recode of negative items.
study participants reported a mean of 30.98 among parenting teens, the Cronbach’s alpha was .84.

The Mastery Scale

This scale was designed to measure perceptions of control (Pallant & Lae, 2002). Developed by Perlin and colleagues, it assesses the degree to which participants regard their life chances as under their control compared to fatalistically ruled (Perlin & Schooler, 1978). It addresses confidence in problem-solving, sense of helplessness, and control over things that happen to the participant (Whitbeck, Yoder, Hoyt, & Conger, 1999). Perlin (1978) discovered that stress, as it relates to marriage, parenting, and household economics, depends heavily on self-reported mastery. Researchers also found that within the population younger subgroups were more likely to entertain a sense of mastery than were older subgroups; however, both mastery and self-esteem were closely associated with achieved status (successfully reached a preset life goal) (Perlin & Schooler, 1978).

The Mastery Scale is a 7-item scale for which participants select how much they agree (strongly agree, agree, disagree, strongly disagree) with each statement related to perception of control (Perlin, Lieberman, Menaghan, & Mullan, 1981). These items such as “There is really no way I can solve some of the problems I have” were included to assess the participants’ overall perceptions of control and possible implications to meaning of success and parenting status.

Whitbeck et al. included the Mastery Scale and RSE to investigate predictors of early sexual intercourse among 457 middle school students (Whitbeck, Yoder, Hoyt, & Conger, 1999). Results concluded small statistically significant effects indicating higher levels of self-esteem and self-confidence were negatively associated with early
intercourse (Whitbeck, Yoder, Hoyt, & Conger, 1999). Ben-Zur (2003) found that among adolescents and college students, high levels of mastery and optimism were negatively associated with the Negative Affect (NA) scale of the PANAS (PA: M= 3.77, SD=.75. NA: M =2.43). He also concluded that adolescents’ mastery (M=5.21, SD= 99), and optimism (M=3.75, SD=.80) were positively associated with Subjective Well-Being (Ben-Zur, 2003). Mastery, dispositional optimism, and affect were used as a measure for Subjective Well-Being (Ben-Zur, 2003).

Higher participant scores indicate high levels of perceived mastery. The scale mean was 22.16 (SD 2.9). Similar to a Shanahan (2004), whose reported mean for 22.8 (SD= 3.18).The Cronbach’s alpha was .61, lower than scores reported by Whitbeck (1991) whose reported Cronbach’s Alpha was .71, and Whitbeck (1999), whose Chronbach’s alpha ranged from .73-.87 for adolescents across mulitple survey points. See Table 3-7 for participant mean score by item.

**Life Orientation Test**

The Life Orientation Test (LOT) (Scheier & Carver, 1985), was developed to measure depositional optimism or an individual’s expectations to experience positive things in life (Vera, et al., 2008), it was proposed that low dispositional optimism could have clear health-related and behavioral consequences (Scheier & Carver, 1985). Scale psychometrics revealed a two-factor analysis (negatively and positively worded items), a Cronbach’s alpha of .76, and test-retest reliability of .79 (Scheier & Carver, 1985). The final scale consists of eight items, although it is often presented with filler items to disguise the overall meaning of the scale. See Table 3-9 for a complete list of items.

Optimism was found to positively correlated with Mastery (RS = .57), among college students (N=97) and (R=.46) among adolescents (N=185-- P<.001) (Ben-Zur,
2003). Vera et al. (2008) found moderate positive correlations with Mastery, and Self-Esteem (R=.34, and .48). Creed, Patton and Bartum (2002), found that using the LOT-R, adolescents who scored high levels of optimism reported higher levels of career decisions, and career related goals. Those with higher pessimism reported low levels of career and decision making knowledge, were more career-indecisive and had lower levels of school achievement (Creed, Patton, & Bartum, 2002). Puskar et al. (1999) found that among rural adolescents ages 14-19, the mean score was lower (NS) than comparable college students, and that rural adolescent females scored slightly lower than adolescent males. The Life Orientation Test-Revised (LOT-R) includes 5 of the original 8 items, two items found to measure coping rather than optimism were removed an additional positively phrased item was included, and a negatively worded item was removed from scoring (Creed, Patton, & Bartum, 2002; Scheier, Carver, & Bridges, 1994).

Higher participant scores imply higher optimism (scale 0-24). The participant mean was 23.8 (SD=4.5) and the Cronbach’s alpha was .80. This is slightly higher than 21.73 (SD=3.69) reported among urban, ethnic diverse adolescents ages 12-15 (Vera, et al., 2008). See Table 3-9 for a complete list of items, scale means, and standard deviations.

Positive and Negative Affect Schedule

The Positive and Negative Affect Schedule (PANAS) was utilized to assess overall affect tendency. The PANAS is a validated measure that suggests a consensual two-factor model (i.e. positive and negative affect; Watson, Clark, & Tellegen, 1988). According to Watson, Clark, and Tellegen (1988), Positive Affect (PA) reflects the extent to which a person feels enthusiastic, active, and alert and Negative Affect (NA) consists
of adverse mood such as anger, contempt, disgust, guilt, fear, and nervousness (Watson, Clark, & Tellegen, 1988). Please see Table 3-10, for a complete list of the scale variables and their corresponding domain. Assessment of each affect domain is assessed with 10 items scored on a 5-point Likert scale. Crocker (1998) determined that among a youth sport sample ages 10-17, the PANAS provided reliability (PA α= .88, NA α= .79) and validity (R=.11) of both Positive and Negative Affect scales.

Each of these scales was included to provide an objective measure of constructs that may be associated with risky behaviors or resilience in adolescent groups. Ames and Archer (1988) investigated motivational processes among middle and high school students. Students who perceived an emphasis on mastery goals reported more effective goal achievement strategies and held a stronger belief that success and effort were linked (Ames & Archer, 1988).

Higher participant scores after adding positive scale items indicate higher levels of Positive Affect (scale 10-50). The mean score for Positive Affect was 30.5 (SD= 7.8) compared to 33.5 (SD=6.85) reported by Vera, et al., (2008), among 151 diverse urban adolescents ages 12-15. Lower participant scores represent lower levels of negative affect (scale 10-50). The mean score for Negative Affect was 21.9 (SD=7.1), lower than a mean 26.73 reported in Vera et al. (2008). The Cronbach’s Alpha was .85 for PA, and .77 for NA. See Table 3-10, for participant mean score by item.

Data Analysis

Quantitative Analysis

The quantitative portion of this study was used to provide a demographic profile of the participant population and to address Research Aim 4: To explore the role of factors such as religion, personal expectations, family dynamics and family history of
teen pregnancy as they relate to single and subsequent adolescent births. Due to the small sample size (n=32), very few statistical inferences can be determined; however, general trends and averages among varying groups are presented in Chapter 4: Research Findings. I used SPSS to analyze this data.

The average age of participants was 17.6 years; the majority of the sample was African American/Black (N=18, 56%), were attending high school full-time (N=21, 65%), and looking for a job (N=19, 60%). Focus group participants were either pregnant or parenting at the time of participation; 40% of interview participants had never been pregnant. A demographic profile of the sample is presented in Table 3-6.

**Qualitative Analysis**

The qualitative portion of this study (interviews and focus groups) helped to address research questions 2-6: 2) what are the similarities and differences in definitions of what it means to have a successful life between the two groups?; 3) what are the similarities and differences in definitions of personal and professional goal aspirations between the two groups?; 4) how do adolescent girls (ages 16-19) who have never been pregnant perceive pregnant or parenting peers? What are their views on adolescent pregnancy/motherhood in the media?; 5) How do primiparous adolescent girls (ages 16-19) describe the context surrounding initial birth?; 6) How do multiparous adolescent girls (ages 16-19) describe the context surrounding subsequent births? Due to difference in sample size, primiparous and multiparous transcript data were analyzed using thematic analysis and I conducted case study analysis on multiparous adolescent data.
Thematic analysis

There are several approaches to qualitative data analysis such as grounded theory analysis (involves open and axial coding), case study and ethnographic research (involves a detailed description of the setting), and phenomenological research (involves generation of meaning units; Creswell, 2009). For this research, I relied mostly on thematic analysis. Thematic analysis is the search for themes that emerge as important to the issue (Daly, Kellehear, & Gliksman, 1997). Based on Creswell (2009) and Fereday & Muir-Cochraine (2006) I used the following steps for thematic analysis:

1) organized and prepared data for analysis, 2) read through all the data, 3) summarized data and identified themes 4) hand coded the data, 5) developed a code manual, 6) computer coded the data, 7) applied template of codes and additional coding, 8) connected the codes and themes, 9) interpreted the meaning of themes, and 10) corroborated the coded themes (Creswell, 2009) (Fereday & Muir-Cochraine, 2006).

The first step I employed was to organize and prepare for data analysis. Data preparation consisted of review and cleaning of each transcription, assessing for privacy concerns (remove names and dates) and accuracy. Creswell (2009) includes transcription, typing filed notes, and data arrangement in this step.

The purpose of the second step is to obtain a general sense of the information and to reflect on overall meaning of the data (Creswell, 2009, p. 185). During this step, I assessed the overall depth, credibility and use of the data (Creswell, 2009).

Step three, was the process of summarizing data and identifying themes (Fereday & Muir-Cochraine, 2006). I read transcripts and listened to raw data. During this step, I also reviewed memos created during the data collection process.
During step four I read each transcript and conducted a preliminary hand code of the data for each construct and interview question. Coding is the process of taking data, organizing them into categories, and labeling the categories (Creswell, 2009, p. 186). There are several different types of coding including descriptive (storing information), topic (gathering material by a specific topic), and analytic (coding aimed at developing concepts (Richards & Morse, 2007, p. 134).

Based on the hand codes, I created a codebook that was used for the computer coding analysis; this was step five. The codebook can serve as a data management tool and is often referenced for scientific rigor and interrater reliability (Fereday & Muir-Cochraine, 2006). In order to test the reliability of my codes, I consulted the use of a qualitative data analysis team and a dissertation committee member to assist in some coding.

During step six, I used the codebook and a computer-based data management tool. I conducted an additional level of coding for which the computer system NVivo was used. I coded the text from each transcript into prescribed nodes that imitated the hand codes finalized in the codebook.

The last steps of analysis included application and collaboration of codes and themes. During step seven, I applied the codes created during hand and computer coding to identify subsets of expressive text, similar to techniques described by Fereday (Fereday & Muir-Cochraine, 2006).

In steps 8-10, I connected the codes, identified themes, and corroborated coded themes. Corroboration, as defined by Crabtree and Miller (1999; p. 170), is the process
of confirming findings. This was done with the use of the data analysis team and qualitative research colleagues.

**Case study analysis**

A case study analysis of the multiparous adolescents was used to address the sixth research question (How do multiparous adolescent girls (ages 16-19) describe the context surrounding subsequent births?) Case study research (CSR), as defined by Woodside and Wilson (2003), is an inquiry focusing on describing, understanding, predicting, and/or controlling the individual (Woodside & Wilson, 2003, p. 493). CSR is often used to provide descriptions of phenomena, develop theory, and test theory (Drake, Shanks, & Broadbent, 1998). Although useful, Flyvbjerg (2006) identified five misinterpretations about CSR. These misinterpretations are: 1) Theoretical knowledge is more valuable than practical knowledge, 2) CSR is more useful in generating hypothesis than hypothesis testing and theory building, 3) CSR creates difficulty in generalizability, 4) CSR lends to bias to verification, and 5) it is difficult to summarize using CSR (Flyvbjerg, 2006).

**Ethical Considerations**

There were several ethical considerations when designing, collecting, and analyzing qualitative data in a setting such as this. The first is the inclusion of several potentially vulnerable populations. Vulnerable populations are groups that could be harmed, manipulated, or deceived by researchers due to reduced competence or disadvantaged status (Rogers, 1990). This may include the poor, women, children, and ethnic minorities (Martin, 1995). This research included participants who were under the age of legal consent (average 17.4-17.8 years old); therefore, per IRB regulations these participants gave the assent to participate but required parental consent. Furthermore,
given the nature of the research study, some participants were pregnant at the time of enrollment. IRB regulations require additional safeguards whenever pregnant women participate in research; these regulations were enacted to protect the mother and fetus. Before the commencement of this research project specific information and justification for the inclusion of pregnant women and children (under the age of 18) was required.

The second ethical consideration was investigation of potentially sensitive topics. Sex, relationships, and pregnancy are sensitive issues when speaking with adolescents. Crowles (1988) noted several issues within qualitative research regarding sensitive topics. One issue is timing; participants who have recently experienced a life changing experience (childbirth) may be unwilling or unable to participate in research (Cowles, 1988). According to Cowles (1988), to be prepared for participant emotional responses the researcher should have contingency plan and a noted prescribed provision within the informed consent process. Particularly important for adolescents in research are the issues of confidentiality and or anonymity (Cowles, 1988); in this case, each participant was insured that responses were completely confidential except for mandatory reporting of abuse such as physical, or sexual. Finally, researcher response and objectivity are both issues in qualitative research and investigation of sensitive issues (Cowles, 1988). Research of sensitive issues can be emotionally taxing for the researcher as well as the participant; ample planning prior to the research interview is essential to help prepare for possible researcher responses during the interview. Objectivity requires the researcher to remain empathic while impartial; this is usually displayed within the researcher response (Cowles, 1988).
The Institutional Review Board 01 at the University of Florida provided research approval on this project from 2/29/12 to 2/14/13, the IRB number is 685-2011.

Chapter 3 Conclusion

I focused on group differences and similarities in the factors related to personal and professional goal aspirations and meaning of success. I conducted thirty individual interviews and two focus groups in Gainesville and Ocala, Florida. Due to the limited data available from multiparous adolescents, these interviews were analyzed using a case study approach. I analyzed potential trends in quantitative responses using The Mastery Scale (Perlin & Schooler, 1978), the Rosenberg Self-Esteem Scale (Stevens-Simons, Dolgan, Kelly, & Singer, 1997), and The Positive and Negative Affect Scale (Watson, Clark, & Tellegen, 1988). Qualitative data were analyzed using Nvivo software and quantitative data were analyzed using SPSS software.
Figure 3-1. Adolescent Birth rate, national distribution. (Birth Rate per 1,000, ages 15-19, 2010.) Original Image (Kaiser Foundation, 2012)

Figure 3-2. Alachua and Marion County sited on Florida Map (Florida Counties, 2013)
Table 3-1. Data amended from Florida Charts County School-aged Child and Adolescent Profile (2011) and County Health Status. Data provided is the most recent data available. (Florida Charts, 2011; Florida Charts, 2013).

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Alachua County</th>
<th>Marion County</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adolescent Race/ Ethnic Distribution</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>2010</td>
<td>65%</td>
<td>75%</td>
<td>71%</td>
</tr>
<tr>
<td>Black</td>
<td>2010</td>
<td>25%</td>
<td>19%</td>
<td>22%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2010</td>
<td>12%</td>
<td>16%</td>
<td>27%</td>
</tr>
<tr>
<td><strong>Socioeconomic Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Household Income</td>
<td>2010</td>
<td>$40,644</td>
<td>$40,339</td>
<td>$47,661</td>
</tr>
<tr>
<td>100 % below poverty</td>
<td>2010</td>
<td>24%</td>
<td>13%</td>
<td>14%</td>
</tr>
<tr>
<td>HS Graduation Rate</td>
<td>2009-10</td>
<td>77%</td>
<td>80%</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Sexual, Maternal and Child Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STDs Youth 15-19 (3 Year) per 100,000</td>
<td>2009-11</td>
<td>3197.5</td>
<td>2943.4</td>
<td>2473.9</td>
</tr>
<tr>
<td>Births Females 15-17 (3 Year) Per 1,000</td>
<td>2009-11</td>
<td>11.8</td>
<td>23.3</td>
<td>15.4</td>
</tr>
<tr>
<td>Repeat Births Females 15-19 (Percent)</td>
<td>2009-11</td>
<td>20%</td>
<td>21%</td>
<td>18%</td>
</tr>
</tbody>
</table>

---

5 Decimals are rounded up to the nearest whole number.

6 Data presented is the most recent available data.
### Table 3-2. Inclusion and exclusion criteria for interview participants

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nulliparous</strong></td>
<td></td>
</tr>
<tr>
<td>- 16-18</td>
<td>- &lt; 16 or &gt; 18</td>
</tr>
<tr>
<td>- No past known pregnancies</td>
<td>- Married</td>
</tr>
<tr>
<td>- Unmarried</td>
<td>- Unable to speak, understand and read English</td>
</tr>
<tr>
<td>- Speak, understand and read English</td>
<td>- Parent or legal guardian unavailable to sign consent if under the age of 18</td>
</tr>
<tr>
<td>- Parent or legal guardian available to sign a consent if under the age of 18</td>
<td></td>
</tr>
<tr>
<td><strong>Primiparous</strong></td>
<td></td>
</tr>
<tr>
<td>- 16-18</td>
<td>- &lt; 16 or &gt; 18</td>
</tr>
<tr>
<td>- 1 prior pregnancy carried to term</td>
<td>- Married</td>
</tr>
<tr>
<td>- Unmarried</td>
<td>- Unable to speak, understand and read English</td>
</tr>
<tr>
<td>- Speak, understand and read English</td>
<td>- Parent or legal guardian unavailable to sign consent if under the age of 18</td>
</tr>
<tr>
<td>- Parent or legal guardian available to sign a consent if under the age of 18</td>
<td></td>
</tr>
<tr>
<td><strong>Multiparous</strong></td>
<td></td>
</tr>
<tr>
<td>- 16-18</td>
<td>- &lt; 16 or &gt; 18</td>
</tr>
<tr>
<td>- 2 or more prior pregnancies carried to term</td>
<td>- Married</td>
</tr>
<tr>
<td>- Unmarried</td>
<td>- Unable to speak, understand and read English</td>
</tr>
<tr>
<td>- Speak, understand and read English</td>
<td>- Parent or legal guardian unavailable to sign consent if under the age of 18</td>
</tr>
<tr>
<td>- Parent or legal guardian available to sign a consent if under the age of 18</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3-3. Inclusion and exclusion criteria for focus group participants

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 14-19</td>
<td>- &lt; 16 or &gt; 18</td>
</tr>
<tr>
<td>- Unmarried</td>
<td>- Married</td>
</tr>
<tr>
<td>- Speak, understand and read English</td>
<td>- Unable to speak, understand and read English</td>
</tr>
<tr>
<td>- Parent or legal guardian available to sign a consent if under the age of 18</td>
<td>- Parent or legal guardian unavailable to sign consent if under the age of 18</td>
</tr>
<tr>
<td>Theme</td>
<td>Lead Interview Question</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Introduction</td>
<td>Tell me about life for girls your age.</td>
</tr>
<tr>
<td>Success</td>
<td>I’d like to talk to you all about success. I’d like for you to think about someone you consider successful, tell me about this person.</td>
</tr>
<tr>
<td>Future Aspirations</td>
<td>Now I’d like for you to imagine yourself 3 years from now. What would you like to be doing?</td>
</tr>
<tr>
<td>Professional Future</td>
<td>Next I’d like for you all to think about your future job or career. Can you tell me your career plans and hopes for the future?</td>
</tr>
<tr>
<td>Personal Future</td>
<td>Okay, now I’d like for you to talk about your personal life. Can you tell me about your family ten years from now?</td>
</tr>
<tr>
<td>Relationships</td>
<td>When did you have your first romantic relationship?</td>
</tr>
<tr>
<td>Sexuality</td>
<td>Next I’d like to talk about sex, please keep in mind, this interview will remain between us, and none of your friends, teachers or parents will see your answers. When did you first learn about sex?</td>
</tr>
<tr>
<td>Pregnancy *</td>
<td>Tell me about your first sexual experience.</td>
</tr>
<tr>
<td>(Nulliparous adolescents)</td>
<td>Next, I would like to talk about girls who have babies in high school. I would like you to think for a minute about a girl your age who has had a baby. Can you describe what you think it is like for girls who have a baby in high school?</td>
</tr>
<tr>
<td>Pregnancy *</td>
<td>Next, I’d like to talk about your pregnancy and birth. Again, this will remain between us and you can skip any question that makes you uncomfortable. Tell me what it was like when you first found out you were pregnant.</td>
</tr>
<tr>
<td>(Primiparous &amp; Multiparous adolescents)</td>
<td></td>
</tr>
<tr>
<td>Motherhood</td>
<td>Can you describe what you think it is like for a teen mother?</td>
</tr>
<tr>
<td>*(Primiparous &amp; Multiparous adolescents)</td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td>MTV has two popular television shows about teen pregnancy and motherhood. Have you seen ‘16 and Pregnant’ or ‘Teen Mom’?</td>
</tr>
<tr>
<td>Past Self</td>
<td>If you could go back and change one thing about the past related to your personal past what would it be? Why is that?</td>
</tr>
<tr>
<td>Future Self</td>
<td>Is there any one thing you are excited about, or looking forward to in the future? Why is that?</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Is there anything else you would like to tell me about being a teenager?</td>
</tr>
<tr>
<td></td>
<td>Is there anything else you would like to tell me about being a mother?</td>
</tr>
</tbody>
</table>

* For Parenting adolescents
Table 3-5. Focus group themes and corresponding questions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Lead Focus Group Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Tell me about life for girls your age.</td>
</tr>
<tr>
<td>Success</td>
<td>I’d like to talk to you all about success. I’d like for you to think about someone you consider successful, tell me about this person.</td>
</tr>
<tr>
<td>Future Aspirations</td>
<td>Now I’d like for you to imagine yourself 3 years from now. What would you like to be doing?</td>
</tr>
<tr>
<td>Professional Future</td>
<td>Next I’d like for you all to think about your future job or career. Can you tell me your career plans and hopes for the future?</td>
</tr>
<tr>
<td>Personal Future</td>
<td>Okay, now I’d like for you to talk about your personal life. Can you tell me about your family ten years from now?</td>
</tr>
<tr>
<td>Sexuality</td>
<td>Next I’d like to talk about sex, please keep in mind, this interview will remain between us, and none of your friends, teachers or parents will see your answers. When did you first learn about sex?</td>
</tr>
<tr>
<td></td>
<td>Tell me about your first sexual experience.</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Let’s talk about girls who have babies in high school.</td>
</tr>
<tr>
<td>Motherhood</td>
<td>If you are a mother, or know a young mother, can you describe what it is like for a teen mother?</td>
</tr>
<tr>
<td>Media</td>
<td>MTV has two popular television shows about teen pregnancy and motherhood. Have you seen ‘16 and Pregnant’ or ‘Teen Mom”?</td>
</tr>
<tr>
<td>Past Self</td>
<td>If you could go back and change one thing about the past related to your personal past what would it be? Why is that?</td>
</tr>
<tr>
<td>Future Self</td>
<td>Is there any one thing you are excited about, or looking forward to in the future? Why is that?</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Is there anything else you would like to tell me about being a teenager?</td>
</tr>
<tr>
<td></td>
<td>Is there anything else you would like to tell me about being a mother?</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Interview</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>N=30</td>
</tr>
<tr>
<td>Age</td>
<td>17.48</td>
</tr>
<tr>
<td></td>
<td>Percent (N)</td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Alachua</td>
<td>43 (13)</td>
</tr>
<tr>
<td>Marion</td>
<td>54 (16)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Black/AA</td>
<td>54 (16)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7 (2)</td>
</tr>
<tr>
<td>White</td>
<td>27 (8)</td>
</tr>
<tr>
<td>Other</td>
<td>13 (4)</td>
</tr>
<tr>
<td>School Attendance</td>
<td></td>
</tr>
<tr>
<td>HS Full Time</td>
<td>67 (20)</td>
</tr>
<tr>
<td>HS Part Time</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Graduate HS</td>
<td>13 (4)</td>
</tr>
<tr>
<td>GED</td>
<td>10 (3)</td>
</tr>
<tr>
<td>HS Drop Out</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>-</td>
</tr>
<tr>
<td>Part Time</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Looking for Job</td>
<td>64 (19)</td>
</tr>
<tr>
<td>Does not work</td>
<td>33 (10)</td>
</tr>
<tr>
<td>Sexual Activity</td>
<td></td>
</tr>
<tr>
<td>Currently Sexually Active</td>
<td>40 (12)</td>
</tr>
<tr>
<td>Used to be Sexually Active</td>
<td>20 (6)</td>
</tr>
<tr>
<td>Not Sexually Active, had Sex</td>
<td>17 (5)</td>
</tr>
<tr>
<td>Never had Sex</td>
<td>23 (7)</td>
</tr>
<tr>
<td>Pregnancy Status</td>
<td></td>
</tr>
<tr>
<td>Never been Pregnant</td>
<td>40 (12)</td>
</tr>
<tr>
<td>Pregnant Once</td>
<td>47 (14)</td>
</tr>
<tr>
<td>Pregnant twice or more</td>
<td>13 (4)</td>
</tr>
<tr>
<td>Parenting Status</td>
<td></td>
</tr>
<tr>
<td>No children</td>
<td>43 (13)</td>
</tr>
<tr>
<td>One Child</td>
<td>47 (14*)</td>
</tr>
<tr>
<td>Two or more children</td>
<td>10 (3)</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>37 (11)</td>
</tr>
<tr>
<td>Girlfriend &lt;6 mos</td>
<td>-</td>
</tr>
<tr>
<td>Girlfriend &gt;6 mos</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Boyfriend &lt;6 mos</td>
<td>13 (4)</td>
</tr>
<tr>
<td>Boyfriend &gt;6 mos</td>
<td>37 (11)</td>
</tr>
<tr>
<td>Engaged</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (1)</td>
</tr>
</tbody>
</table>
Table 3-7. The Mastery Scale (Perlin & Schooler, 1978). ** Items recoded for scale (e. What happens to me in the future mostly depends on me M= 3.75; g. I can do just about anything I set my mind to M =3.84)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>There is really no way I can solve some of the problems I have.</td>
<td>32</td>
<td>3.1</td>
<td>.77</td>
<td>3% (1)</td>
<td>16% (5)</td>
</tr>
<tr>
<td>b.</td>
<td>I have little control over the things that happen to me</td>
<td>32</td>
<td>3.2</td>
<td>.69</td>
<td>0% (0)</td>
<td>16% (5)</td>
</tr>
<tr>
<td>c.</td>
<td>Sometimes I feel like I am being pushed around in life.</td>
<td>32</td>
<td>2.6</td>
<td>.94</td>
<td>6% (2)</td>
<td>50% (16)</td>
</tr>
<tr>
<td>d.</td>
<td>There is little I can do to change many of the important things in my life</td>
<td>32</td>
<td>2.9</td>
<td>1.06</td>
<td>12% (4)</td>
<td>22% (7)</td>
</tr>
<tr>
<td>e.</td>
<td>What happens to me in the future mostly depends on me.**</td>
<td>32</td>
<td>1.25</td>
<td>.51</td>
<td>78% (25)</td>
<td>19% (6)</td>
</tr>
<tr>
<td>f.</td>
<td>I often feel helpless in dealing with the problems of life.</td>
<td>32</td>
<td>2.75</td>
<td>.84</td>
<td>3% (1)</td>
<td>41% (13)</td>
</tr>
<tr>
<td>g.</td>
<td>I can do just about anything I set my mind to. **</td>
<td>32</td>
<td>1.2</td>
<td>.37</td>
<td>84% (27)</td>
<td>16% (5)</td>
</tr>
</tbody>
</table>
Table 3-8. The Rosenberg Self-Esteem Scale (Rosenberg, 1965) ** Mean presented is after recode for congruency. Items recoded for scale (1 = strongly disagree to 4 = strongly agree)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th>Strongly Agree</th>
<th>Agree 2</th>
<th>Disagree 3</th>
<th>Strongly disagree 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. I feel that I am a person of worth, at least on an equal plane with others.</td>
<td>32</td>
<td>1.5</td>
<td>.62</td>
<td>53% (17)</td>
<td>41% (13)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>b. I feel that I have a number of good qualities.</td>
<td>32</td>
<td>1.4</td>
<td>.56</td>
<td>63% (20)</td>
<td>34% (11)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>c. All in all, I am inclined to feel that I am a failure. **</td>
<td>32</td>
<td>3.4</td>
<td>.87</td>
<td>6% (2)</td>
<td>6% (2)</td>
<td>31% (10)</td>
</tr>
<tr>
<td>d. I am able to do things as well as most other people.</td>
<td>32</td>
<td>1.5</td>
<td>.57</td>
<td>50% (16)</td>
<td>47% (15)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>e. I feel that I do not have much to be proud of. **</td>
<td>32</td>
<td>3.1</td>
<td>1.1</td>
<td>12.5% (4)</td>
<td>16% (5)</td>
<td>22% (7)</td>
</tr>
<tr>
<td>f. I take a positive attitude toward myself.</td>
<td>32</td>
<td>3.2</td>
<td>.64</td>
<td>12% (4)</td>
<td>57% (18)</td>
<td>31% (10)</td>
</tr>
<tr>
<td>g. On a whole, I am satisfied with myself.</td>
<td>32</td>
<td>1.6</td>
<td>.75</td>
<td>47% (15)</td>
<td>44% (14)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>h. I wish I could have more respect for myself. **</td>
<td>32</td>
<td>2.8</td>
<td>.99</td>
<td>12.5% (4)</td>
<td>19% (6)</td>
<td>41% (13)</td>
</tr>
<tr>
<td>i. I certainly feel useless at times. **</td>
<td>32</td>
<td>3.0</td>
<td>.87</td>
<td>3% (1)</td>
<td>25% (8)</td>
<td>38% (12)</td>
</tr>
<tr>
<td>j. At times I think I am no good at all.</td>
<td>32</td>
<td>3.1</td>
<td>1.0</td>
<td>9% (3)</td>
<td>19% (6)</td>
<td>25% (8)</td>
</tr>
</tbody>
</table>
Table 3-9. The Life Orientation Test (Scheier & Carver, 1985) sample means, standard deviation and distribution.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In uncertain times, I usually expect the best.</td>
<td>32</td>
<td>1.9</td>
<td>.89</td>
<td>37% (12)</td>
<td>41% (13)</td>
<td>16% (5)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>b. If something can go wrong for me, it will.</td>
<td>32</td>
<td>2.7</td>
<td>.93</td>
<td>9% (3)</td>
<td>34% (11)</td>
<td>34% (11)</td>
<td>22% (7)</td>
</tr>
<tr>
<td>c. I always look on the bright side of things.</td>
<td>32</td>
<td>1.8</td>
<td>.79</td>
<td>41% (13)</td>
<td>44% (14)</td>
<td>12% (4)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>d. I'm always optimistic about my future.</td>
<td>32</td>
<td>1.7</td>
<td>.86</td>
<td>50% (16)</td>
<td>37% (12)</td>
<td>6% (2)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>e. I hardly ever expect things to go my way.</td>
<td>32</td>
<td>2.9</td>
<td>.97</td>
<td>9% (3)</td>
<td>22% (7)</td>
<td>37% (12)</td>
<td>31% (10)</td>
</tr>
<tr>
<td>f. Things never work out the way I want them to.</td>
<td>32</td>
<td>2.8</td>
<td>.79</td>
<td>6% (2)</td>
<td>25% (8)</td>
<td>53% (1)</td>
<td>16% (5)</td>
</tr>
<tr>
<td>g. I'm a believer in the idea that “every cloud has a silver lining.”</td>
<td>31</td>
<td>1.9</td>
<td>.73</td>
<td>25% (8)</td>
<td>56% (18)</td>
<td>12.5% (4)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>h. I rarely count on good things happening to me.</td>
<td>32</td>
<td>2.7</td>
<td>1.0</td>
<td>16% (5)</td>
<td>25% (8)</td>
<td>31% (10)</td>
<td>28% (9)</td>
</tr>
</tbody>
</table>
Table 3-10. The PANAS Scale (Watson, Clark, & Tellegen, 1988) Means, Standard Deviation, and Distribution

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Very slightly or not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the past 2 weeks, how much have you felt….</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Interested+</td>
<td>32</td>
<td>3.3</td>
<td>1.3</td>
<td>12.5% (4)</td>
<td>12.5% (4)</td>
<td>25% (8)</td>
<td>34% (11)</td>
<td>16% (5)</td>
</tr>
<tr>
<td>b. Distressed -</td>
<td>32</td>
<td>2.5</td>
<td>1.3</td>
<td>28% (9)</td>
<td>28% (9)</td>
<td>16% (5)</td>
<td>22% (7)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>c. Excited +</td>
<td>32</td>
<td>3.2</td>
<td>1.3</td>
<td>9% (3)</td>
<td>22% (7)</td>
<td>28% (9)</td>
<td>19% (6)</td>
<td>22% (7)</td>
</tr>
<tr>
<td>d. Upset -</td>
<td>32</td>
<td>2.8</td>
<td>1.2</td>
<td>12.5% (4)</td>
<td>31% (10)</td>
<td>25% (8)</td>
<td>19% (6)</td>
<td>12.5%</td>
</tr>
<tr>
<td>e. Strong +</td>
<td>31</td>
<td>3.3</td>
<td>1.3</td>
<td>6% (2)</td>
<td>26% (8)</td>
<td>26% (8)</td>
<td>16% (5)</td>
<td>26% (8)</td>
</tr>
<tr>
<td>f. Guilty -</td>
<td>32</td>
<td>1.7</td>
<td>1.3</td>
<td>72% (23)</td>
<td>3% (1)</td>
<td>9% (3)</td>
<td>13% (4)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>g. Scared -</td>
<td>31</td>
<td>2.0</td>
<td>1.3</td>
<td>52% (16)</td>
<td>16% (5)</td>
<td>20% (6)</td>
<td>6% (2)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>h. Hostile-</td>
<td>31</td>
<td>1.8</td>
<td>1.1</td>
<td>53% (17)</td>
<td>22% (7)</td>
<td>12.5%</td>
<td>6% (2)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>i. Enthusiastic+</td>
<td>32</td>
<td>3.3</td>
<td>1.4</td>
<td>6% (2)</td>
<td>28% (9)</td>
<td>25% (8)</td>
<td>9% (3)</td>
<td>31% (10)</td>
</tr>
<tr>
<td>j. Proud+</td>
<td>32</td>
<td>4.0</td>
<td>1.2</td>
<td>3% (1)</td>
<td>9% (3)</td>
<td>19% (6)</td>
<td>25% (8)</td>
<td>44% (14)</td>
</tr>
<tr>
<td>k. Irritable -</td>
<td>31</td>
<td>2.7</td>
<td>1.3</td>
<td>26% (8)</td>
<td>19% (6)</td>
<td>23% (7)</td>
<td>23% (7)</td>
<td>10% (3)</td>
</tr>
<tr>
<td>l. Alert +</td>
<td>32</td>
<td>3.5</td>
<td>1.5</td>
<td>12.5% (4)</td>
<td>16% (5)</td>
<td>22% (7)</td>
<td>12.5%</td>
<td>37% (12)</td>
</tr>
<tr>
<td>m. Ashamed -</td>
<td>32</td>
<td>1.6</td>
<td>1.0</td>
<td>69% (22)</td>
<td>12.5% (4)</td>
<td>12.5% (4)</td>
<td>3% (1)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>n. Inspired +</td>
<td>32</td>
<td>3.6</td>
<td>1.2</td>
<td>3% (1)</td>
<td>19% (6)</td>
<td>19% (6)</td>
<td>31% (10)</td>
<td>28% (9)</td>
</tr>
<tr>
<td>o. Nervous -</td>
<td>32</td>
<td>2.7</td>
<td>1.3</td>
<td>25% (8)</td>
<td>16% (5)</td>
<td>25% (8)</td>
<td>28% (9)</td>
<td>6% (2)</td>
</tr>
<tr>
<td>p. Attentive +</td>
<td>32</td>
<td>3.1</td>
<td>1.3</td>
<td>12% (4)</td>
<td>16% (5)</td>
<td>37% (12)</td>
<td>19% (6)</td>
<td>16% (5)</td>
</tr>
<tr>
<td>q. Jittery -</td>
<td>32</td>
<td>2.0</td>
<td>1.4</td>
<td>53% (17)</td>
<td>16% (5)</td>
<td>16% (5)</td>
<td>6% (2)</td>
<td>9% (3)</td>
</tr>
<tr>
<td>r. Active +</td>
<td>32</td>
<td>3.4</td>
<td>1.3</td>
<td>9% (3)</td>
<td>16% (5)</td>
<td>25% (8)</td>
<td>28% (9)</td>
<td>22% (7)</td>
</tr>
<tr>
<td>s. Afraid -</td>
<td>32</td>
<td>1.9</td>
<td>1.1</td>
<td>50% (16)</td>
<td>22% (7)</td>
<td>22% (7)</td>
<td>3% (1)</td>
<td>3% (1)</td>
</tr>
</tbody>
</table>
CHAPTER 4
FINDINGS

Overview

Both quantitative and qualitative methods were used in this study. Chapter 4 provides both quantitative and qualitative findings organized by research question or research aim. This research project had six research questions and five research aims. The research aims were: 1) to explore the role of factors such as demographics, family dynamics, family/peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect, on single and subsequent adolescent births; 2) to explore the themes associated with what it means to have a successful life between nulliparous and parous adolescent girls (ages 16-19); 3) to explore the themes associated with personal and professional aspirations between nulliparous and parous adolescent girls (ages 16-19); 4) to investigate the explanatory models of nulliparous adolescent girls associated with parous peers, and their views on adolescent motherhood in the media; and 5) to explore the described context of conception, delivery and motherhood (for single and subsequent pregnancies) among parous adolescent girls (ages 16-19). Table 4-1 depicts each research aim and its associated research question. The quantitative and qualitative findings are presented below by research question. Tables 4-2, 4-3, and 4-4 provide a more complete description of quantitative findings than those summarized. Following a description of findings by question, I have provided a topic analysis of teen motherhood in foster care.
RQ 1. What are the Similarities and Differences in Demographics, Family Dynamics, Family/Peer History of Teen Pregnancy, Religion, and Psychosocial Constructs Such as Self-Esteem, Mastery, Optimism, and Positive/Negative Affect between Nulliparous and Parous Adolescents?

Quantitative analyses were conducted on demographic, family history, and family and peer dynamics related to nulliparous and parous status. However, due to a small sample size and skewed participant responses there were limited statistical tests that could be performed. Although chi-square analysis is routine for categorical data this was not performed due to cells with zero responses and cells with less than 5 responses, both of which are violations to chi square statistical analysis. See Tables 4-1 through 4-3 for summary data on demographic, family dynamics, family history, peer dynamics, and standardized scale, the Rosenberg Self-esteem Scale (Rosenberg, 1965), the Mastery Scale (Perlin & Schooler, 1978), the Positive and Negative Affect Scale, (Watson, Clark, & Tellegen, 1988), and the Life Orientation Test (Scheier & Carver, 1985) results. Statistical tests for significance are presented in Tables 4-1, 4-2 and 4-3 when possible.

**Background Characteristics**

Detailed demographics are presented in Tables 4-1 and 4-2. Participant recruitment was determined by age and birth status. The average age of nulliparous participants (N=12) was 17.17 (SD = .85), the average age for parous (N=20) participants was 17.7 (SD .86). Of nulliparous participants, 75% were Black, 8% were White, and 17% were other. Of parous participants, 45% were Black, 35% were White, 10% were Hispanic, and 10% were other.

The majority of nulliparous participants were enrolled in high school full-time and a few had graduated from high school. Half (50%) of nulliparous participants reported
getting “good grades” (As’ and Bs’) and half reported getting “OK” grades (Bs’ and Cs’). Slightly more than half of parous participants (60%) were enrolled in school full time; also a higher percentage than nulliparous participants had earned a GED. Parous participants reported getting mostly “OK” grades (60%). See Table 4-1 for a more complete breakdown of participant responses.

The majority of nulliparous participants reported being single (67%); a few (17%) reported being with a committed boyfriend for less than 6 months. About half (55%) of parous participants reported being with a boyfriend for more than 6 months; the remaining participants were either single or had varied relationship statuses (identified in Table 4-2).

Just over half (58%) of nulliparous participants reported never having sex, and one-third reported being currently sexually active. However, almost half (45%) of parous participants reported currently being sexually active, and one-third used to be sexually active. Demographic information reported separately for focus group and interview participants are reported in Chapter 3, Methods. See Table 4-1 for a summary of demographics by participant status.

**Family Dynamics**

Just under half of nulliparous participants (42%) reported living with their mother, as did just under half of parous participants (45%). Parous participants were more likely to report living with a romantic partner (20% vs. 0%). Sixteen percent of parous participants reported not living with their child at the time of the interview. Nulliparous participants reported living in a house (50%), followed by an apartment (33%). Parous participants reported living in house (50%), followed by a group home (30%).

110
Due to a revision to IRB half way through recruitment, 20 participants were asked about parental education, employment, and income status. The average years of school completed was 12.60 (SD = 2.4) for their mothers, and 12.24 (SD = 2.0) for their fathers. Nulliparous participants reported their mothers’ average years of education as 13.80 years (SD = 1.87), significantly higher than parous participants (11.4 years, SD = 2.3) (t = 2.5, df = 18, p = .02). Nulliparous participants reported an average income of $31,000 yearly compared to $15,000 yearly for parous participants. About one-third of nulliparous participants (33%) reported their mother’s employment as full-time, and 42% reported full-time employment for their fathers. Ten percent parous participants reported their mother’s employment as full time compared to 15% for their fathers.

**Family History of Teen Pregnancy**

There were no significant findings associated with family history of teen pregnancy among female or male relatives. Nulliparous and parous participants reported a higher incidence of teen pregnancy among their cousins, followed by an aunt or uncle. More nulliparous participants than parous reported having a grandfather who was a teen parent (33% versus 5%).

**Sexuality and Teen Parenthood among Peers**

A higher percentage of parous participants reported knowing girls who were sexually active (90% versus 67%). There is a slight difference in teen motherhood among friends of nulliparous and parous participants. Parous participants were more likely to reported having friends who were teen parents (65% versus 47%).

Seventy-five percent of nulliparous and 90% of parous participants reported knowing male peers who were sexually active. More nulliparous participants than parous reported having male friends who were teen parents (58% versus 40%), but
parous participants reported having more best male friends who were male parents. About one-third (35%) of parous participants, compared to 17% of nulliparous, reported having male best friends who were parents. One-third of parous participants (30%) and nulliparous participants (33%) reported not knowing any males who were teen parents.

**Psychosocial Constructs**

Low levels of self-esteem, optimism, and mastery have been predicted to be correlated to risky sexual behavior among adolescents, which can lead to adolescent pregnancy and repeat pregnancy (Whitbeck, Yoder, Hoyt, & Conger, 1999). Each participant completed a study intake form including validated measures of self-esteem, mastery, positive/negative affect, and optimism. Participant means were consistent with those found in the literature; however, I identified no significant difference in means between nulliparous and parous participants.

**The Rosenberg Self-Esteem Scale:** The mean score for the Rosenberg Self-Esteem Scale (Rosenberg, 1965) among nulliparous participants was 32.3 (SD=3.6, α=.69). The mean score for parous participants was 30.7 (SD=3.3, α=.56). The t-test results indicated that the difference in means on the Rosenberg Self Esteem Scale (Rosenberg, 1965) was not significant (t= .24, df = 30, p= NS)

**The Mastery Scale:** The mean score for the Mastery Scale (Perlin & Schooler, 1978) among nulliparous participants was 22.6 (SD=2.9, α=64). The mean among parous participants was 21.9 (SD=3.01, α=.59). The t-test results indicated that the difference in means was not significant (t = .75, df = 30, p= NS)

**Positive and Negative Affect Schedule:** The mean score for Positive Affect in the PANAS (Watson, Clark, & Tellegen, 1988) was 31.50 (SD=9.2, α=.91) among nulliparous and 30.0 (SD=6.9, α=81) among parous participants. The mean score for
Negative Affect was 21.9 (SD= 6.6, α=.69) for nulliparous participants and 22.0 (SD=7.5, α=.81) for parous participants. See Figures 4-1 and 4-2 for a visual comparison in box plots of the participants’ scoring on the PANAS (Watson, Clark, & Tellegen, 1988) by birth status. The t-test results indicated that the differences in Positive and Negative Affect means were not significant (PA, t= .51, df = 30, p= NS; NA, t= .08, df = 30, p= NS)

**The Life Orientation Test:** The mean score for the Life Orientation Test (Scheier & Carver, 1985) among nulliparous participants was 24.7 (SD=4.9, α=.84). The mean score for parous participants was 23.3 (SD=4.3, α=.77). These differences were not significant (t= .87, df = 30, p= NS)

**Group Differences:** I made an age comparison between participants 17.5 years or less (N=12) and those over the age of 17.5 years (N=20). Both age groups scored similarly on self-esteem (30.6 versus 31.7), and on Mastery (21.1 versus 22.8). Differences in the Life Orientation Test (Scheier & Carver, 1985) were not significant (t= -1.8, df = 30, p =.09), but those over the age of 17.5 years, reported average dispositional optimism of 24.9 compared to 22.1 for those under the age of 17.5 years. There was no significant difference found between groups related to Negative Affect; however, there was a statistically significant difference identified on Positive Affect. Participants over the age of 17.5 years had a higher Positive Affect mean (32.9) compared to those under the age of 17.5 years (26.7) (t= -2.3, df = 30, p=.03).

There were no statistically significant differences between Black (Black; N=18) and non-Black participants (N=14) related to the Rosenberg Self-Esteem Scale.
(Rosenberg, 1965), the PANAS (Watson, Clark, & Tellegen, 1988), the Life Orientation Test (Scheier & Carver, 1985), or the Mastery Scale (Perlin & Schooler, 1978).

**RQ 2. What are the Similarities and Differences in Definitions of What it means to have a Successful Life between the two groups?**

The qualitative findings below are summarized for the research question and are emphasized with participant quotes. Participants have been de-identified and renamed for the purpose of analysis and publication. No real names were used in this review. Please see Table 4-4 for a complete list of participant pseudonyms, birth status, age, and race/ethnicity.

**Meaning of Success**

The participants meaning of success can be summarized in one of three ideologies: distance traveled, goals achieved, and status achieved. Although, some participants described success as a combination of two or three of the identified ideologies one ideology was usually more salient. The prominent ideology was usually highlighted in the participant’s description of a profile of success and their identified characteristics of successful and unsuccessful people in the community.

**Ideology 1 distance traveled:** Some participants felt that success was not determined by current achievements (amount of money earned) but it was based on current achievements relative to previous status. Success in this circumstance was comparative to the quality and quantity of the barriers an individual has overcome to obtain specific achievements such as earning a GED or living on their own. Participants also thought that effort was essential to success. Carmella, characterized success as “turning their life around”; Jennie, described success as coming through something, and
accomplishing what loved ones could not. Jerri stated “You’ve gotta put your heart into something.” She explained:

She has her heart into whatever she wants to do in life; whether it be going to college, alternative things, she tries. She doesn’t have to have a high school diploma. Yeah, it’s a good idea for success, but it’s not completely necessary.

**Ideology 2 goals achieved:** Participants who subscribed to this ideology felt that success was directly proportionate to the individuals’ current achievement relative to their personal and professional goals. Participants thought that success was based on achieving preset individual goals. Lenore, stated success was “…doing what you set out to do;” she confirmed this by adding, “That’s about it. I feel like if you work at McDonald’s and that’s what you really wanna do, you’re a success.” Roxie stated, “She [mom] actually did what she wanted to do in life”, when asked to describe someone successful in her life. Some stipulated that individuals had to possess goals to be successful and that they must be moving forward, Noreen stated “Being able to, like, go a step forward and being able to better yourself.”

**Ideology 3 Status achieved:** Participants who subscribed to this ideology thought that someone was successful based on preconceived goals, often societal norms. Participants described actual or visible accomplishments that measured their personal meaning of success. These included earning a high school diploma/GED, or college degree, financial stability such as being debt free, not struggling, and having the ability to their pay bills on time, renting or owning assets such as cars and houses, and being self-sufficient by being able to provide for themselves and their family.

Essential to each of these ideologies was independence. Participants universally agreed, to be considered successful an individual must first be independent.
Independent in these terms meant not relying on others such as parents, family, or friends for necessities such as food, money, shelter, or transportation. Independence was especially important when raising a child and it was considered a prerequisite to adequately supporting a family.

Interviewer: … so how do you decide if someone’s successful? … what do you use to measure success?

Lakisha: About their independent.

Interviewer: … independence, tell me more about that?

Lakisha: Like if they have to depend on a lot of people to take them places or something like that.

Profile of Success

I asked each participant about specific individuals who they felt were successful. Participants identified individuals who were typically family members including mothers, grandmothers, aunts, fathers, grandfathers, brothers, female and male cousins, friends, or famous persons. Family members were listed as successful due to the distance traveled; participants described them as coming from nothing and gaining an education, independence, financial stability, tangible assets such as nice cars and house, and caring for and providing their family. Alexandra describes her father has successful due to his willingness to provide for his family.

Um, I think that my father is successful. And besides the whole alcoholic thing, he has always done what he had to do for his kids. Like he will work like two jobs for his children. And he was in the military and he has never gone without working.

Parous participants (3/20) listed friends who were also mothers but had achieved a higher level of perceived independence; these friends were identified as being good mothers, having a driver’s license, doing well in or having finished school, and being
close to getting their “own place.” Eve describes multiparous participant Carmella as successful due to some of these reasons.

Carmella, the girl has got two babies and still in school. I think she does a wonderful job…. She does, and she stays strong. And I know she has a lot goin’ on, but she puts on this happy, you know, they keep a positive attitude for her kids and just stayin’ in school. She does a good job. I give probably say 100 percent.

Famous persons (Oprah and Tyler Perry) were listed as successful due to high levels of accomplishments including monetary assets, and altruism as demonstrated by giving back to the community and helping others to reach success.

Generational differences in success centered on the perceived roles and achieved level of self-sufficiency. Successful female adolescents (16, 17 or 18 years old) were expected to be doing well or have completed high school, be planning for or enrolled in college, have a driver’s license or car, be drug and alcohol free, and if mothers, taking care of their children. Successful male adolescents were expected to be doing all of the same things and additionally playing sports if still in school and being sure to take care of any children they may have. Ten years later (26, 27, or 28 years old) women were expected to have a degree or two, have a good job, own their house, a good car, be married or engaged, and if they have children, be taking care of them. Men of the same age were expected to be doing the same, with the added responsibility of supporting their family, not being on drugs, and not being in prison.

**Characteristics of Successful and Unsuccessful Members in the Community**

I asked participants to list characteristics of successful and unsuccessful people in their community. Nulliparous participants identified tangible items such as having a high school diploma, college degree, good job, house, and a car. Personality traits included being caring, hardworking, understanding, and goal oriented. Independence
and having their life on track were also considered successful characteristics among nulliparous participants. Parous participants identified similar characteristics of successful people but included having a family and children as tangible characteristics of success. Parous participants were less likely to list personality characteristics of success and more likely to emphasize the importance of independence (providing for your family, being on your feet, not struggling) essential attributes. See Figure 4-2 for a model depiction of successful community member characteristics.

Characteristics of unsuccessful people in their community also included categories of lack of tangible accomplishments, self-sufficiency, and having negative personality traits. Nulliparous participants identified tangible characteristics such as being uneducated, having no money, being alone, and not having a job. Some personality traits included being bitter, uncaring, rude, or disrespectful, having no direction, and not being goal oriented. Nulliparous participants, also identified being dependent on others, living on the system, using/dealing drugs, and homelessness as unsuccessful characteristics. Parous participants identified dropping out of school, not working, having no car or money, and being single as tangible descriptions of unsuccessful community members. They identified being lazy, unhappy, dishonest, lacking determination, drug users, and dependent on others as descriptors. See Figure 4-3 for a model depiction of unsuccessful community member characteristics.

**Success Rankings**

Based on the characteristics of successful and unsuccessful community members, participants were asked to rank themselves on a community ladder. Girls placed their perceived rank currently, where they thought they would be in three years, and where they wanted to be in three years. Rank one was considered the bottom of
the ladder or among the unsuccessful people in the community, and rank 10 indicated the top or the most successful people in their community. Nulliparous participants ranked that they were currently at an average of 6.1 (SD=1.6) on a 10 point ladder compared to 5.5 (SD=1.7) among parous participants. The difference in means was not significant. When asked to describe their current location, nulliparous and parous participants described “being on their way,” defined as currently enrolled or graduated from school, getting good grades or improving their grades, looking for a job, and not doing drugs or alcohol, but that they were still a work in progress. They often identified as “not being there yet” due to dependence on others for transportation, money, and, among parous participants, to help care for their child. Roslyn described perseverance and determination as her main reasons for her perceived current level of success:

Evelyn: …So how are you on your way?

Roslyn: Like I'm doing everything to put me on track to be there. Like I'm staying in school, I have a plan, you know, I have a future and—and I'm not gonna let anybody or anyone get in the way of it.

Evelyn: … so when you talk about not letting anyone get in the way, what do you mean by that?

Roslyn: Not gonna let boys, you know, just like push me like away like make me like drop outta college or do what they want. I'm not gonna let, you know, people's—people's views of being a teenage mom, you know, not like let me be successful. I feel like I can prove 'em wrong, you know, I can be a successful teenage mom.

She described people around her who expected her to fail because she is an adolescent mother and her persistence to “prove them wrong”:

Evelyn:… When you talk about people's views about teen motherhood, who are you talking about?

Roslyn: It's like they like, look at us like … You got a kid, they expect us to fail. I don't expect myself to fail. I feel I can do it. You know. I just want to prove them wrong like, no people. I'm not going to fail. And when I don't fail I just want
to laugh at them in their face you know. They just have their view, they
don’t really know me. They don’t even want to take the time to you know
get to know me. Or talk to me. They don’t know.

Both nulliparous and parous participants ranked that they thought they would be
2 to 2.5 points higher in three years (nulliparous = 8.0, parous 8.1). There was no
significant difference between the two groups on where they wanted to be in three
years, 9.5 (SD=.94) among nulliparous and 9.4 (SD=.73) among parous participants.

When asked to describe the top of the success community ladder nulliparous and
parous participants described similar perspectives of success. These ‘success’
environments included being enrolled in or finishing college, being independent, not
wanting for anything, being wiser, more focused, and having accomplished their career
goals.

**Facilitate Success**

From there, participants were asked to rank several specific accomplishments on
how they would assist them in getting to the top of the success ladder the fastest. The
accomplishments ranked first (most helpful) to tenth (least helpful). Participant rankings
were: 1) graduate from high school (m=1.4); 2) go to college (m=2.70); 3) get a job
(m=2.77); 4) have lots of money (m=4.93); 5) own something costly (car or house,
m=5.47); 6) get married (5.80); 7) go out more (6.80); 8) have a/another baby (m=7.40);
and 9) other. ‘Other’, was an open-ended card that allowed participants to list an
accomplishment that was not included in the list. Most participants (18/30) did not
specify an additional item. For those who added to the list, getting a driver’s license,
being happy, working in a salon, having another baby, having grandkids, and retirement
were added accomplishments. There were no significant differences in the rankings
between the two groups except for accomplishment, getting married. Nulliparous
participants ranked getting married significantly higher (5.1) than parous (6.3) \( (t = -2.3, df = 28, p = .03) \). See Table 4-4 for each accomplishment ranking and t-test results.

Graduating from high school was listed first most frequently for both nulliparous and parous participants. The identified reason for ‘graduating from high school’ as being the most important to facilitate success was that it was a means to an end. Graduating from high school was seen as necessary to go to college, which would then lead to a good job and more money. Some stated that it was essential to graduate or get a GED to get any job. A diploma was considered the ‘base’ or starting point to reach success. Having a/another baby was listed as last (least helpful) for both nulliparous and parous participants. Nulliparous participants stated that having a baby would slow or derail plans. Both nulliparous and parous participants stated that they wanted to be ‘settled,’ ‘on top,’ and have everything in place before they had their first or another child. Some referred to the ‘good of the child,’ stating it was important for their child’s future and happiness that they were settled before bringing a baby into the world. Diana an 18-year-old primiparous participant replied, “I guess if it happens, it happens but mainly because I want to have everything situated before I bring another baby into the picture” when asked why she identified having another baby as the least helpful to reaching the top of the ladder. Lauretta (primiparous, 17-years-old) explained why having another baby was the “last thing she needed right now.”

I already have one life to take care of, and I know that’s gonna be challenging enough, and I’m not set. I don’t have a set career. I’m not, I’m able to take care of this child, but I know it’s gonna be tough as it is, … adding another child’s just gonna complicate things even more.

Following the finalization of their accomplishment rankings, participants were asked how they made their final decision. Strategies for deciding what order to list the
accomplishments included thinking about what applied to the participant, picking a starting point (starting from the top or bottom), thinking about their goals, and using their preset goals to guide them.

RQ 3. What are the similarities and differences in definitions of personal and professional goal aspirations between the two groups?

One of the primary goals of this research project was to understand and investigate potential differences in personal and professional goal aspirations among nulliparous, primiparous and multiparous adolescents. Participants were asked about their goals for their personal and professional futures as well as any adjustments in their goals. In this next section, I summarize the findings related to personal and professional aspirations of nulliparous and parous participants.

**Personal Aspirations**

Parous participants described a personal future that included being engaged or married in 10 years and having additional children. Participants typically described being married to the father of their child or current boyfriend. One-third of parous participants (6/18) dreamed of being married in the near future (ages 18 and 19). These participants described being married to the father of their child or current boyfriend. Some reported currently being engaged or promised. Tia described being engaged to her significant other (not the father of her children) for three years but having limited contact with him. “Um, well, I’ve been engaged to somebody for three years. I’m not really sure, like, I haven’t talked to him since I got put in foster care.” Some girls who were no longer in a relationship with the father of their child hoped to marry their current partner, and others dreamed of marrying the father of their child. Diana, who was
currently dating her high school sweetheart (not the father of her child), described her partner as special due to his promise:

But I guess what really makes him that special person is, when he found out I was pregnant, he stepped up and said, “Two years after high school, we’ll be married.” And I was like, “What?” It just made me feel safe with him, yeah.

Diana has plans to be married by the age of 23. Claire, who was not currently in a relationship with the father of her child, still hoped they would be married by age 24. When asked to describe her future husband she replied, “I don’t know. He gonna be like, he gonna look good. I hope that it’s my baby dad, but I don’t know cuz he’s like on some other stuff right now…. He has his own little girlfriend and everything, so I don’t know.” Eve wants to have three kids and hopes for a future with her boyfriend who is father of her child, but was unable to describe concrete personal aspirations due to unknown factors. When asked about additional children in 10 years she replied, “It depends if I’m doin’ good, if I can afford it, cuz I know me [I] couldn’t really afford it,” She explained, “Baby daddy doesn’t have a job. He needs to get one.”

Some parous participants aimed to be married in their or late 20’s and early 30s (ages 28-35); they described being married after they were ‘settled,’ indicated by having finished school, having a good job and having an apartment or house of their own. Although some participants characterized children after getting married, most did not stipulate getting married before having additional kids. The girls imagined additional children within the next 10 years (ages 26, 27 and 28), and typically described being finished with children by age 30-34. They wanted an average of 3-4 children total, and hoped for the next child after they were financially stable. Liza, narrated,

After this one. Well, later on in life. Not right now, but yeah, I want a little boy. And then, I wanna put her [daughter] in like things like whatever interests her and you know like go out on trips with my family.
Nulliparous participants also desired to be being engaged or married in 10 years. Those who were in a relationship were less committed to be 'married' to that person within the next 10 years. Jerri was in a committed relationship, and although she thought she might get married she wasn’t committed to marrying her current partner, “He might be the guy I’m with, technically, now. We’re having issues, so it’s weird, but I don’t know. I mean, I’m not picky,” she thought marriage was useful but not necessary:

Like, it—to me, marriage isn’t really, because of all of the crap and drama that people have thrown into it, it’s the same. It’s just, if he is in the military, we get stationed in the same place. And if he’s not, tax deductions. I mean, it’s just a simple fact that it’ll save money and time. You don’t—my parents [were] married for 40 years. They stuck together. My grandparents on my mother’s side were never married. But they have been together my entire life, and some.

One participant had no desire to get married or have children. Three others also admitted to not wanting children, but stated they may reconsider when they were married. Those who strived to get married (11/12) in the future aimed to do so in their mid-20’s (25-28), specifically after they completed college, had a career and were settled described as being independent, having a house or apartment, and being financially stable. Nulliparous participants who wanted children (8/12) wanted an average of 2-3 children but not until after they were settled but not necessarily before they were married. Participants aimed to be done having children by the age of 28-30. Jennie was currently single and characterized her future husband as “religious, tall, and tan”; she planned for two children after she was married, but did not have a concrete time plan or either marriage for children.

Professional Aspirations

In addition to personal aspirations, I asked participants about their career plans and hopes for the future: “Next, I’d like for you to think about your future job or career.
Can you tell me your career plans and hopes for the future?” I probed participants on why they selected that career, if their career goals had changed and if so, why it changed, and if their career plan was moving along as planned. Participants aspired to be in fields related to health, cosmetology, childcare, or other careers.

**Health Care Field:** Careers in the health care field covered a wide range of technical and professional degrees. Fifteen participants (48%) listed career goals in the health field. Health care related choices were nursing assistant, nursing, paramedic, psychology or counseling, and physician. Reasons for wanting to pursue a career in health care were their personal or family’s positive or negative personal experiences, having a mother, sister or aunts in the health care field, being able to help others, possessing personality traits compatible with health care, and the desire to work with children (pediatrician).

Four parous adolescents and two nulliparous adolescents aspired to be nurses. The main reasons for wanting to become a nurse were to help others, because of having a family member in the medical field, and personal experience, such as the participant’s experience during prenatal care and delivery.

Two nulliparous participants desired to be doctors, specifically a pediatrician, OB/GYN, or general practitioner. Reasons included, wanting to working with children and pregnant women, wanting to provide patients and families encouragement, and personal experience. Lilia stated personal experience as her main reason for wanting to become a general practitioner.

But I really decided to stick with it after my mom died because she got the run-around at the hospitals here, and it was really poor treatment. And I didn’t like it, and I didn’t like that the doctors were very pessimistic and rude. So I want to
be that one doctor that can change somebody’s life, not just physically, but even emotionally.

Other health related fields, included nursing assistant, paramedic, psychology or counseling and overall health field. One 18-year-old white primiparous adolescent aspired to be a nursing assistant due to her positive experience while giving birth. A 16-year-old nulliparous African American participant aspired to be a paramedic because she wanted to learn how to take care of people. Two participants, one nulliparous and one primiparous desired to be a counselor due to positive and negative personal experiences with counseling. Lenore, a primiparous adolescent who was not parenting stated, “I had to have a lot of counseling and I just feel really failed, so I wanna be a good counselor… so—I suppose I’ve learned what not to do.”

The plan to work in the health field differed slightly for physicians than the other medical professionals. The participants’ plans to become a doctor included getting good grades, graduating from high school, going straight to college, getting good grades in college, and applying to medical school. Participants’ plans to become a nurse included getting good grades, graduating from high school, enrolling in the local community college for an AA degree, and pursuing a higher nursing degree after community college. Some participants stated they were on track for their career goal described as currently making good grades, participating in their high school health program, and being dually enrolled at the local community college, while others felt they were not on track described as needing to be more studious or not participating in the high school health program.

**Cosmetology:** Six-out-of-30 participants (20%) described cosmetology related career goals. Of these, five (83%) were primiparous adolescents. Reasons for wanting
to pursue a degree or career in cosmetology were the opportunity for creativity, being self-taught and/or the potential for independence in the field characterized as being your own boss and owning your own salon and personal learning style (hands-on). Some participants described the ability to do for others such as making someone pretty or doing for someone who cannot do for themselves as a reason for choosing cosmetology. Amie stated, “I hate seeing someone just like down and everything. Like they have the stuff to look pretty, they just don’t do anything with it ‘cause they don’t know how to do it.”

For the majority of participants the cosmetology career plan was not new. The majority of the girls described a long time interest in doing hair or nails. Eve said she first made the decision when she was six; Amie described an interest at eight years old, while playing with her own hair.

When probed about their plan to work in cosmetology, the majority of these participants stated they were on track and that their plan was going the way they wanted. Eve replied “I do some people’s hair, like my—well my – best friend, I do her hair for her sometimes,” when asked if her plan to become a cosmetologist was going the way she wanted it to.

**Child Care or Child Development:** Three participants, all of whom were mothers, one participant had two children, described a future in childcare development or day care. Reasons for wanting to work in child development were personal experience, experience babysitting, or family members who work in childcare and interest, time, child care described as quick and easy degree, good money,
independence, characterized as being your own boss, owning own daycare) and benefit to own child or children.

A personal interest in working with children and a personal and or family history of working with children was the number one reason for selecting childcare or child development. Participants described having mothers or aunts who worked in or owned a childcare service. Participants also expressed the benefit of being able to be home with their child or children and the benefit of the interaction for their children; April described “…then my daughter, she can get used to being around other kids.”

When asked about their plan to pursue a career in childcare or child development, participants stipulated that they were on track. This typically meant that they had researched and or enrolled in child development courses at their local high school and had researched potential college programs in their area. Another sign of being on track was their previous experience in childcare, such as babysitting for family or friends in their earlier years.

**Other:** Those participants who did not want to be in the health care field or cosmetology described a range of other career choices. Eleven participants (36%) discussed choices such as police officer, lawyer, social worker, veterinary technologist, real estate agent, graphic designer, Army soldier, and homemaker.

Two primiparous and one nulliparous adolescents aspired to work in criminal justice and social work for reasons such as solving a mystery, helping others, and personal experience as a victim of rape. Participants described their plan as graduating high school or getting a GED, enrolling in community college, going to university and
getting a bachelor’s degree. Most thought it was on track because they were currently in school and had researched the requirements for careers in criminal justice.

One nulliparous adolescent aspired to work as a veterinary technician due to her personal love for animals and the flexibility to work in a wide range of avenues. Another aspired to work in graphic design due to the flexibility and creativity associated with the position. Kathleen aspired to work as a chef for some of the same reasons, creativity, and the different choices in foods. Noreen listed job and paycheck guarantees as her main reasons for selecting the Army as her future employer.

**Changes in Goal Aspiration:** Almost all interview participants (N = 24 or 80%) were able to articulate whether their career goals had changed. Seven parous and three nulliparous participants attested to no change in their career goals for the future. Nine parous adolescents and five never pregnant adolescents described some change in career aspirations. Reasons for adjustments in career aspirations were personal interest adjustments, “I changed my mind as I got older”, less time in school/training, job placement concerns, and money. Diana (primiparous) stated she used to want to be a traveling RN; however due to time and money spent on college, she thought cosmetology was a better choice since becoming a mother. Carmella (multiparous) described a change from pediatrician to child development, “And I didn’t wanna leave them behind just to go to college, and all that kind of stuff. I just wanna have something quick and easy where I’m making good money.” April described a similar decision path: Well, I wanted to be a pediatrician, but they, you gotta, they say you gotta be in college for like four years for that. So I want to be like a—well, I—I could like daycare or something—watch kids.

Tia, a 17-year-old, mother of three, described switching career choices from social work to day care to elementary school teacher due to time and money concerns.
As soon as I got a kid mine changed. I wanted to be a social worker but you have to go
to school and get a master’s degree before you could really do anything
good in that field. I was gonna do daycare worker, but all you get is
minimum wage on that, so then I moved it to an elementary teacher so I
can get benefits with it.

Michelle described switching from psychology to the health care field due to job
placement concerns:

“As I grew up I learned more and more about how many people have like gone to like
big name universities and majored in psychology and those people are
like out here lookin’ for a job…. I'm gonna do somethin' that will help me
get a job.

RQ 4. How do Adolescent Girls (Ages 16-19) who have Never Been Pregnant
Perceive Pregnant or Parenting Peers? What are their Views on Adolescent
Pregnancy/Motherhood in the Media?

Several casual and explanatory factors were explored as related to adolescent
pregnancy, these included participation in risky versus safe sexual behavior, perceived
sexual activity of peers, exposure and quality of informal and formal sex education, and
beliefs associated with preventing sexually transmitted diseases and pregnancy. In this
section, I provide the themes associated with each of these factors.

Sexually Active Peers

Both nulliparous and parous participants noted friends or acquaintances who
were sexually active. The majority of participants felt it was their [friends’] business, and
their responsibility to ensure they were being safe by using condoms and birth control.
Lilia, a 17-year-old nulliparous participant, recalled this about a pregnant classmate,
“Like there was a girl this morning I found out at school is pregnant. And she was upset
about it, but she made that choice. She was upset that other people knew about it.
Again, she made that choice.” Others described indifference towards their friends’
sexuality; responses such as ‘I don’t care,’ and ‘that’s them’ were frequent.
Sex Education aka ‘The Talk’

Participants were able to recall various degrees of formal and informal sex education. Formal sex education included sex education at school from school personnel such as teachers or nurses, and at home from parents or guardians. Informal sex education included lessons from peers such as friends, cousins, and siblings, media, and prior experiences of abuse. The described content of both formal and informal types of sex education is presented below.

**Formal Sex Education:** The most common type of formal sex education was delivered through the school system. Participants related the ‘talk’ or sex education to a specific class grade and as being a momentous learning event in that year. Both nulliparous and multiparous adolescents associated the talk with a discussion on puberty (girls get their period) and protection (if you have sex use condoms). The majority of participants recalled the ‘talk’ occurring around the 5th (50%) or 6th (16%) grade, with a few recollecting their first introduction to sex education was as late as 8th grade. Some participants were unable to recall participating in sex education at school; these participants were typically residing in foster care and they reported not attending school regularly. When asked about sex education at school, Rae, a 17-year-old who was 6 months pregnant and had a 1-year-old in state custody replied, “Not really, cuz I wasn’t really in school. This is my first time like actually going to school… I used to be on [the] run alot.”

Continuing sex education at school was recalled infrequently. Those who stated receiving follow up education as they aged described it as occurring in distinct settings.

---

7 Participants speculated that all incidences of abuse were reported to the authorities.
including science or health class, with varying degrees of coverage. Some participants recalled discussing “everything” meaning pregnancy and STD prevention, abstinence, condom use, and HIV/AIDS. Others recalled only discussing STD prevention or the science behind pregnancy and childbirth.

Formal sex education at home occurred less frequently than at school and varied widely in detail. Nulliparous and parous adolescents described formal home sex education or the ‘talk’ from their mothers occurring on or around the initiation of puberty. Some girls described being told everything including sex, STDs, pregnancy and birth control, others described being told very little such as information about female anatomy and the menstrual cycle. A few girls recalled the offer of birth control when they became sexually active to avoid pregnancy, contingent that they spoke with their mother upon sexual initiation. Claire explained that her mother put her on birth control when she was in 8th grade to be safe. However, she was confused because she wasn’t having sex at the time. Michelle, a nulliparous 16-year-old, recalled being thankful, despite her peers’ reaction, when her mother put her on birth control in the 9th grade because mother discovered she was sexually active. Michelle was grateful to be rid of her period, a welcomed side effect of birth control. One participant recalled distinctly ‘missing’ the sex talk with her mother. Roxie, a parous 16-year-old explained that her mother planned to discuss sex with her at age 16; she became pregnant with her son at age 15.

**Informal Sex Education:** Informal sex education occurred in various settings and had varying degrees of accuracy. Both parous and nulliparous participants recalled being first introduced to sex by various forms of media. Some girls spoke of Lifetime ® movies they were forbidden to watch; others described secretly watching pornography
with friends, sisters, and cousins. I asked Allie when she first learned about sex which she attributed to Lifetime®, “I’ve always known about it. I’ve always knew what it was cuz I watched so much Lifetime. I grew up on Lifetime. My mom was a Lifetime freak, so I always really knew what it was.” Five parous adolescents (four of whom were in foster care) recalled their first introduction to sex was in the form of sexual abuse between the ages of 4-8 years old. These participants described being confused and being unable to remember the details. Participants also recalled not receiving any formal sex education at home, and recalled inconsistent sex education at school, typically due to attendance.

Other forms of informal sex education included information from peers, such as siblings and friends. Peers were rarely cited as their first introduction, but instead served as a secondary avenue for information. Participants described their friends as providing tale-bearing information instead of educational. Lakisha, who plans on waiting to marriage to have sex, described talking about sex with her sexually active friends as awkward.

**Best Perceived ways of Preventing Pregnancy and Sexually Transmitted Diseases (STDs)**

Participants were asked about the best way to prevent sexually transmitted diseases (STDs) and pregnancy. Almost 60% of nulliparous participants listed abstinence as the best way to prevent STDs and approximately 30% listed condoms as best. Other mechanisms such as getting tested, being faithful in the relationship, and being with a partner you can trust, were listed as the second best ways to prevent STDs by 33% of participants. Approximately 41% of nulliparous participants listed condom use and 41% listed birth control as the best ways to prevent pregnancy. Abstinence was listed as a close second by 30% of participants.
Almost 65% of parous participants listed abstinence as the best way to prevent STDs and 35% listed condom use as the best way. Although, Allie stipulated abstinence as the best way to prevent sexually transmitted disease she follows up with a detailed contingency plan.

Not doing it, but if you’re in a committed relationship where you are doing it you need to keep up with your partner, like you need not to do it with anybody else. You need to know that he is committed with you 100 percent, you know. Get him tested, get you tested every few months, like so on and so on.

Forty-seven percent of parous participants listed condom use as the second or third best way to prevent STDs. Other mechanisms such as being tested regularly, restricting your number of sexual partners, and trust were listed as the second or third best way to prevent STDs by 29% of parous participants. Forty-one percent of parous participants listed abstinence as the best way to prevent pregnancy and 41% listed condom use as the best way to prevent pregnancy. Birth control was listed as the second or third best way to prevent pregnancy by 41% of participants; 41% listed abstinence and 24% listed protection through condom use.

**Actual Pregnancy Prevention:** Participants reported a range of current birth control methods to prevent pregnancy. Depo-Provera (Depo), and birth control pills (the pill) were reported most often. Among nulliparous participants, 54% were virgins at the time of the interview and were using sexual abstinence as a way to prevent pregnancy. Despite claims to be preventing pregnancy, some nulliparous and parous adolescents were not taking active prevention measures, while others were behaving inconsistently. Three nulliparous participants (23%) reported using some form of birth control such as birth control pills, Depo, and the patch to prevent pregnancy and three reported not doing anything to prevent pregnancy. Jerri, a nulliparous adolescent, replied, “Yeah”,

134
when asked if she was currently trying to prevent pregnancy. However, she rescinded her response, when asked about her specific prevention methods, “Well, I guess, realistically, I'm not, but I should be [laughter].” Jerri also admitted to several episodes of unprotected sex.

Twenty-nine percent of parous participants reported Depo as their method to prevent pregnancy. Four participants (23%) reported not using any method or recently stopping their previous form of birth control. Two participants reported using birth control pills; the use of the NuvaRing, condoms, or Implanon were reported by one participant each. One parous participant reported using sexual abstinence to prevent pregnancy. Tia reported not using any traditional methods of birth control but listed ‘not trusting men’ to prevent pregnancy.

I struggled a lot with birth control. I know I’d say you should be on it no matter what, but I won’t get on it myself… I’ve just seen a lot of negative things come out of birth control, where infertility happens, or it messes with the hormones, or your body, and all that, and that just scares me. I don’t want, you know, to prevent having kids for a year, and then wind up never being able to have kids again. That just terrified me.

Tia attributed all three of her pregnancies to sexual coercion or rape and, therefore, if she had not trusted the perpetrators in these situations she would not have become pregnant.

Similarly to Tia, other participants had strong feelings and beliefs related to various forms of birth control. Due to these beliefs, adolescents often described upcoming plans to switch birth control. The birth control pill was described as difficult to use due to the responsibility placed on the user. Failure of the birth control pill was often related to the strict requirement to take them daily and at the same time each day.
Although easier to use because it is only received every three months, Depo was often associated with negative side effects. Those using and not using Depo described the long acting birth control shot as making them fat or blown-up. Roslyn, a 17-year-old mother of one, stated she stopped taking the pill because her boyfriend was in jail and it was difficult to remember. Although Depo made her fat, she plans to “get on it” when her boyfriend is released from jail. Depo was sometimes associated with negative emotional responses. Noreen an 18-year-old mother of one currently using the NuvaRing® described being scared of Depo because of a medical history of depression and the potential for psychological side effects.

Despite non-use among the participants, many reported substantial side effects believed to be associated with the IUD. Diana, an 18-year-old mother of one, who was currently using Depo but hoping to switch to Implanon, described a horror story associated with the IUD and a family member, “Because, um, I had a family member die because she, well, she never went and got it checked. She got pregnant with one inside of her still. It grew into her, um, uterus...” Others related information passed on by health care providers. Roxie, a 16-year-old mother of one currently using low estrogen birth control, recalled asking her doctor about the IUD:

I asked my doctor about that, but he said it’s for people who don’t want kids anymore or who have already had a few kids and don’t want anymore. I’m not sure. So, he said I couldn’t get on it.

Roxie also reported her insurance company dictated which method of birth control she was able to use, “My insurance only pays for the Depo shot and the pill.”

**Nulliparous perceptions of adolescent motherhood:** To further investigate the explanatory models of nulliparous adolescent females associated with primiparous and multiparous peers, nulliparous participants were asked to identify some reasons why
girls have a baby in high school. The context of sex was identified as the number one reason: thinking it’s okay to have sex early, wanting to have sex, having sex for love, getting drunk and having sex, being forced to have sex, and not using protection due to lack of planning such not planning protection, or planning to have sex. Baby identified reasons were thinking it is cute to have a baby and wanting someone to love. Miscellaneous reasons for having a baby in high school included needing a way out of their current situation and wanting a fast track to independence; pregnancy was viewed as an excuse to drop out of school and get a job.

In addition to these identified reasons for having a baby early, nulliparous participants thought it was hard, difficult, or a struggle to be a mother while still in school. Participants thought it would be harder to graduate, balance school and a child, and have to worry about baby related costs for diapers, formula, and medical bills. Participants also thought it would be harder to attend college, achieve their goals, and get a job due to childcare and transportation constraints. Some identified positive outcomes associated with having a child while in high school included love, increased motivation to better themselves, faster maturation, and learning responsibility. Perceived personal, romantic, and career adjustments are discussed further below.

**Personal and Romantic Adjustments:** Nulliparous participants described having to mature faster due to pregnancy. Participants described “not being a teenager anymore,” “not thinking about yourself,” and not “being able to socialize,” such as party, shop, and hang out with friends as frequently as before. They stated the need to worry about everything including grades, bills, children, and the future due to having a child early.
Romantic adjustments due to pregnancy included the inability to date (time, school, childcare complications), and complications in finding a boyfriend/partner. Participants described it as being harder to find someone because of the unwanted responsibility of a child. Zelma described adolescent boys as not wanting added responsibility, “Usually guys in this age group now do not wanna be taking on the responsibility of a child. They wanna be able to be with a girlfriend who doesn't have any connections to anything.” She described a primiparous friend’s relationship, “I know my friend's boyfriend, he doesn't like think of her the same. He doesn't respect her as much as he used to…He’s, he just calls her names. He’s not very nice to her.” Zelma attributes these changes to “getting what he wanted,” sex.

**Education Adjustments:** Participants typically described negative adjustments in education associated with being a teen mother. Expected adjustments included delaying plans such as high school completion and college enrollment, changing goals such as having to get a GED instead of a diploma or getting a faster degree, financial planning such as needing a job and having to find and pay for daycare, and psychosocial changes such being stressed and thinking about now instead of the future.

**Career Adjustments:** Nulliparous participants thought that being a teen parent may have positive, negative, or neutral effects on career plans. A positive effect described is determination such as striving to get a job/career quicker and to work harder on the job. Negative effects listed were difficulty getting a job due to employers who may not want someone who is pregnant/has a young child, difficulty getting promoted due to being perceived as irresponsible because they are a teen parent, the need for pre-planning including having to find a babysitter, and added financial
responsibilities due to daycare and transportation expenses. Neutral adjustments listed were the type and location of a job; participants felt that teen mothers would need to work closer to home, and would prefer a career working with children.

**Media**

Participants were asked their opinions on two popular MTV shows that portray adolescent pregnancy and motherhood. “MTV has two popular television shows about teen pregnancy and motherhood. Have you seen ‘16 and pregnant ®’ or ‘Teen Mom®’? What are your thoughts about each show?”

**Effect of 16 and Pregnant ® and Teen Mom on Teen Pregnancy®**

Nulliparous adolescents were more likely to believe that the two MTV shows portrayed the reality associated with teen pregnancy and motherhood. Jennie stated that she believed the show was successful in decreasing rates of teen pregnancy:

I mean teens like not to get pregnant like what they could be going through. And I was watching it and the statistics from teen pregnancy has gone down since the show aired. And that’s like the first time that has ever happened so I think the show is like really successful.

Julianne expressed similar beliefs although she stated that she thought some teens may get pregnant to get on the show.

Some participants felt the show might negatively influence teen pregnancy. Erica thought that both shows glorify teen pregnancy.

I mean media glorifies it and them glorifying it just means people who don’t have a mind of their own, teens who don’t have a mind of their own will go buy that… we’re gonna have more teen pregnancies because they don’t have a mind of their own.

Selena a 17-year-old primiparous participant stated similar views “I think it boosted up teen pregnancy. Well, because you were seeing all these girls with their cute bellies and their baby daddies… getting their own apartments. They had freedom.”
Media and Reality

Parous adolescents were more likely to believe both 16 & Pregnant® and Teen Mom® distorted reality (10/13 or 77%), compared to nulliparous adolescents (7/12 or 58%). Parous adolescents thought the show made teen pregnancy and motherhood seem harder than it really was. April stated they make it seem like it’s the hardest thing in the world. They show the babies waking up crying; my baby is different she wakes up laughing. Carmella an 18-year-old mother of two, stated:

It makes it seem harder than it really is. Yeah, it’s hard being a teen mom, but at the same time, you still have your freedom to do what you wanna do. It’s all in support. If you don’t have that support system from, like, your mom or your dad, whoever you live with, to your boyfriend or whoever, if you don’t have that, then yeah, it’s gonna be really hard on you.

Nulliparous Adolescents were more likely to feel that the show provided an adequate description of teen motherhood or that it downplayed the hardships associated with teen motherhood. Margery specified:

I think it shows them in a better light, because, you know, they actually have stuff with their child…. they kinda have it better because most of them still have parents that’s willing to do stuff for them and like people that they can go to. Like most people in reality don’t have anybody to turn to.

Zelma stated she thought the show was adequate because it was very similar to what a primiparous friend experienced. Lilia, a 17-year old, nulliparous adolescent, stated that the show tells teens what it’s like to have a child young:

When I look at it, I’m like—I feel like that’s what my mom was trying to tell me. Um, my parents, all my family, this is what happens when you decide to have sex, and then you have a baby.

Other Media

In all, approximately 50% of participants (14/27) could not recall other types of TV shows, movies, or other media that discuss teen pregnancy and motherhood. The
main types of other media that discussed teen motherhood were various Lifetime® movies (16 and Pregnant®, Pregnancy Pact®), TV shows on ABC Family® (The Secret Life of the American Teenager®) and reality shows such as Pregnancy High®. Participants thought that other media types did a better job of portraying the various realities of adolescent motherhood, but specified they were Hollywood. These realities included abortion, adoption, mother or family raising the child, and the teen being disowned by family.

**RQ 5. How do Primiparous Adolescent Girls (Ages 16-19) describe the Context Surrounding Initial Birth?**

The fifth research question was intended to explore the context surrounding birth among primiparous adolescents. Participants were asked about the discovery of their pregnancy, the duration of the pregnancy, the birth, and motherhood.

**Discovery**

Participants described a range of emotions when they first discovered they were pregnant. Fear, happiness, anxiousness, confusion, and distress were some of the emotions described at the discovery of pregnancy. Alexandra, a 17-year-old White female, described being happy and anxious to meet her child. Alexandra was the only participant who noted planning her pregnancy with her fiancé. Six out of 18 interview participants reported having a feeling and ‘just knowing’ prior to confirmation of pregnancy; this feeling was sometimes linked to biological symptoms such as a missed period or nausea. Despite intuition, these same participants reported confusion, devastation, and fear at pregnancy confirmation. Confusion was linked to the pregnancy decision-making many girls described going through-- abortion, adoption, or keeping the baby. Although seven out eighteen girls specifically mentioned contemplating an
abortion, participants decided not to abort due to personal and family beliefs against abortion. Some girls described family members mostly mothers or fathers and the baby’s father as advocates for abortion, while others described mothers as being strongly against abortion. Amie, a 17-year-old Hispanic mother-of-one, described her state of mind after her first pregnancy (at age 14) ended in abortion at her mother’s insistence.

“Amie, you’re only like 14, like what were you doing?” And I was like, “I don’t even know.” So after that we just went to the abortion clinic, and she paid like $400 just for it. And, um, I woke up, like three hours later, after my abortion, and I felt sick. Like I felt like they snatched somethin’ outta me. It just felt so nasty. And then you’re like bleeding and you still have them hormones that you’re pregnant, so I’m throwing up like crazy. I’m peeing like crazy. I feel like crap, and I just cried for like—I cried for like a whole year. Just cried, cried, cried, cried.

Evelyn: …who did you tell first when you found out you were pregnant?

Amie: I didn’t tell nobody. I didn’t even know myself. And, um, I didn’t want anybody to know, ‘cause I didn’t want anyone to judge me about the whole abortion thing. I still don’t like tellin’ people about it, because it’s like I don’t want people to judge me. How can you have a baby right now and not have a baby, because you gave it up to abortion and everything…

Although, adoption was considered a better choice than abortion, mothers typically opted against adoption due to the predicted attachment formed with their child during pregnancy. Others felt it was their responsibility after ‘making’ the child, to raise the child. Alexandra expressed her views on adoption and abortion when talking about the shows 16 & Pregnant® and Teen Mom®.

And the only thing that I don’t like about that show [16 & Pregnant®] is that they put a lot of moms on there that put their babies up for adoption. [I] mean that’s not bad because that happens but I could never. Abortion. Adoption. No. I laid down and I had that baby. I made that, step-up and be a mom.

Participants described feeling afraid and apprehensive to tell their family or boyfriend about the pregnancy. Fear of disclosure was associated with the participant’s
mother (9/20), father (2/20), or grandmother (1/20). One participant noted being fearful of her partner’s reaction to her pregnancy. Lenore, an 18-year-old primiparous adolescent, who was not parenting, explained that although her boyfriend was mad, he wasn’t mad with her.

No, I told my friend first, then I told him, and I did call him. I didn’t, like, wanna be face to face, ‘cause I, like, just swore he was gonna get mad. And he did get mad, but not at me.

The majority of participants noted similar reactions from mothers, fathers, boyfriends, and friends to their pregnancy. Mothers were described as being upset or disappointed at the initial news of pregnancy, followed by acceptance during pregnancy, excitement/happiness at delivery, and bliss/enjoyment at the present day. Some participants noted that their mother was not “really mad” but more “disappointed” that they got pregnant. Speculated reasons for their ‘disappointment’ was that it was due to the context of conception such as lack of protection use, family history of teen pregnancy, and the young age of participant. Diana, an 18-year-old mother of one, stated her mom was disappointed because she repeated the cycle of adolescent pregnancy. “…My mom kinda seen it as she didn’t really, she was disappointed because she felt like I repeated a cycle.” However, Diana described her father’s reaction as firmer. “And my dad, he was angry, very angry. He didn’t talk to me for about a couple of days. And I was, and that kinda scared me ‘cuz me and my dad never not talk.” Like Diana’s, fathers were typically described as having a stronger reaction to the news of their pregnancy. Participants noted their father was angry/mad at the initial news of pregnancy; however most fathers resolved to being accepting or happy at present day. Diana noted that although her father seemed better since she delivered, he
still seemed to hold a grudge due to her status as a mother; she attributed his feeling
due to the family cycle of premature childbearing in the family.

And he made me carry the baby, the bags, and everything in the house by myself. And
when I stopped on the front porch. He was like. You know why I make you
do this, so you will never forget. It’s like he holds it against me. That’s not
something you are supposed to be punished for. Yea I made the mistake I
had sex. I had a baby. It was like… I made the choice not to protect myself
and I got pregnant. But get over it. It’s like how do you think you got here?
Because his mom had him at… my grandma had her first child at 16 and
then a year later, 17 years old she had him and then, it just continued
because she had 5 kids before she was I say when I was born she was
maybe 30…

The current relationship status with the father of their children was variable
described as committed, off and on, or no relationship. Mothers who attributed their
pregnancy to a true accident, neither partner nor teen “planned” the pregnancy and
were “with” their baby’s father at conception, described his feelings as initially shocked
or angered followed closely by happy. The partners were described as being happy or
pleased with the prospect of fatherhood. Participants also noted these dads/partners left
the pregnancy decision of abortion, adoption, or to keep the child to the teen but
promised to support them regardless of their choice. Three participants, all in foster care
noted they were unsure of the father of their child identity due to sexual promiscuity or
being victims of abuse during conception. Three mothers had broken-up with the father
of their child since conception. All three described a strained personal relationship with
their previous partner and a non-existent relationship between their child and his/her
father. Two of the three girls attributed the relationship strain due to the partner’s repeat
pregnancy with an outside female. Roslyn, a 17-year-old white mother of one who was

---

8 Reported to the authorities prior to study enrollment.
living in Foster Care despite being engaged to a different man described being confused at the situation with the father of her child.

He didn't know [about delivery] for weeks 'cause he like didn't have no way to contact me. So once I told him, like once he called me up and like heard the baby crying, he was like, "Who is that?" and I was like, "Your son," and he was like, "Oh." And he was like happy at first and then just everything went to hell.

Evelyn: ... So when did he ... fall out of your life?

Roslyn: When he met the other chick and got her pregnant.

Evelyn: ...How far along is she? Do you know?

Roslyn: She's almost six months. Like what I found out is like I thought it was just him denying the baby, but his other—like his other girlfriend, she was like, "Well, it's either me or your son." So he chose her, which was pretty bad to me.

Roslyn then described her frustration with her ex-partner and her anger for her son over the neglectful way her child is treated.

It was hard because my baby's father lives up there and everything, which me and my baby's father, he got another female pregnant with twins, and his reason, he told me he don't want nothing to do with [son]. He still denies [son] is his after our DNA test, and it makes me—like it hurts my heart because I believe my son does like deserve to know his father, but it's just hard for me. Like I can't accept it, like there's so many times I find myself like cussing him out and getting mad 'cause I feel anger for my son.

**Birth**

The participants described the birth of their child in varying contexts, exciting, amazing, scary, fast, and dramatic. Some participants stated their labor was induced through breaking of their water, and/or Pitocin while others stated they went into labor naturally. Some participants recalled being in labor, from initial contractions through delivery for a short period of time (5 hours) while others were in labor for an extended period of time (20 plus hours). All of the participants had a vaginal birth. The majority of
participants (16/20) had varying forms of pain control such as an epidural and/or IV drugs during delivery. Four participants described drug/epidural-free births due to personal beliefs, fears, or family tradition. Noreen opted against IV drugs because she didn’t want a ‘drugged up’ baby; she opted against an epidural due to horror stories associated with the procedure.

I’m scared to death of needles and the needle going in my back. And I didn’t want my baby to be drugged up when she came out … I wanted that crying baby that—not the one that was just drowsy from the medication. …And I’ve heard a lot about the epidural and people getting’ paralyzed, so it scared me.

Mothers, aunts, cousins, boyfriends, and sometimes friends, accompanied the adolescent throughout delivery. Some participants described their delivery as nice or amazing; others described it as scary, intense or painful. Participants who described it as nice or amazing associated the delivery as being pain free, due to an epidural, and fast. Those who described their delivery as scary, intense, or painful often did not get an epidural, or it ‘wore off’ and described longer interval deliveries; two participants also described experiencing panic attacks during delivery. All participants noted a feeling of awe and happiness when meeting their child for the first time, described as an instant connection, love and enjoyment.

**Motherhood**

Overall changes to life since motherhood were adjustments to free time, not going out as much, the need for pre-planning, having to secure a baby sitter, and changes in priorities such as thinking of their child more than themselves. The aspects of motherhood participants found to be easy included loving their child, being with their child, playing with, feeding, and changing their child. Some felt it was easy due to motherly attachment and instinct, Diana stated she felt it came naturally; once she had
a baby it just clicked. Others felt it was easy because of their child’s ‘easy going’

temperament and described having a good baby who does not cry.

Aspects that participants found hard or difficult about motherhood included their
child’s crying, perceived helplessness, being tired, their child’s illness, and finances.
Eve a 16-year-old primiparous adolescent stated, “I can’t do nothin’ [financially] for my
baby which is sad,” when asked about the hardest parts about motherhood. Participants
found a child’s sickness such as ear infections, diarrhea, and unexplained sickness and
discomfort due to teething to be difficult due to ‘uncontrollable’ crying and helplessness
at not being able to fix it. Others found that general and unexplained tears were difficult
also due to helplessness.

Despite difficult aspects of motherhood, most (19/20) chose to keep their baby
and some specifically noted that it was not hard as hard ‘people’ say. Allie felt
motherhood was fairly easy. Claire stated that motherhood eased her loneliness and
gave her someone to raise and love. Diana stated it was not ‘as bad’ as people think,
and success depended heavily on support. She also thought having a child at age 13 or
14 was a lot worse.

But if you’re like 13, 14, having kids, and you have to depend on your parents, and not
only do you have to depend on your parents, but your parents have to
take care of you and your child, and you’re still a baby yourself, it’s like,
that just bothers me.

Lenore, who made similar statements about the ease associated with loving her
son, found the other aspects of motherhood so difficult she relinquished custody to her
mother.

Evelyn: …what were some of the best things about being a mom?

Lenore: Um, the superficial stuff that a lot of girls look at when they get pregnant. “Oh,
you know, a bouncing baby boy,” and, you know, things like that. You
know, yeah, I love him. Yeah, he’s cute, but other than that, it was just hard.

Following general feelings about motherhood, each participant was asked about personal, romantic, educational, and career adjustments due to becoming a mother. Participant responses are detailed below.

**Personal and Romantic Adjustments:** Both primiparous and multiparous participants reported wide degrees of adjustment when they became a mother. Participants were asked about general, personal, educational, career, and romantic changes since becoming a mother. Responses ranged from nothing changing through drastic changes. Personal changes were usually isolated to the amount and type of socializing before and after birth. Participants described not being able to ‘party’ or go out as much as before. Others noted the need for pre-planning, such as day care and transportation arrangements as opposed to just getting up and going. Some participants described the need to screen personal connections and limit the type and amount of people around their children. Selena, a 17-year-old Hispanic mother of one stated, “I can’t just do what I wanna do. I can’t just be wild and date who I wanna date, you know. I have to be more cautious about who I allow into my life ‘cause of my son,” when discussing changes to her personal and romantic plans since becoming a mother. Participants who were currently in a relationship often described the need to ‘settle down’ and ‘become a family’ and they described the need for marriage and a father figure for their child.

**Education Adjustments:** Educational changes were either noted as no change, a positive change or a negative change. Eight parous participants noted an increase in self-motivation, determination, and will since becoming a mother. The girls described
the will to ‘do better’ and succeed. Participants attributed the change to wanting to be a ‘good role model’ for their child. Other reasons included the need to be able to provide, monetarily, thus requiring they do well and finish high school. Rae, who was 6 months pregnant with her second child at the time of the interview, stated, “It changed it a lot. It makes me want to be something for both of my kids…. don’t want them to think ‘oh, my mom’s a dummy.’ Actually makes me want to get my degree. So they can go to college.” Prior to her first and second pregnancy, Rae was on the run from foster care, and she acknowledged that she was not attending school. Alexandra who dropped out of high school prior to getting pregnant described renewed education motivation due to motherhood.

… Now a days you have to have an education to get somewhere, to have a job. Anything besides fixing cheeseburgers and that’s not what I want to do. If I want my son to look up to me and to be like hey my mom is not a failure she has a degree she may not have had it while she was young but she did it for me. I just want my son to have someone to look up to. I want him to be able to look up to his parents and say hey, they did the best that they could for me. They did what they had to do for me.

Negative educational changes associated with pregnancy were typically attributed to an adjustment or delay in educational plans/goals. Girls described not being able to complete school, having to get their GED instead of a high school diploma, delaying enrollment in college, and a subsequent delay in their timeline for completion of their high school or college education. Four participants noted no change in education and described plans to continue as necessary to go to school get a diploma, regardless of being a mother.

One of my primary research goals was to explore the differences between primiparous and multiparous adolescents. Unfortunately, I was unable to recruit more than three multiparous adolescents. Each story is unique and provides different contextual clues to the situation surrounding their first and subsequent pregnancies. Although parts of their stories are included in the analysis of parous participants, in this next section I will introduce each participant and provide insight into her story.

Carmella’s Story: Told on April 22, 2012

Carmella is a bright 18-year-old Black girl who lives with her mother, younger brother, and two children ages 1 and 3 months. Carmella is a senior in high school and reports getting really good grades (As and Bs). Although Carmella’s mother had her first child at age 24 and father at age 20, Carmella has both female and male cousins who were teen parents. Carmella was raised in a religious environment, attending church once a week. Carmella’s boyfriend, the father of her children who is a twin, who attends a private Catholic school and is a football ‘star.’ Although Carmella had two children in a short time span, she reported being optimistic about her professional and personal future and somewhat realistic about her romantic future.

First Pregnancy: Carmella discovered her first pregnancy due to a missed period. Although she stated she was scared, she recollected the discovery with nonchalance and humor.

But, um, okay when I found out I was pregnant with [eldest], I never missed my period, like, ever, ever missed my period. Always came on the same time, so I always knew. And then when I missed my period for a whole month, and I told my boyfriend, I was like, “You know my period didn’t come on.” He was like, “Maybe you’re pregnant.” I was like, “Maybe I am. Like, you ain’t
scared ‘cause I'm scared.” He was just like, “Yeah, I’m scared,” and stuff like that. And then, I got a home test. I took two, they were both positive.

Carmella admits to not using any protection when she conceived her first child and as such, she wasn’t really shocked. Carmella characterized her mother as being both practical and supportive during this time; her mother took her to get the pregnancy confirmed and allowed Carmella to continue from there. Carmella stated her mother’s reaction was somewhat surprising.

She wasn’t as mad as I thought she was. Like, everybody’s like, “Oh, man, if I ever got pregnant, my mom would kill me.” No, your parents would not do that, and my mom did not do that. She was just like, “Well, if you think you’re pregnant, we gonna do what we gotta do,” and end of that, and, you know, keep going on in life.

Carmella’s friends were not surprised by the unplanned pregnancy-- they knew she was sexually active-- and were very supportive throughout and after her delivery.

Carmella’s mom was happy at her delivery and has been supportive since.

**Second Pregnancy:** Carmella’s portrays the discovery of her second pregnancy with a little more drama. She stated her second pregnancy wasn’t really a surprise but both she, her mother, and boyfriend reacted differently to the news compared to her first pregnancy.

The second time, I was actually using, um, the pills, but I wasn’t taking them like I should’ve been taking them, so I was like—me, I was like, “You know what? I better go get on something that I know I really don’t have to take every day,” and all this. So I went to get on Depo, and they asked me to take a pregnancy test. I took it, and it was positive. So I couldn’t get on Depo, so I was like, “Oh.” Now that, it—that wasn’t really shocking to me either, because even after I knew I wasn’t using protection, even though I was on birth control, and I knew I wasn’t taking it. So it wasn’t a shock to me that I was pregnant, but the fact that it was a second child, and I’m only in high school, was just like, “What am I gonna do?” And I don’t know. It made me cry.
Carmella’s mom who was calm and reflective at the discovery of her first pregnancy initially kicked her out of the house at the news of the second pregnancy.

…Just like, “So where’d they shoot you? In the arm or the butt,” and I was like, “It ain’t none of your business,” like, playing around. I was like, “Bye,” and then I was like, “Man, I better just tell her.” So when I told her, she was just like, “You better get your stuff and find you somewhere to go,” and duh, duh, duh. And I know my mom, like, I’m just like, “My mom is not for real,…”

However, after some cooling off, her mother calmed down, and talked with Carmella about ‘The Decision’ faced by most women with an unplanned pregnancy.

…then she called me back and was like, “Well, what you gonna do? Are you gonna keep it?” Now this is when the fact came in, are you gonna keep it, are you gonna get rid of it, what are we gonna do. And, um, I mean we just talked about it, and she said, “Well, you know, whatever you decide to do, I’ll support you with it,” so, and we just went from there.

Carmella recollects her decision (an abortion) as one she was unable to go through with although, her boyfriend/father of her children preferred it. She was frustrated with the limited financial support she was able to get for necessities such as diapers, contrary to the speed for which he was able to obtain the funds necessary for an abortion.

We were getting an abortion. And I mean it’s so crazy because when I just had my first child, and I can call him and ask him for $20 so I can get some diapers, and it’s just like, “Oh, I can’t get it right now. Maybe I’ll have it in a week or two.” When that abortion came up, he had that money the next day. I was like, “Dang, you can come up with $400 faster than you can $20?” And I was like, um, it crossed my mind getting an abortion, like, man, should I do this? I mean, how’s it gonna be? But the fact that you have something growing inside of you that you don’t know what it could grow up to be, or how it could be, I was just like, I can’t do that, and so, we never got one.

**Motherhood:** Carmela characterized motherhood as fun, a compromise, and hard. Carmella thought that going out with her sons was fun, and something she anticipated. Prior to motherhood she recalled fun times at the movies or a party; as a
mother she has fun by taking her sons to the park and the library. She described a compromise associated with motherhood.

I mean, you might not be able to go out every weekend, like, to the movies, or to a party, or something like that, but having a kid, you make the best out of that. You go to the park. You find other things that can make you happy, um, just have fun.

Although Carmella described fun times as a mother, when asked what was easy she wasn’t able to think of anything. Instead, she spoke about the financial hardship of being an adolescent mother.

Evelyn: …. what are some of the easiest things about being a mom?

Carmella: There is not really anything easy.

Evelyn: Okay.

Carmella: Everything, everything's hard. Financially, it's nothing really easy about being a teen parent. Everything is hard. You have no job, so you have no money to support your child, so basically, I’m not taking care of neither one of my kids, my mom is. So I mean, and that puts a toll on you because it makes you think, like, man, I can’t even take care of myself, how am I gonna take care of two kids? But nothing is easy.

Carmella then articulated the complexities of gaining her independence while being an adolescent mother.

Evelyn: … what are some of the hardest things about being a mom?

Carmella: Everything. Um, the hardest, hardest is the financially. Like, I’m just now in the process—I wanna get my own place, and it goes by your income. I have no income, but if I put that my mom gives me $50 a month, something like that, I can move into there. So it’s the fact that even if—what’s the point of me moving out of my mom’s house to move in somewhere else, where she gonna be paying there, too? So I mean, ugh, I don’t know. It’s iffy, it’s very, very iffy.

Despite the current hardships associated with teen motherhood, Carmella illustrates resilience associated with her educational and personal plans. She even attributes motherhood to improving her romantic future.
Evelyn: And what about your romantic plans?

Carmella: No, that just made it even better 'cause now that we have kids, there's nowhere he can go, so yeah. [Chuckle]

Carmella concluded the interview with a piece of advice for her past self -- to wait, and her excitement over the future. She stated the desire to have waited until she got married, until she “settled down” to have sex.

… I don’t regret anything from my past ‘cause a lot of stuff from my past I’ve learned from, but I would just wish I would’ve waited, waited on a lot of stuff. Like my kids, having sex, and all that. I love my kids to death, but I wish I would’ve waited.

Carmella is excited about graduating from high school, getting married and earning a degree. Although, she admits she may change her mind again, previously she wanted to be a pediatrician and currently she wants a career in child development, she described being “so happy” to earn a degree in anything, and to have done it with two kids.

**Rae’s Story: Told on September 27, 2012**

Rae is 17-year old Black and Italian girl currently in the foster care system. Rae has been in foster care since the age of 12 due to sexual abuse by a family member. Rae talked of past abuse and hardship often; however, her story is filled with hope for the future. Rae has an uncanny ability to remember dates; she recalled the details of her past with exceptional clarity, down to the exact date. Rae was attending high school full time and reported getting good grades in school (As and Bs). At the time of the interview, Rae was 6 months pregnant with her second child. Rae became pregnant with her first child at age 15 and gave birth when she was 16. Rae’s oldest daughter was 1 year old at interview and was currently in state custody.
Rae described her adolescence in three stages: 1) before she became pregnant the first time, 2) after her daughter was removed from her care, and 3) after she became pregnant the second time.

**Stage 1:** Prior to becoming pregnant, Rae frequently missed school, ran away from foster care, and got into fights resulting in multiple arrests. Rae’s boyfriend is the same age as Rae, but is not part of the foster care system. Rae’s story is unique from others in this analysis because she described her boyfriend as wanting both pregnancies despite her apprehension. Rae described intentionally initiating birth control to avoid her boyfriend’s planned pregnancy.

Evelyn: So you mentioned that he was trying to get you pregnant. He wanted a baby?

Rae: He actually did. He kept telling me he wanted a baby. I was like “you better go fuck somebody else.” Don’t mean to cuss, but that’s what I told him. [Laughter] He was like, “No. Guess I won’t have a baby.” I was like, “I guess you won’t.”

Evelyn: Oh, so why did he, do you know why?

Rae: He like, he told me before like with some girl, she had a abortion. And he said he was upset. And I was like, just because she had an abortion, I don’t want to get pregnant. He was like “I just love you so much.” I was like, “and the girl who got pregnant?” He said it was a mistake. I says it’s not a mistake when you don’t wrap your willy up.

Rae described “both of her moms’ ”- biological mother and close family friend- as being happy when they found out she was pregnant despite not expecting pregnancy from her. Furthermore, although Rae’s boyfriend was thrilled with the idea, his mother was not pleased. She insinuated that Rae’s boyfriend may not be the father of her child and insisted on a DNA test to prove pregnancy. After delivery, Rae described both her mothers, biological and close family friend, and her boyfriend as being happy.
He was happy. He was always like, “I wanna see my baby.” Cuz I lived at [foster home for pregnant teens #1] and he would come up there, spend time with me and L* [oldest daughter]. He would take her some time. He’s so cute.

The baby’s father, her guardian ad litem, and her caseworker for the delivery accompanied Rae. When discussing her delivery, Rae’s voice lit up with pride; although it was difficult she did “well.”

Rae: Then I was in labor, actually, for 24 hours and 30 minutes because, since I didn’t have Pitocin epidural, my cervix dilated real slow. And they almost had to do a C-section because they was like a dry birth is not good, it’s gonna hurt you really bad. And the contractions was like [snapping fingers] coming. They were so intense. And then like 24 hours and 30 minutes exact into it, I was like, “I need to go shit.” … I’m looking at my baby daddy and my guardian ad litem. I was like, oh my god! No, I don’t want to do this! I was panicking and my heart was beating so fast, and she came. I pushed for; I pushed 10 minutes, and pushed her out for eight minutes.

She was almost 11 pounds. I was out to here. Was like huge. And then I, the ultrasound I had got while I was at JVC, like, three days before, I was about to deliver. They were like, she’s only eight pounds even. She came out, I seen her. They put her on top of me and she just stretched. I’m like, oh my god! My baby daddy, he’s like, he just stood there crying. She’s so beautiful! It was funny.

Although, she admits to not having a very close relationship with her mother, she opted to follow tradition in her family and have a drug free birth.

Evelyn: … So how did you decided on going natural, natural birth?

Rae: My mom, she’s Jamaican. She don’t believe in epidural. She don’t believe in Pitocin. She believes, basically, you did it, no medicine.

But she was happy, but she was like, “every, all of us went through it. Your grandma, your great-grandma. You’re gonna go through it. When L* [Oldest Daughter] give birth, she’s gonna go through it.” I said, “Not a chance.” But I can’t watch L* [Oldest Daughter] go through that pain. I’m like, you get [drugs] after me.

When her daughter was 2 months old, she was removed from Rae’s custody.

Rae recalls a false accusation of abuse due to an IV bruise. Despite proof contrary to
abuse, Rae is resolved to ‘prove’ to them that she is a good parent and get her baby back the ‘proper way.’

Rae: And when I did have her, I loved it. And then they made false accusations against me, I would say, that I had beaten my daughter, but I didn't. And I even had hospital records show that she had a needle in her arm, she had a needle in her leg. They [old facility] was telling somebody bruised her, I was like yeah, okay. Then I was like, I just want to get [the] case plan, get my baby back.

Evelyn: ... So they’re saying that you abused her, but it was a shot, she had shots?

Rae: Yeah, in, it proved to the court. He [the judge] was like, well, why did we take this child? So I was like, I’d rather show y’all.

**Stage 2:** Although she did not plan either pregnancy, Rae described being especially devastated at the news of her second pregnancy. Rae discovered she was pregnant at her medical clearance for foster care placement; she described crying and being very upset at the news.

Rae: Oh. I went to the hospital. I was on runaway. I went to the hospital to you know, get myself medically cleared so I can go into a group home. And they were like, they come in my room. “Congratulations.” I was like, “what are you saying congratulations for?” Cuz I didn’t have any symptoms. I didn’t have a missed period. I actually had just gotten my period. And I was eating a lot, but I thought that was normal, cuz I always do that before my period comes. Like, “congratulations.” “What are you saying congratulations for?” “You’re pregnant.” “What?” “You are pregnant.” I said “No. I’m not pregnant. Can you do a pregnancy test over?” She says, “No, you’re definitely pregnant.” So I’m like, “Oh, my god!”

Evelyn: How far along were you?

Rae: Six weeks and three days….Yes. I was not happy. I’m like, wow. It caught me off guard. Cuz I wasn’t trying to get pregnant this time. I wasn’t trying to get pregnant last time. He was trying to get pregnant.

Evelyn: So how did your boyfriend feel when you got pregnant the second time?

Rae: He’s like, “yes!” I’m like, it’s not good to have all these kids, [BF]. He’s like, “I don’t care.”

Evelyn: How, how old was your daughter?
Rae: She had to be at least nine or 10 months, if not I think eight.

Evelyn: ... And, and he was excited?

Rae: He was. He thought it was the best thing on earth that ever happened.... Cuz he’s like, “you’re pregnant again. You’re pregnant again. I’m gonna be a daddy again.” He thought it was cute. I didn’t think it was cute. I was so mad.

**Stage 3:** Although, she initially described returning to her old ways, after losing custody of her daughter she described a 360 upon her second pregnancy, with the help of a new placement and outlook on life.

Rae: I used to run away a lot, get arrested. Then my daughter got took out of my custody. And then I started getting arrested a lot again. And then I got pregnant with this baby, but didn’t know I was pregnant. I found out June 8th. Came to Marion County and I just turned, did a 360 turn.

Evelyn: .. Tell me about that 360 turn.

Rae: I gave a life to God. I go to school now...Have not been arrested. That makes me happy. Um, and I’d doing what I have to do to get my daughter back.

Rae interprets things as going well since becoming pregnant and moving into her new placement. “Made it a whole year that my daughter’s been out of my care, and I been doing my case plan to get her back. I’m almost done, just need three more classes.” Rae hasn’t been going to jail, is making good grades, and is doing well on probation. Her plan for success includes gaining custody of her daughter, aging out of the system, getting an apartment for herself and children, and getting her GED so she may begin college. Although Rae will be eighteen in 6 months, and admits to being a little scared, she looks forward to ‘being an adult’ and not being in foster care.

Rae: Well I basically don’t live a teenager life anymore. It’s time for, it was time for me to put my big girl panties on. Personally, the old teenager life I used to live was not good. Smoking weed, that, I think that teenager life now for me is like immature.

Evelyn: ... So you don’t really live that life anymore.

Rae: No.
Evelyn: …And, … how do you feel about that?

Rae: I feel good about it. It makes me know I’m turning into a grown woman. It makes me happy I’m maturing. It’s basically transitioning.

Rae regrets her academic past, skipping school, a lot the most, and is most excited about getting her daughter back, having her second daughter, getting an apartment and “and getting her life on track.” Rae characterized on track as, “Doing what I’m doing now, like, going to school. Going to church. Doing what I have to do,” and that doing so, will make her feel good about herself.

Tia’s Story: Told on October 16, 2012

Tia’s story is riddled with abuse, hardships, and coercion, but sprinkled with perseverance. Tia is 17-years-old and had three children ages 3, 2 and 11 days at the time of the interview. Tia was in foster care due to physical and sexual abuse by multiple family members including her biological mother. Tia earned her GED, finished one semester of college, and reported earning good grades (As and Bs), while in school.

Multiple Pregnancies: Tia described being in a ‘relationship’ with the father of her first child (father #1), although he was much older than she was and was essentially coercing her into having sex. She characterized sex as something she did as a repayment for love.

I never thought that if he didn’t use a condom, you’re gonna get pregnant because I didn’t really know much about it. Um, when we started having sex, I hated it. I just did it because I thought, you know, he loved me for it.

Following the discovery of her pregnancy, she recalled the pressure from the father to blame the pregnancy on her ex-boyfriend with whom she never had sex, and have an abortion.
During her first pregnancy, she met the father of her second child, who also coerced her into having sex. Although she was somewhat aware of the coercive nature of the relationship, she stated satisfaction at just having him near.

...before I even had her, I got with another person, who is my son’s father, and I think he was, kind of, my escape. I used my pregnancy to—he used my pregnancy, pretty much, get me to be with him. I think he seen me as weak and somebody he could just get along—I mean someone that was just easy to target, I don't know. Um, so I think I pretty much didn’t think about anything, ‘cause I had him there.

At the discovery of her second pregnancy she recalled not being scared of being pregnant but scared of the father of her child. Her ex-boyfriend (father #2), had become abusive and stalked her; although he is prison she is still afraid he will return to hurt her.

Tia then recounted excitement during the birth of her second child. She attributed the excitement to her old foster mom who grew into her mother. “Um, I had a really good support system, so I think I was pretty excited.”

Due to unforeseen circumstances, Tia was placed back into the foster system and was moved to her current placement. Tia’s third pregnancy was the product of rape; she recalled trusting the “wrong type of men” and, thus, ending up pregnant.

And then I asked him [friend from GED Class] to take me home another time, and he said he had to drive by his house first to tell his dad that he was driving me home, because it wasn’t his car. And he end up—we were kissing at first, and it was consensual, and when I told him to stop, he wouldn’t, so...

With this newest pregnancy and birth, she has mixed feelings, both happiness at knowing father #3 will never know about their daughter and a feeling of failure as a mom.

Mainly because my [eldest] daughter had her father’s day thing at daycare, when Father’s Day come, and she asked me why she didn’t have a dad. And that just killed me ‘cause I don’t know, you know, I mean what do you tell her? I mean, I told her that Jesus was her dad... I’ll always know that it’s
'cause her dad’s a lowlife piece of crap, and you know. I'll love ‘em, and I have to tell them the same thing.

**Motherhood:** Tia described motherhood as hard, challenging but doable. She stated routine and schedule are essential when having three kids. The easiest part for Tia as a mother is loving her children. She also stated that although motherhood takes compromise, “It’s just about doing it and sucking it up, and realize that you made a choice, not them;” she noted that there was no use in having a “pity party” over having kids. Similar to Carmella, the hardest part of motherhood for Tia was supporting her children.

Because it’s like, I had a plan to get a job, and, you know, save up money and all that stuff for when I turn 18 and all that, but now, you know, I have a newborn and I can’t just go out and get a job and work, ‘cause I have to wait till she’s old enough... So it’s just you gotta think about every, every single thing you do is just affected by having kids, I think.

She stated that motherhood had altered her educational plans to getting a GED instead of high school diploma, and changed her career plans to choosing a career that would take less school such as an elementary teacher. Tia also recognized that motherhood changed her romantic plans, and made her smarter about the men she dates.

… I think it’s made me smarter on who I choose. And not just running after every guy who seems like they’re good.... And just realizing that, you know you have to wait for the right person to come around...

This change also coincided with the biggest change she would make about her past, being more choosey and waiting to be in relationships, and the advice she has for her future-- being smarter about guys. She stated she would have waited until she finished school to have kids and “stayed away from guys.”
Unexpected Findings: Adolescent Mothers in Foster Care

A proportion of the parous participants (30%, 6/20), were in foster care at the time of study enrollment. These participants highlighted the added complexities of being an adolescent mother in the foster care system compared to being a “normal” adolescent mother. In focus group and interview analysis, some participants (4/6) characterized motherhood while in foster care as being constant state of apprehension, fear of persecution, and being unable to make decisions or ‘parent’ their child as they could if they were not in foster care. Selena, a 17-year-old, White participant who had previously lost and then regained custody of her child, felt foster care was like being under a magnifying glass with people waiting for her to make a mistake:

Selena: I think it’s hard. I think it’s harder on us cuz we’re in foster care and we’re under like a magnifying glass and any little mistake, it’s like an abuse report. It’s hard to make common mistakes as a parent without, oh my God, they’re gonna take my baby…

Evelyn: ...you mentioned common mistakes in motherhood. What sort of mistakes are you talking about?

Selena: Like you leave your baby on the bed and your baby rolls off the bed. I mean, a lot of babies do that. You don’t know your baby’s rolling—not your baby just rolled off the bed and has a bruise on its head. Oh, you just threw your baby into a wall. That’s what happened. You know… it’s like you can’t do common things. Your baby has an ear infection—

Tabitha, alleged that instead of teaching you about parenting, foster care was more of a prosecution:

....when you’re not in foster care, there’s more people teaching you and when you’re in foster care, it’s more of a prosecution. Like your child can hit the wall. Now, you should’ve been watching him better, but you see reports on TV where kids are falling in pools and they don’t look at the parents.

Tabitha was also upset, about not being able to move in with a new boyfriend due to foster care regulations and thought that foster care “puts a hold” on being a teen
mother. Tia believed that being in foster care inhibited the way she could parent her children.

Tia: My thing is, there’s so many things I would allow my kids to do, but I feel like if I allow them to do that, I’m gonna have somebody trying to take my kid and I’ve always felt that way since I got in foster care. I feel like every move I make, my kids can get taken from me, so it makes me put a tighter leash on them than I normally would.

Evelyn: Like what sort of things?

Tia: Like them being able to run around the house, something like that. I feel like I have to tell them not to because if they accidentally trip or even when they’re roughhousing with each other and they just wanna play and be siblings, I have to say, “No, no, no, no. You guys have to stop,” because if one bump head, gets hurt, one bruise on an arm, that’s my kids. I lose them. You know how hard it’s gonna be for a 17-year-old with three children to get her children back when I can’t prove I can support anything? Like you can lose them through anything.

Selena also believed that foster care changed the she way would parent her child; she characterized her parenting beliefs as similar to Attachment Parenting (Sears & Sears, 2001), but worried about the ramifications of those practices.

I’m different. I don’t vaccinate. I co-sleep. I do things that I wanna do with my child that aren’t illegal. I can legally choose not to vaccinate my child because of my religion. I can legally choose to sleep with my child, but because ‘they’ feel like it’s not right, they wanna charge me with medical neglect. Because they feel like it’s not right, they wanna charge me for endangering my child. It’s like, it’s not fair.

Despite these generally negative feelings about parenting in foster care, the participants described their current placement (a home for parenting girls) was better than most. Participants characterized their current placement as homey, roomy, and more relaxed than some of the locations in which they were placed in the past. Other participants noted their foster mother spent more time with them and cared more about them when compared to previous foster mothers. Due to her negative experiences as a mother in foster care and positive experiences in her current placement, Selena talked
about her desire to open up a facility for teenage mothers in foster care because she saw limited options for girls in similar situations as a problem.

**Summary of Findings**

Based on statistical analysis there were no differences between nulliparous and multiparous participants on self-esteem, optimism, mastery or positive/negative affect. Nulliparous participants ranked getting married as more importance to achieving personal success than parous participants. Please see Tables 4-2 through 4-4, for demographic distribution and statistical findings. Success was described in one of three ideologies, 1) determined by the quantity and quality of conquered barriers, 2) determined by accomplishing individual and preset goals, and 3) determined by meeting society norms such as education, job, car, and independence. Independence is essential to all three ideologies of success and stipulates that the individual does not have to rely on others for necessities such as food, shelter, money, or transportation. See Figure 4-3 and 4-4 for identified characteristics of successful and unsuccessful people in their community. Personal aspirations in 10 years included being finished with school, owning a house, owning a car, being engaged, or married, and starting a family. Professional aspirations included jobs in health care, childcare/child development, and cosmetology. Both groups described changes in professional aspirations; parous participants described changing career choices to have careers with shorter training requirements.

Nulliparous participants perceived adolescent motherhood as hard, and predicted personal, romantic, career, and educational changes to motherhood. Parous participants described motherhood as not that hard. The easiest part was caring for the child; the hardest part was inconsolable/unexplained crying and financial dependency.
Parous participants felt the shows 16 & Pregnant and Teen Mom portrayed life as more difficult than reality; nulliparous participants thought the show was accurate. See Table 4-6, for a complete list of research question and associated themes.

**Chapter 4 Conclusion**

In Chapter 4, I have highlighted the quantitative and qualitative findings by each research question. Statistical analysis revealed very few statistically significant differences between nulliparous and multiparous participants. Qualitative findings highlighted that nulliparous participants perceived adolescent motherhood as difficult and that it activated several personal and professional adjustments. Parous participants admitted to some adjustments but described motherhood, as ‘not that hard’ and they were still hopeful for the future. The context and consequence surrounding subsequent births in the multiparous participants differed for each multiparous participant and included birth control nonuse, misuse, and failure.
<table>
<thead>
<tr>
<th>Number</th>
<th>Research aim or question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim 1</td>
<td>To explore the role of factors such as demographics, family dynamics, family/peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect, on single and subsequent adolescent births.</td>
</tr>
<tr>
<td>Research Question 1</td>
<td>What are the similarities and differences in demographics, family dynamics, family/peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect between nulliparous and parous adolescents?</td>
</tr>
<tr>
<td>Aim 2</td>
<td>To explore the themes associated with what it means to have a successful life between nulliparous and parous adolescent girls (ages 16-19).</td>
</tr>
<tr>
<td>Research Question 2</td>
<td>What are the similarities and differences in definitions of what it means to have a successful life between the two groups?</td>
</tr>
<tr>
<td>Aim 3</td>
<td>To explore the themes associated with personal and professional aspirations between nulliparous and parous adolescent girls (ages 16-19).</td>
</tr>
<tr>
<td>Research Question 3</td>
<td>What are the similarities and differences in definitions of personal and professional goal aspirations between the two groups?</td>
</tr>
<tr>
<td>Aim 4</td>
<td>To investigate the explanatory models of nulliparous adolescent girls associated with parous peers, and their views on adolescent motherhood in the media.</td>
</tr>
<tr>
<td>Research Question 4</td>
<td>How do adolescent girls (ages 16-19) who have never been pregnant perceive pregnant or parenting peers? What are their views on adolescent pregnancy/motherhood in the media?</td>
</tr>
<tr>
<td>Aim 5</td>
<td>To explore the described context of conception, delivery and motherhood (for single and subsequent pregnancies) among parous adolescent girls (ages 16-19).</td>
</tr>
<tr>
<td>Research Question 5</td>
<td>How do primiparous adolescent girls (ages 16-19) describe the context surrounding initial birth?</td>
</tr>
<tr>
<td>Research Question 6</td>
<td>How do multiparous adolescent girls (ages 16-19) describe the context surrounding subsequent births</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Nulliparous (N= 12)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>17.48</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Black/AA</td>
<td>75% (9)</td>
</tr>
<tr>
<td>White</td>
<td>8.3% (1)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>16% (2)</td>
</tr>
<tr>
<td><strong>School Attendance</strong></td>
<td></td>
</tr>
<tr>
<td>HS Full Time</td>
<td>75% (9)</td>
</tr>
<tr>
<td>HS Part Time</td>
<td>8.3% (1)</td>
</tr>
<tr>
<td>Graduate HS</td>
<td>16.7% (2)</td>
</tr>
<tr>
<td>GED</td>
<td>0</td>
</tr>
<tr>
<td>HS Drop Out</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grades</strong></td>
<td></td>
</tr>
<tr>
<td>Good Grades</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Ok Grades</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Poor Grades</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Full Time</td>
<td>0</td>
</tr>
<tr>
<td>Part Time</td>
<td>0</td>
</tr>
<tr>
<td>Looking for Job</td>
<td>67% (8)</td>
</tr>
<tr>
<td>Does not work</td>
<td>33% (4)</td>
</tr>
<tr>
<td><strong>Sexual Activity (SA)</strong></td>
<td></td>
</tr>
<tr>
<td>Currently SA</td>
<td>33% (4)</td>
</tr>
<tr>
<td>Used to be SA</td>
<td>0</td>
</tr>
<tr>
<td>Not SA, had Sex</td>
<td>8% (1)</td>
</tr>
<tr>
<td>Never had Sex</td>
<td>59% (7)</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>67% (8)</td>
</tr>
<tr>
<td>Same Sex &lt;6 mos</td>
<td>0</td>
</tr>
<tr>
<td>Same Sex &gt;6 mos</td>
<td>0</td>
</tr>
<tr>
<td>Boyfriend &lt;6 mos</td>
<td>17% (2)</td>
</tr>
<tr>
<td>Boyfriend &gt;6 mos</td>
<td>8 % (1)</td>
</tr>
<tr>
<td>Engaged</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>8.3 (1)</td>
</tr>
<tr>
<td><strong>Religious Status</strong></td>
<td></td>
</tr>
<tr>
<td>Never Attend</td>
<td>0</td>
</tr>
<tr>
<td>Attend on Holidays</td>
<td>25% (3)</td>
</tr>
<tr>
<td>Attend once a week</td>
<td>25% (3)</td>
</tr>
<tr>
<td>Attend 2 ≥ times week</td>
<td>50% (6)</td>
</tr>
<tr>
<td><strong>Living Environment</strong></td>
<td></td>
</tr>
<tr>
<td>House</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Apartment</td>
<td>33% (4)</td>
</tr>
<tr>
<td>Mobile Home</td>
<td>17% (2)</td>
</tr>
<tr>
<td>Group Home</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 4-2. Continued.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nulliparous (N= 12)</th>
<th>Parous (N= 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lives With…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Only</td>
<td>42% (5)</td>
<td>45% (9)</td>
</tr>
<tr>
<td>Father Only</td>
<td>8% (1)</td>
<td>0</td>
</tr>
<tr>
<td>Mother &amp; Father</td>
<td>8% (3)</td>
<td>15% (3)</td>
</tr>
<tr>
<td>Grandmother</td>
<td>33% (4)</td>
<td>15% (5)</td>
</tr>
<tr>
<td>Romantic Partner</td>
<td>0</td>
<td>20% (4)</td>
</tr>
<tr>
<td>Child</td>
<td>0</td>
<td>80% (16)</td>
</tr>
<tr>
<td>Teen Motherhood Among Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Sister</td>
<td>25% (3)</td>
<td>15% (3)</td>
</tr>
<tr>
<td>Younger Sister</td>
<td>0</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Cousin</td>
<td>58% (7)</td>
<td>55% (11)</td>
</tr>
<tr>
<td>Aunt</td>
<td>50% (6)</td>
<td>40% (8)</td>
</tr>
<tr>
<td>Grandmother</td>
<td>60% (7)</td>
<td>30% (6)</td>
</tr>
<tr>
<td>None</td>
<td>8% (1)</td>
<td>25% (5)</td>
</tr>
<tr>
<td>Teen Fatherhood Among Relatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Brother</td>
<td>17% (2)</td>
<td>20% (4)</td>
</tr>
<tr>
<td>Younger Brother</td>
<td>0</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Cousin</td>
<td>42% (5)</td>
<td>55% (11)</td>
</tr>
<tr>
<td>Uncle</td>
<td>42% (5)</td>
<td>30% (6)</td>
</tr>
<tr>
<td>Grandfather</td>
<td>33% (4)</td>
<td>5% (1)</td>
</tr>
<tr>
<td>None</td>
<td>33% (4)</td>
<td>35% (7)</td>
</tr>
<tr>
<td>Female Peer Sexual Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some girls</td>
<td>67% (8)</td>
<td>90% (18)</td>
</tr>
<tr>
<td>Some Friends</td>
<td>75% (9)</td>
<td>70% (14)</td>
</tr>
<tr>
<td>Some Best Friends</td>
<td>58% (7)</td>
<td>60% (12)</td>
</tr>
<tr>
<td>Very Best Friends</td>
<td>42% (5)</td>
<td>60% (12)</td>
</tr>
<tr>
<td>None</td>
<td>8% (1)</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Female Peer Teen Motherhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some girls</td>
<td>92% (11)</td>
<td>80% (16)</td>
</tr>
<tr>
<td>Some Friends</td>
<td>42% (5)</td>
<td>65% (13)</td>
</tr>
<tr>
<td>Some Best Friends</td>
<td>33% (4)</td>
<td>55% (11)</td>
</tr>
<tr>
<td>Very Best Friends</td>
<td>18% (2)</td>
<td>30% (6)</td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>15% (3)</td>
</tr>
<tr>
<td>Male Peer Sexual Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some guys</td>
<td>75% (9)</td>
<td>90% (18)</td>
</tr>
<tr>
<td>Some Friends</td>
<td>83% (10)</td>
<td>75% (15)</td>
</tr>
<tr>
<td>Some Best Friends</td>
<td>50% (6)</td>
<td>65% (13)</td>
</tr>
<tr>
<td>Very Best Friends</td>
<td>50% (6)</td>
<td>70% (14)</td>
</tr>
<tr>
<td>None</td>
<td>8% (1)</td>
<td>5% (1)</td>
</tr>
<tr>
<td>Male Peer Teen Parenthood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some guys</td>
<td>58% (7)</td>
<td>60% (12)</td>
</tr>
<tr>
<td>Some Friends</td>
<td>58% (7)</td>
<td>40% (7)</td>
</tr>
<tr>
<td>Some Best Friends</td>
<td>16% (2)</td>
<td>35% (7)</td>
</tr>
<tr>
<td>Very Best Friends</td>
<td>25% (3)</td>
<td>30% (6)</td>
</tr>
<tr>
<td>None</td>
<td>33% (4)</td>
<td>30% (6)</td>
</tr>
</tbody>
</table>
Table 4-3. Standardized scale means

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Nulliparous</th>
<th>Parous</th>
<th>t-test</th>
<th>df</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at First child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>20 (3.7)</td>
<td>21 (5.4)</td>
<td>-.51</td>
<td>29</td>
<td>NS</td>
</tr>
<tr>
<td>Father</td>
<td>22.5 (6.7)</td>
<td>24 (5.3)</td>
<td>-.73</td>
<td>26</td>
<td>NS</td>
</tr>
<tr>
<td>Estimated Yearly Income⁹ (average)</td>
<td>$31,000</td>
<td>$15,000</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>25% (3)</td>
<td>35% (7)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$10,000 to $19,999</td>
<td>8% (1)</td>
<td>5% (1)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>17% (2)</td>
<td>5% (1)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$30,000 to $39,999</td>
<td>8% (1)</td>
<td>5% (1)</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$40,000 to $49,999</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$50,000 to $59,999</td>
<td>8% (1)</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$60,000 to $69,999</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$70,000 to $79,999</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Highest Grade</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>13.8 (1.9)</td>
<td>11.4 (2.3)</td>
<td>2.5</td>
<td>18</td>
<td>.02</td>
</tr>
<tr>
<td>Father</td>
<td>12.6 (1.5)</td>
<td>11.8 (2.5)</td>
<td>.7</td>
<td>15</td>
<td>NS</td>
</tr>
<tr>
<td>PANAS (Average)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Affect</td>
<td>31.5 (9.2)</td>
<td>30.0 (6.9)</td>
<td>.51</td>
<td>30</td>
<td>NS</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>21.9 (6.6)</td>
<td>22 (7.4)</td>
<td>.08</td>
<td>0</td>
<td>NS</td>
</tr>
<tr>
<td>Mastery Scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.6 (2.9)</td>
<td>21.9 (3.0)</td>
<td>.75</td>
<td>30</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Rosenberg Self-Esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.3 (3.6)</td>
<td>30.7 (3.3)</td>
<td>.24</td>
<td>.84</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Life Orientation Test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.7 (4.9)</td>
<td>23.3 (4.3)</td>
<td>.87</td>
<td>30</td>
<td>NS</td>
<td></td>
</tr>
<tr>
<td>Community Success</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Ladder</td>
<td>6.1 (1.6)</td>
<td>5.5 (1.7)</td>
<td>.84</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Want Ladder</td>
<td>8.0 (1.5)</td>
<td>8.1 (1.4)</td>
<td>-.10</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Think Ladder</td>
<td>9.5 (.94)</td>
<td>9.4 (.9)</td>
<td>.35</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Facilitate Success*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graduate HS</td>
<td>1.58 (.9)</td>
<td>1.28 (.75)</td>
<td>1.0</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Go to College</td>
<td>2.4 (.8)</td>
<td>2.9 (.9)</td>
<td>-1.5</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Get a Job</td>
<td>2.9 (.9)</td>
<td>2.7 (.7)</td>
<td>.86</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Have lots of Money</td>
<td>4.5 (2.2)</td>
<td>5.2 (1.5)</td>
<td>-1.2</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Own something Costly</td>
<td>5.75 (.9)</td>
<td>5.3 (1.6)</td>
<td>.91</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Get Married</td>
<td>5.1 (1.8)</td>
<td>6.3 (1.0)</td>
<td>-2.3</td>
<td>28</td>
<td>.03</td>
</tr>
<tr>
<td>Going out More</td>
<td>6.6 (1.7)</td>
<td>6.9 (1.5)</td>
<td>-.62</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Having a/another baby</td>
<td>6.9 (2.5)</td>
<td>7.7 (1.0)</td>
<td>-1.1</td>
<td>28</td>
<td>NS</td>
</tr>
<tr>
<td>Other</td>
<td>8.0 (2.5)</td>
<td>6.8 (3.3)</td>
<td>1.1</td>
<td>28</td>
<td>NS</td>
</tr>
</tbody>
</table>

⁹ IRB revision submission to add income therefore income data not available on all participants.
Table 4-4. Description of participant sample

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Age</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra</td>
<td>2 months; Son</td>
<td>17 years 8 months</td>
<td>White</td>
</tr>
<tr>
<td>Allie</td>
<td>6 months; Daughter</td>
<td>18 years 0 months</td>
<td>White/ Hispanic</td>
</tr>
<tr>
<td>Amie</td>
<td>5 months; Daughter</td>
<td>17 years 8 months</td>
<td>Hispanic</td>
</tr>
<tr>
<td>April</td>
<td>5 months; Daughter</td>
<td>17 years 6 months</td>
<td>Black</td>
</tr>
<tr>
<td>Carmella</td>
<td>1 year &amp; 3 months; Sons</td>
<td>18 years 6 months</td>
<td>Black</td>
</tr>
<tr>
<td>Claire</td>
<td>10 months; Son</td>
<td>18 years 2 months</td>
<td>Black</td>
</tr>
<tr>
<td>Diana</td>
<td>4 months; Son</td>
<td>18 years 5 months</td>
<td>Black</td>
</tr>
<tr>
<td>Eleanor**</td>
<td>3 months; Daughter</td>
<td>19 years 3 months</td>
<td>Black</td>
</tr>
<tr>
<td>Erica</td>
<td>Never Pregnant</td>
<td>18 years 5 months</td>
<td>Black</td>
</tr>
<tr>
<td>Eve</td>
<td>3 months; Son</td>
<td>16 years 8 months</td>
<td>White</td>
</tr>
<tr>
<td>Jennie</td>
<td>Never Pregnant</td>
<td>16 years 1 months</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Jerri</td>
<td>Never Pregnant</td>
<td>18 years 10 months</td>
<td>Black, Hispanic, American Indian</td>
</tr>
<tr>
<td>Julianne</td>
<td>Never Pregnant</td>
<td>18 years 10 months</td>
<td>Black</td>
</tr>
<tr>
<td>Kathleen</td>
<td>Never Pregnant</td>
<td>17 years 6 months</td>
<td>Black</td>
</tr>
<tr>
<td>Kenya</td>
<td>Never Pregnant</td>
<td>18 years 0 months</td>
<td>Black</td>
</tr>
<tr>
<td>Lakisha</td>
<td>Never Pregnant</td>
<td>16 years 9 months</td>
<td>Black</td>
</tr>
<tr>
<td>Lauretta</td>
<td>3 months pregnant (daughter)</td>
<td>17 years 2 months</td>
<td>Black</td>
</tr>
<tr>
<td>Lenore</td>
<td>1 year; Don (Not Parenting)</td>
<td>18 years 2 months</td>
<td>Black</td>
</tr>
<tr>
<td>Lilia</td>
<td>Never Pregnant</td>
<td>17 years 0 months</td>
<td>Black</td>
</tr>
<tr>
<td>Liza</td>
<td>1 month; Daughter</td>
<td>18 years 6 months</td>
<td>Black</td>
</tr>
<tr>
<td>Lorrie</td>
<td>Never Pregnant</td>
<td>16 years 7 months</td>
<td>Black</td>
</tr>
<tr>
<td>Margery</td>
<td>Never Pregnant</td>
<td>16 years 1 months</td>
<td>Black</td>
</tr>
<tr>
<td>Michelle</td>
<td>Never Pregnant</td>
<td>16 years 5 months</td>
<td>Black</td>
</tr>
<tr>
<td>Noreen</td>
<td>4 months; Daughter</td>
<td>17 years 8 months</td>
<td>White</td>
</tr>
<tr>
<td>Rae</td>
<td>6 months preg, 1 year; daughters (Not Parenting)</td>
<td>17 years 7 months</td>
<td>Black, Italian</td>
</tr>
<tr>
<td>Roslyn</td>
<td>6 months; Son</td>
<td>17 years 9 months</td>
<td>White</td>
</tr>
<tr>
<td>Roxie</td>
<td>2 months; Son</td>
<td>16 years 0 months</td>
<td>White</td>
</tr>
<tr>
<td>Sandra**</td>
<td>2 months; Daughter</td>
<td>16 years 3 months</td>
<td>Black</td>
</tr>
<tr>
<td>Selena</td>
<td>10 months; Son</td>
<td>17 years 9 months</td>
<td>Hispanic</td>
</tr>
<tr>
<td>Tabatha</td>
<td>3 months; Daughter</td>
<td>16 years 10 months</td>
<td>White</td>
</tr>
<tr>
<td>Tia</td>
<td>3 yrs, 2 yrs, 11 days, Daughter, Son, Daughter</td>
<td>17 years 6 months</td>
<td>White</td>
</tr>
<tr>
<td>Zelma</td>
<td>Never Pregnant</td>
<td>16 years 6 months</td>
<td>White</td>
</tr>
</tbody>
</table>
Table 4-5. Summary of research findings by research question

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Associated themes</th>
</tr>
</thead>
</table>
| **1.** What are the similarities and differences in demographics, family dynamics, family/peer history of teen pregnancy, religion, and psychosocial constructs such as self-esteem, mastery, optimism, and positive/negative affect between nulliparous and parous adolescents? | Average age 17.5 SD .87  
56% were Black, 25% were white, 6.3% were Hispanic, and 12.5% were other  
Mothers of parous participants (11.4) had significantly less reported education than nulliparous (13.8) (t = 2.5, df=18, p = .02)  
No identified difference in self-esteem, optimism, mastery or positive/negative affect between nulliparous and parous participants |
| **2.** What are the similarities and differences in definitions of what it means to have a successful life between the two groups? | Three theories of success identified:  
a). Distance traveled ~ success determined by characteristics of conquered barriers  
b) Goals achieved vs. goals set ~ success determined by individuals preset goal. Participant has to be moving forward  
c) Status achievement ~ success determined by reaching society norms: education, job, financial stability, and independency |
| **3.** What are the similarities and differences in definitions of personal and professional goal aspirations between the two groups? | Nulliparous participants rated getting married with higher importance to success (t=-2.3, df= 28, p=.03), and described children less often in personal future (10 years)  
Both groups describe changes to professional aspirations  
Parous participants attributed professional change to careers that are perceived to be “quicker” (less school time). |
| **4.** How do adolescent girls (ages 16-19) who have never been pregnant perceive pregnant or parenting peers? What are their views on adolescent pregnancy/motherhood in the media? | Nulliparous participants perceived adolescent motherhood as hard/difficult  
They predicted personal, romantic, and educational changes due to motherhood  
Participants described the shows 16 & Pregnant © and Teen Mom © as ‘real’ and showing teens what its really like to be a teen mom |
| **5.** How do primiparous adolescent girls (ages 16-19) describe the context surrounding initial birth? | Participants felt shocked, scared and excited at discovery of pregnancy. Family was described as being upset or disappointed at discovery, but happy at delivery |
| **6.** How do multiparous adolescent girls (ages 16-19) describe the context surrounding subsequent births | Participants described motherhood ‘as not that hard’ the easiest part was caring for their child, the hardest part inconsolable crying and financial dependency  
The context of subsequent pregnancies in multiparous participants differed for each girl. |
Figure 4-1. Box Plot presentation of PANAS mean difference
Figure 4-2. Characteristics of Successful people in the community identified by Nulliparous and Parous participants
Figure 4-3. Characteristics of Unsuccessful people in the community identified by Nulliparous and Parous participants
CHAPTER 5
DISCUSSION AND CONCLUSIONS

Overview of the Study

The primary goal of this research study was to investigate the differences in the meaning of success and the professional and personal goal aspirations of nulliparous, primiparous and multiparous adolescents. Additionally, I sought to investigate how nulliparous adolescents perceive parous peers, the context of the index birth as described by primiparous adolescents, and the context of subsequent births among multiparous adolescents. I addressed these goals with qualitative methods, supported by quantitative methods. Some findings coincide with those in the literature, while some highlight newly emerging themes.

RQ 1. What are the Similarities and Differences in Demographics, Family Dynamics, Family/Peer History of Teen Pregnancy, Religion, And Psychosocial Constructs Such As Self-Esteem, Mastery, Optimism, and Positive/Negative Affect between Nulliparous and Parous Adolescents?

I conducted two focus groups with parous participants ages 16-19 (N=11), and thirty interviews with nulliparous and parous participants ages 16-18 (9 adolescents participated in both a focus group and an interview). The average age of interview participants was 17.5; 53% were black, 27% were white, 20% were other, and 6.7% were Hispanic. The average age of focus group participants was 17.8; 54% were Black, 18% were White, 10% were Hispanic, and 10% were other. Participants’ self-reported self-esteem via the Rosenberg Self-Esteem Scale was 32.5 (SD=5.0) higher than results reported by similar studies (scale 10-40; higher scores represent higher self-esteem) (Hudson, Elek, & Campbell-Grossman, 2000). Participants’ mean on the Mastery Scale (Perlin & Schooler, 1978) was 22.2 (SD=3.0). Higher scores indicated high levels of mastery (scale 7-28). This score is comparable to those found among
pregnant (M=20), parenting (M=20) and comparison teens (M=19.7) reported by (Barth, Schinke, & Maxwell, 1983). Self-reported rankings of the LOT (Scheier & Carver, 1985) and PANAS (Watson, Clark, & Tellegen, 1988) were also congruent with the literature (Purskar, et al., 2010). Participant’s mean on the LOT was 23.8(SD= 4.5); on which higher scores represent higher optimism (scale 8-32). The PANAS means were 30.6 (PA, SD= 7.7) and 21.8 (NA, SD=7.0) similar to Fox, Halpern, Ryan, and Lowe’s (2010) values of means of 33.91 (PA) and 21.89 (NA) among 63 adolescent females (including a subset of adolescent mothers). Higher participant scores indicate higher levels of positive affect and lower scores represent lower levels of negative affect (scales 10-50).

Socioeconomic status and family education achievement revealed significant differences between the two groups. Nulliparous participants reported an average yearly income of $31,000 compared to $15,000 among parous participants. Nulliparous participants reported their mother’s average years of education as 13.8 years, compared to 11.4 years among parous participants. There were no differences in father’s average years of education among participants.

RQ 2. What are the Similarities and Differences in Definitions of What It Means to Have a Successful Life between the Two Groups?

Participants described success in one of three ways, distance traveled, goals achieved, and status achieved.

Ideology 1 Distance Traveled: Some participants characterized success as distance traveled-- based on current achievements relative to previous status. An example would be an ex-con or drug dealer who had to work hard and overcome barriers to get and maintain a good job and support a family. He was potentially more
successful than an ‘Average Joe’ who did not have to overcome substantial hurdles along the way.

**Ideology 2 Goals Achieved:** According to the second explanation, goals achieved relative to goals set, participants noted that success was proportionate to the individual’s execution of preset goals. A participant described someone whose goal was to work at McDonalds and who was currently working at and enjoying his position at McDonalds, as successful.

**Ideology 3 Status Achieved:** In explanation three, participants noted that someone was successful based on standards, often societal norms, such as graduating from high school, earning a college degree, having a good job, and having adequate money to support their lifestyle. Participants described success as being free of debt and financial stressors, and being able to make financial choices with ease (i.e. spontaneous purchases). These findings are similar to those found in Katz (1954) and Bradford and Hey (2007), authors discovered that the meaning of success was related to wealth and possessions followed by occupational or educational status.

Separate, but congruent with each of these explanations, was the concept of independence. Both nulliparous and parous participants stated that in order for a post-adolescent (after graduating from high school/college) to be considered successful, she had to be independent. Independent, in their terms, meant not relying on parents, family, or friends for necessities such as food, money, shelter, or transportation. Independence was especially important when raising a child and it was considered a pre-requisite to adequately supporting a family.
Participant explanations of success centered on perceived roles and expected levels of self-sufficiency. Successful female adolescents ages 16, 17 or 18 were expected to be doing well in school, planning for or enrolled in college, to at least have a driver’s license and/or car, and if they were mothers, taking care of their children. Successful male adolescents were expected to be doing all of the same things and playing sports if they were still in high school, and if they were fathers, taking care of their children. Ten years later, successful females ages 26, 27 or 28 were expected to have a degree or two, own their house, have a car, be engaged or married, and taking care of their children, if they are mothers. Men of the same age were expected to be doing all of the same things with the added responsibility of not being on drugs or in jail/prison.

Characteristics of successful and unsuccessful people in the participant’s community differed slightly between nulliparous and parous participants. Nulliparous participants characterized successful people as those that have met tangible accomplishments such as a high school diploma, job, college degree, money, and support. Characteristics of independence included having their life on track and the ability to give their children a good future. Nulliparous participants described more personality traits signifying success, these included being caring, hardworking, loving, understanding, studious, strong minded and helpful. Parous participants described similar tangible accomplishments including having savings and a family, as well as similar descriptions of independence. Personality traits described by parous participants included being determined, driven, motivated, goal oriented, honest, and advising others.
Characteristics of unsuccessful community members described by nulliparous participants included lack of tangible items such as not having a job, having no money, having no one to support them, and being alone; additional items included using or dealing drugs, being homeless, and idle. Dependence related items included living off the system, living with parents, and not taking care of their children. Nulliparous participants described unsuccessful/negative personality traits such as being bitter, uncaring, undisciplined, indecisive, impressionable, disrespectful and having no goals. Parous participants described tangible items such as being uneducated, having no money, no car, no family and being single; they also described being on drugs and on the streets as unsuccessful. Dependence related items included having to rely on others, living with their parents, asking for money, and not taking care of their children. Parous participants listed fewer personality traits than nulliparous participants, but these included being lazy, undetermined, unhappy, and having unrealistic goals.

There were no statistical differences between the groups on their current perceived level of success (life ladder), where they projected they would be in three years, or where they wanted to be in three years. Additionally, analysis of participants’ achievement rankings on steps needed to help them reach success (the top of the ladder), indicated a significant difference on the importance of “getting married.” Nulliparous participants placed “getting married” with higher importance than parous participants.

RQ 3. What Are the Similarities and Differences in Definitions of Personal and Professional Goal Aspirations between the Two Groups?

Parous participants were more likely than nulliparous participants to describe a personal future at ages 26, 27 or 28 as being engaged or married. These participants
often illustrated a future partnered with their current companion, usually the father of their child or a boyfriend. Parous participants also illustrated a future with additional children; however, children were expected after the participant was settled. Settled, in some cases was synonymous with independence; participants aspired to be have finished high school and college, be financially stable, have a home or apartment, and have a good job/career. Nulliparous participants also illustrated a personal future with a spouse and children; however, a higher percentage described not wanting to get married or not wanting to have children. These differences in personal romantic expectations may be due to the context of relationship dynamics as hypothesized in Salmivalli, et al. (2009).

There were slight differences in professional aspiration trends illustrated by nulliparous and parous participants. Participants aspired to work in health, cosmetology, childcare, or other careers. Identified health careers were both technical, such as nursing assistant, paramedic and professional, e.g. medical physician. Reasons for these career choices were family professional experience, altruism, and negative or personal experiences in health care. More parous participants identified careers in cosmetology or childcare than nulliparous participants. Reasons included altruism, creativity, and professional independence associated with the desire to own their own business. Some additional careers identified by participants included careers in criminal justice, social work, real estate, the military and homemaking. Reasons for these selected careers were personal interest, altruism, and personal and professional experience. These findings are similar to Yeager and Bundick (2009) who discovered
that 30% of adolescents aspired for occupations that would contribute to the world beyond themselves and 68% of careers were normative.

Hellenga, Aber, and Rhodes (2002), discovered that adolescent mothers with higher grade point averages, who lived with biological parents and had a career mentor were more likely to experience with expectation and aspirations. Although, participants did not describe gaps between expectation and aspirations, there were notable discrepancy in goal aspirations and realistic plans for achieving these goals, thus highlighting the need for a career mentor. Half of the parous participants and almost 30% of the nulliparous participants attested to some change in career aspirations. Reasons for adjustment included personal interest, time, job placement concerns, and money. Participants described changing their interests as they got older, experienced more things, and learned about different careers. Parous participants often described concern for the amount of time required for college and opted for careers that required less training such as changing from social work to elementary school teacher. Both parous and nulliparous participants listed job placement concerns and money as motivation for career adjustments.


Never pregnant participants attributed adolescent pregnancy among peers to a variety of reasons, including ignorance (not knowing how to prevent pregnancy), thinking ‘early’ sex was ‘ok’, and participating in unplanned and unprotected sex. Participants also thought there were some girls who wanted to have a baby because they thought it was ‘cute’ or they wanted someone to love. Regardless of factors leading
up to adolescent motherhood, nulliparous participants uniformly thought that life, as an adolescent mother would be hard.

Nulliparous participants perceived life as an adolescent motherhood as difficult for varying reasons. Some spoke of the difficulty (isolation and stigma) while being pregnant in a local high school. These findings coincide with Wiemann et al. (2005); they found that 40% of postpartum adolescents reported feeling stigmatized, which translated to increased feelings of abandonment, fear of parent notification, and contemplation of abortion. Participants also theorized that having a child in high school added difficulties and potential personal, romantic, or career adjustments. Personal adjustments and hardships, such as financial, social, and academic stress, were the most frequently noted. Participants illustrated that it would be especially difficult to balance the added financial hardships associated with early motherhood due to the need to purchase necessities such as formula, diapers, childcare and health care. Participants also described perceived struggles with balancing school and homework due to the added responsibility of taking care of a child.

Perceived social constraints associated with early child bearing included difficulty and restricted opportunity to socialize with peers. Nulliparous participants thought it would be difficult to find the time to ‘party’ and ‘hang-out.’ Participants described two options when considering socializing as an adolescent mother: finding a baby sitter or taking their child everywhere they went. Some also thought it would be irresponsible to hang out or party when you have a child. Romantic adjustments to having a child while still in high school included difficulty dating. Girls spoke of difficulty finding a partner (boyfriend) who would support both the adolescent and her child. Girls noted that most
men their age (16, 17 and 18) would not want to date someone with a child and would not take responsibility (play with or help financially support) for a non-biologic child. Participants also perceived that in most cases of adolescent pregnancy the father of the child would leave, thus adding the stress of being a single mother.

Career adjustments due to adolescent childbearing were described in three cases. Case 1, due to the added and competing responsibilities (child and school) the girl would most likely perform poorly or drop out of school, thus limiting her ability to get a good job. Case 2, also due to added and competing responsibilities (taking care of the child and work), transportation stressors such as needing to maintain adequate transportation, and financial stressors associated with the need to work to pay for the child, the girl would most likely have to delay or decide against college, thus limiting her ability to get a good job. Finally, case 3, due to financial and transportation issues the girl would most likely not be able to get and keep a good job. One participant suggested that a future boss or manager might perceive the girl as irresponsible due to poor decision-making that led to an adolescent pregnancy, thus restricting her ability to get hired, and once hired to get promoted.

Similar to findings reported by Herman (2008), a few participants predicted positive personal adjustments due to early childbearing. Potential positive adjustments included increased maturity and accountability. Participants described friends who “got it together,” finished school, got a job, and got a car, due to having a baby and having a child increased their self-motivation to care and do well for their child.

Participants described emotions such as fear, happiness, and anxiety at the discovery of their pregnancy. The majority of the participants noted inconsistent and inaccurate pregnancy prevention behaviors or no pregnancy prevention efforts. Most partners were described as being shocked, followed closely by being pleased and excited. Parents and guardians were described as being upset or disappointed, but were ultimately happy at the time of delivery.

Although the literature describes a pregnancy decision tree among women facing unplanned pregnancy (Cohan, Dunkel-Schetter, & Lydon, 1993), the majority of participants seemed to go through this process very quickly. Participants eliminated abortion as an option due to personal beliefs, familial/partner beliefs, and predicted feelings of guilt later in life. They eliminated adoption due to attachment formed during the pregnancy and the predicted difficulty of giving up the child post-delivery.

The father of their child/boyfriend and family (child’s maternal and paternal grandmother, aunts, or cousins), and/or close friends, typically accompanied participants during their delivery. Despite feelings at discovery, participants, partners, family, and friends were described as being excited and happy at the delivery of the baby.

In general, participants characterized both easy and difficult aspects to motherhood. They felt that it was easy to love, be with, feed, and take care of their child. They found it hard to deal with helplessness, associated with inconsolable or sick children, and their reduced independence brought on by limited finances. Although some participants felt it was especially frustrating to not be capable of taking care of
their children financially, most stated that adolescent motherhood was not as hard as adults, peers, media, and society predicted. Participants spoke of slight adjustments but they were characterized as being bearable and often welcomed changes. Some participants described a renewed motivation to do well academically to ensure a better future for their child. These findings are congruent with those of other researchers (e.g Ronsengard, Pollock, Weitzen, Meers, & Phipps, 2006; SmithBattle, 2007).

**Sex Education:** Participants described exposure to formal and informal sex education. Formal sex education consisted of the ‘sex talk’ delivered through the school system. Participants most often attended this talk in the 5th or 6th grade. Few participants recalled continued or follow-up sex education after the initial lesson. Among those who participated in follow-up sex education, it typically occurred in specific settings’, such as science class, and it was not a school wide program. Formal sex education at home from a parent or guardian who reviewed comprehensive sexual issues occurred less frequently than school-based education. The quality of information varied from a comprehensive account of sex, STDs, pregnancy, and birth to specific topics such as the female anatomy and the logistics of puberty.

Participants were able to list the best ways to prevent pregnancy and sexually transmitted disease; however, participants often described incorrect or inconclusive information about specific contraceptive methods (i.e. the IUD). Furthermore, very few sexually active participants (parous and nulliparous) were practicing consistent behaviors to prevent pregnancy. Sixty percent (3/5) of sexually active nulliparous participants were not currently using any birth control method to prevent pregnancy (birth control or condoms) and 22% of parous participants either were not currently
using any form of birth control or had recently quit using their birth control. Similar to Wilson et al. (2011), participants who were using contraception had varying levels of satisfaction with it and spoke of plans to switch methods in the near future. Barr et al. (2003) identified that a possible explanation for the lack of preventive methods among parous participants may be the favorable community and peer perceptions of unwed adolescent mothers. Researchers who have investigated the risk for repeat pregnancy among primiparous African American youth found an association with social comparison, prototype favorability, and risk images (Barr, Simons, Simons, Gibbons, & Gerrard, 2013).


Given the limited sample of multiparous adolescents, I conducted a case analysis of each participant. Each of the participants provided a unique context surrounding their index and subsequent pregnancies.

Carmella, Rae, and Tia each attributed different factors and life events as leading to their pregnancies. Carmella’s mother is very supportive and although Carmella yearns for independence, she is aware that her options as an adolescent mother are limited. Carmella hopes that furthering her education will award her the necessary opportunities to become independent. Rae has limited support from her family; however, she described her caseworker, guardian ad litem, and current foster mother as being sources of motivation and support. Rae is hopeful of a future during which she has completed school, regained custody of her child, has an apartment for herself and her two children, and has taken the steps necessary to complete the path to independence. Tia described a life with very little nurturing or supportive role models.
Tia characterized her days as doing what she can to raise her children in the best environment possible and instilling the Christian values she considers important. Tia noted looking forward to aging out of foster care, completing a degree in elementary education, getting married, and raising her children free of outside input or judgment.

The context of repeat pregnancy for each participant illustrates different risk and protective factors. Participants each demonstrate a certain amount of resilience. Initiating long acting birth control may have prevented a repeat pregnancy (Stevens-Simon, Kelly, & Kulick, 2001) for Carmella and Rae. However, Rae’s secondary pregnancy may be partly attributed to the unfavorable outcome of her first pregnancy of losing custody of her child (Boardman, Allsworth, Phipps, & Lappane, 2006). Tia possesses strong negative beliefs about most long acting birth control that stem from negative experiences of friends or family. As such, fostering hope and self-efficacy to make safe sex decisions may be more effective in reducing repeat pregnancy.

**Additional Findings: Adolescent Motherhood in Foster Care**

A subset of the parous participants were in foster care at the time of study enrollment. Based on participant stories, adolescents in foster care have unique circumstances that may lead to adolescent pregnancy. The participants in foster care were more likely to report informal sex education attributed to sexual abuse situations\(^\text{10}\). Research indicates that victims of sexual abuse are more likely to experience adolescent pregnancy (Francisco, et al., 2008). The participants were also more likely to report inconsistent school attendance and fewer sources of nurturing and supportive adults. Both of these factors lead to decreased access to formal sex education and are

\(^{10}\) Reported to the authorities prior to study enrollment, sometimes the reason for foster care placement, among adolescents in foster care.
consistent with findings of similar research studies (Connoly, Heifetz, & Bohr, 2012; Svoboda, Shaw, Barth, & Bright, 2012). Participants reported being in and out of foster care or “on the run,” It was during these “on the run” episodes that most participants reported conceiving their child. The diagnosis of pregnancy was in most cases the catalyst that motivated participants to return to foster care.

As a new mother, the foster care system highlighted several added complexities including added apprehension, fear of persecution, and lack of autonomy. Participants described a motherhood under the threat of the Department of Children and Families (DCF), such that a ‘little or common mistake’ could lead to severe consequences such as the loss of their child. These are similar to findings regarding homeless adolescent mothers who reported fear of theft of their child as a top concern (Scappaticci & Blay, 2009). Participants felt that this fear of persecution restricted their autonomy and ability to make normal parenting decisions and mistakes; similar findings were identified by (Connoly, Heifetz, & Bohr, 2012). Due to these reasons, participants stated that they were not permitted to be normal ‘teen moms,’ and as such life was more complicated. One participant recollected the immense pressure she felt to place her child up for adoption during her second and third pregnancies. She recalled advice from her caseworker, guardian ad litem, and foster mother to place her babies for adoption due to the perceived benefits of decreased stress for her and increased opportunity for the child.

Despite lack of definitive plans for the future, participants were most excited about aging out of the system. Research suggests that motherhood could be a source of healing for adolescents in foster care through balancing previous experiences and
planning for a future outside the system (Pryce & Samuels, 2010). These findings require additional research because the participants were all currently living in the same placement and although some girls spoke of about their experiences in previous locations they were all locations in the state.

**Strengths and Limitations**

This project entails a variety of strengths and limitations. A strength of this study was the use of focused ethnographic methods, which is often used to evaluate or elicit information on a special topic or shared experience (Richards & Morse, 2007). Information on the meaning of success and personal and professional goal aspirations were elicited directly from the sample in question, adolescent mothers and peers. Additionally, the qualitative findings were strengthened by quantitative methodology, used to elicit important background information about the sample such as family dynamics, familial and peer history of teen pregnancy, and psychosocial variables such as self-esteem. Furthermore, the use of standardized scales, all of which were validated, to assess self-esteem, positive and negative affect, mastery, and optimism strengthened the quantitative findings of the study. Participant means on most scales were similar to those reported in the literature, thus validating the results. Some identified themes related to the context of motherhood, the effect of motherhood on future aspirations, adolescent motherhood in foster care are similar to those identified in the literature, thus validating the findings. New themes related to adolescent motherhood in the media, the meaning of success, and differences in personal and professional aspirations between nulliparous and parous participants may contribute to understanding perceptions of adolescent pregnancy and new avenues to reduce the rates of adolescent pregnancy and repeat pregnancy.
Limitations to the study include issues related to recruitment methods and sample size. Due to recruitment methods, purposeful and snowball sampling, the quantitative findings cannot be generalized beyond the study participants. Also, due to the small sample size limited statistical inferences can be made. Although the mean age of participants was 17.5 and the range was 16-18, quality of participant interviews suggest participants varied in maturity, development, and literacy; further evidence of why these findings cannot be extrapolated out of the participant sample. There are also possibilities of reporting and interviewer bias. Due to the sensitivity of some of the interview questions and the young age of participants, participants may not have answered all questions fully and truthfully; additionally, the interviewer may have unknowingly influenced participant responses.

**Implications for Policy**

The research findings highlight several potential policy adjustments from various avenues to reduce rates of adolescent pregnancy and repeat pregnancy. Possible policy interventions could be tailored to the quantity and quality of school based sex education, adequate information about birth control methods, school-based career planning information, and suggestions for special populations such as adolescents in foster care.

Qualitative findings suggested there were little differences in exposure to sex education between the nulliparous and parous groups. Participants described inconsistent access and quality of sex education. Beliefs, inaccurate information, and practice put nulliparous adolescents at risk for pregnancy and primiparous adolescents at risk for a repeat pregnancy. Policy adjustments that increase access to continued quality comprehensive sex education via the school system are essential. Bay-Cheng
(2003) identified three critiques of school-based sex education. The identified critiques were that school based education attends exclusively to the dangers and risks associated with teen sex, it exemplifies narrow definitions of normal sex, and it fails to address gender, race, class and sexual differences (Bay-cheng, 2003, p. 61). Furthermore, research concluded that school-based sex education is often met with political, policy, and community backlash (Bay-cheng, 2003). Understanding these limitations of school-based sexual education, and recognizing the school system as a safety net of captured teachable adolescents may influence a new direction in school based sex education. Participant responses suggest that, although memorable, school-based sex education was infrequent and mostly nonexistent during the critical period of adolescent sexuality development (high school years). Additionally, personal accomplishments, such as getting married, were expressed as having more importance to personal success among nulliparous than parous participants, further indication that an abstinence until marriage approach will not be effective among parous participants. Nation, state, and community wide policies that address quality and quantity school based education are necessary to counteract sporadic home based education and misguided informal education.

Policy adjustments to address access to pregnancy prevention services and health education campaigns related to birth control methods are essential. Information and an accurate clinical risks and benefit assessment of birth control methods was lacking based on participant responses. Incorrect and misguided information regarding birth control methods (specifically the IUD) was a common theme in the data. Although participants were aware of the IUD, most spoke unfavorably of this birth control method.
relating it to negative side effects such as sterility and death. This is contrary to findings by Whitaker and colleagues (2008); they discovered that only 20% of participants ages 16-18 knew of the IUD prior to a health education intervention. Furthermore, sources of information about the IUD prior to intervention were professional (86%), peer (36%), family 29%, and the media (37%), suggesting that although most young women were unaware, those who had prior knowledge, received information from multiple sources (Whitaker, et al., 2008).

In addition to misguided beliefs about some birth control methods, some reported difficulty accessing their preferred birth control method. Some parous participants stated they were unable to access their preferred birth control method, the Implanon, due to provider and insurance restrictions. Research supports these participant’s positive attitudes about the Implanon and indicates that long acting birth control methods such as the Implanon are associated with extended birth control use (24 months postpartum) and reduced repeat pregnancy (Lewis, Doherty, Hickery, & Skinner, 2010). Lewis et al. (2010) discovered that among parous adolescents who used the Implanon as their primary method of birth control, participants liked that they did not have to remember it, that it was long acting, effective, and convenient. Furthermore, Kavanuagh et al. (2013), found that among publically funded family planning facilities nationwide, 70% provide outreach to young people, 27% use social network media as an outreach strategy, and 64% have flexible hours. These facilities provide access to preferred birth control methods for adolescents and young adults and improving access and reducing limitations will reduce unplanned pregnancy. Although alternatives to primary care providers may be available in the community, such as Planned Parenthood, adolescent
populations may be unaware of these services and may benefit from advocates to inform and assist them in navigating system politics. Identified youth related limitations reported by publically funded family planning facilities; 33% reported service costs were too high for adolescents, 30% reported confidentially concerns of adolescents, 25% reported inadequate staff training or experience with adolescents, and 15% reported staff difficulty relating to adolescents (Kavanaugh, Jerman, Ethier, & Moskosky, 2013).

Access to adequate and continued sex education for special populations within foster care is a possible policy intervention that can reduce rates of pregnancy within this unique population. Barriers to accessing adequate pregnancy prevention services such as sex education include inconsistent adult relationships, placement changes, and developmental needs of the population (Svoboda, Shaw, Barth, & Bright, 2012). The parous participants in foster care reported less formal sex education than those not in foster care. Most reported that their mothers or foster guardians did not discuss sex and they did not attend many school-based sex education courses due to frequent delinquency. Furthermore, those who did receive formal sex education received it from other affiliates of the foster care system such as a caseworker or guardian ad litem. Given that many of the participants reported multiple placement and subsequent school changes, sex education from adult professionals who remain constant in the adolescents life is essential. Foster care affiliates such as the adolescents’ caseworker and guardian ad litem should be trained in sex education and have access to pregnancy preventative services. Parous participants in foster care often described transitioning in and out of foster care supervision. As such they reported being ‘on the run’ when they conceived and returning to foster care to receive health care services. Educating at risk
adolescents in foster care on how and where to seek pregnancy prevention services when out of foster care supervision can assist in reduction of unplanned pregnancy within foster care and in a reduction system costs.

**Implications for Practice**

Basch, (2011) found that adolescent mothers are 10-12% less likely to complete high school and have a 14-29% lower rate of attending college. However, Yakusheva (2011) found that the economic disadvantages (lower education and increased poverty) experienced by adolescent mothers might be due to preexisting differences in educational and fertility expectations. Additionally, although research suggests that lower academic achievement is associated with adolescent pregnancy (Scales & Lefferet, 1999) and that goals compatible with motherhood may indicate higher risk for repeat pregnancy (Camerena, Minor, Melmer, & Ferrie, 1998), my findings suggest that some adolescents (parous and nulliparous) possess unrealistic expectations of career training and education requirements. Parous participants reported slight adjustment in professional aspirations, apart from shifting to careers that were perceived to be ‘quicker,’ and the overall sample lacked a realistic knowledge base of career expectations and logistics. My findings also suggest that participant goal aspirations are not rooted in realistic expectations, but are rooted in personal interest and are fluid as experiences and contexts change. As such, fluctuations in professional aspirations may not be solely based on adolescent pregnancy, but rather on developmental processes and career information knowledge base. This is signified by statements such as “I wanted to be a pediatrician but that takes four years,” when in actuality becoming a pediatrician requires up to 11 years of education and training (4 years undergraduate training, 4 years of medical school, and 3 years of residency). Unrealistic expectations
were also evidenced in incomplete and misguided plans for professional success. One 17-years old participant, who noted no change in professional aspirations at six months pregnant described plans to attend one of three universities six months from the interview; however, she had not taken the necessary steps to secure acceptance or even apply to the aforementioned universities. Findings suggest that career mentoring, planning and job skill assessment are necessary for all adolescents before career mentoring may be effective to reduce pregnancy and repeat pregnancy. Services should start in the 9th grade and continue through the 12th grade. Career mentoring to prevent adolescent pregnancy cannot be effective if unrealistic professional aspirations are present. Recommendations for practice also include academic interventions that influence goal orientation and self-efficacy. Caraway (2003) found that higher grade point average was predicted with higher self-efficacy, lower fear of failure, and lower social desirability among a South Eastern high school student sample, and that higher goal orientation and generalized efficacy predicted higher levels of school engagement. School programs that foster goal orientation and self-efficacy can essentially increase school engagement and academic achievement and reduce risk for adolescent pregnancy.

Currently, pregnancy prevention and intervention programs utilize implications of adolescent pregnancy findings as avenues to reduce adolescent pregnancy. Unfortunately, my findings suggest that adolescent pregnancy and repeat pregnancy often stem from poor planning, and participants undertake the process of cognitive dissonance when they become a new mother. As such, participants, perhaps unknowingly, change their beliefs and attitudes to better reflect their new role.
Furthermore, some participants reported renewed focus and motivation since motherhood, findings supported by SmithBattle (2007) who found that participants often reported a renewed sense of focus on education and success. Although these may be useful coping strategies in that it may foster hope, it may counteract the efficacy of adolescent pregnancy and repeat pregnancy programs. I recommend public health interventions that use an asset mapping approach, and thus recognize the coping strategies used by adolescent mothers and repeat mothers as a framework to prevent further unplanned pregnancies. Kegler and colleagues used youth assets such as aspirations for the future, constructive use of time, and skills for meaningful employment to reduce risky behavior among adolescents (Kegler, Rodine, Marshall, Oman, & McLeroy, 2003). Similar programs that use assets of adolescent mothers and repeat mothers can mobilize the community (adolescent mothers) to reduce negative outcomes such as decreased high school graduation, college enrollment and associated economic consequences.

Parous participants within the foster care system reported inadequate support as an adolescent mother and excess judgment compared to adolescent mothers not in foster care. Participants reported pressure to place their child for adoption in place of access to training and parenting education. Changes in practice to improve and increase access to parent education and parenting programs that recognize the role of the child in the adolescent’s life are essential. Compared to adolescents not in foster care, a child may serve as the only consistent family member and source of love through multiple foster placements and guardians. Connolly (2012) found that among adolescents in foster care, the infant was used to fill an emotional void and motherhood
was perceived as positive and stabilizing. Recognizing these strengths to improve on repeat pregnancy prevention programs as well as policy interventions to improve access to pregnancy prevention services will decrease rates of adolescent pregnancy and reduce system burden by reducing the rates of second generation foster children.

**Implications for Theory and Suggestions for Future Research**

Findings provide insight into the meaning of success among nulliparous, primiparous and multiparous participants. Additional research is needed to further explore the three identified themes and the construct of independence. Future research to investigate generational, gender and racial or ethnic differences in the meaning of success is needed. Research is also needed to address how preconceived meanings of success affect personal and professional goals and achievement. Parous participants recognized independence as paramount ultimate success. However, quantitatively most noted that they were successful or making ample progress in becoming successful contrary to qualitative reports of dependence on others to meet the tangible needs of their child such as diapers, formula, day care, and money for health care expenses. These findings indicate further research on the meaning of self-reflected meaning of success and measures of success for outsiders. Findings also warrant further investigation on what it means to be a “good mother.” Parous participants reported aspirations to be a good mother; however, based on current dependence on others to meet the basic needs of their children it may signify they are not “good mothers.” Research to investigate potential generational, gender, and racial or ethnic differences on the meaning of motherhood/fatherhood and being a good mother/father are essential to understand the context of adolescent pregnancy among adolescent parents.
Future research should include input from adolescent fathers and maternal grandmothers who were not included in this study. Nelson et al. (2012) found that among non-married Black adolescent mothers, participants felt that their babies’ father would always be a part of their lives, they would always care about their babies father, and that the babies’ father could always get sex as long as they were on good terms. Participants described mixed levels of support from the father of their children and less overall impact of parenthood on the lives of the father. The impact was described as greater if the father lived with the adolescent and child, otherwise child-father interaction was often restricted to the weekend. Decreased impact of fatherhood may influence higher rates of unplanned/planned pregnancy by the male partner, as indicated in the findings. One participant described a coveted repeat pregnancy on the part of her boyfriend who did not live with or participate daily in their oldest child’s life. Two other participants characterized the father of the child as non-existent and contributed this, partly due repeat pregnancies with outside women. Research indicates that co-parenting and social support have a greater effect on engagement for adolescent fathers than adult fathers, suggesting that parent engagement needs to be fostered early in parenthood (Fagan & Lee, 2011). Furthermore, findings from Boardman et al. (2006) indicate that a prior poor birth outcome, such as losing custody of your child, may translate to adolescent fathers, suggesting that co-parenting can reduce rates of repeat pregnancy among male adolescents and young adults.

The role of maternal grandmothers and other family members can have a substantial effect on the perceived difficulty or ease of motherhood among adolescents. Some participants described supportive and nurturing families who assist the
adolescent in caring for her child and going to school. Others describe family members who provide tangible support and limited emotional and social support. Follow up research to investigate the differences in provided support from the adolescent and families’ perspective and its effect on repeat pregnancy is needed. Perhaps social and emotional support is reflective of risk for repeat pregnancy; coaxing adolescents to turn to male partners for nurturing may increase the risk for secondary pregnancies.

Adolescent motherhood described by nulliparous participants was speculated as difficult and stressful. However, adolescents described life as a mother as an adjustment, and not that hard. Specifically, not as hard as peers, parents, and society proposed. “Not that hard” should be investigated over time, as perceptions adjust and as parous participants experience reality. Additionally, participant views on the television shows 16 & Pregnant © and Teen Mom© reflect similar findings, suggesting the show’s potential to influence adolescent pregnancy may be diminished by incidence of adolescent pregnancy among close friends. Although the nulliparous perspective suggests both shows portray the hardships of motherhood, close friendships with parous participants who perceive life as “not that hard” may counteract perceptions of nulliparous participants.

In conclusion, future research questions should include:

1. What is the meaning of success? Does “success” differ within circumstance/ context and if so how?
2. Does the meaning of success differ with different generation, gender, or race/ethnic identity?
3. How does the individual meaning of success affect personal and professional goal aspirations?
4. What is the meaning of motherhood among adolescent mothers and maternal grandmothers? How do their meanings differ, and how are they the same?
5. What is the impact of fatherhood among adolescent fathers? How and why does this differ from experiences of adolescent mothers?

6. How does adolescent motherhood affect the lives of paternal grandmothers? How much responsibility does the adolescent father and family bear in pregnancy prevention, pregnancy support, and raising the infant?

7. How has adolescent motherhood in the media (16 & Pregnant and Teen Mom) affected perceptions of adolescent mothers among the adolescent population?

Chapter 5 Conclusion

Risk factors and implications of adolescent pregnancy and repeat pregnancy extend across the disciplines of epidemiology, social and behavioral sciences, health policy, nursing, medicine and social work. As such, implications for practice should include input from each of these disciplines. Success had explicit meaning to the participants including having a good job, having a house and car, and being financially independent. The easiest part of motherhood for parous participants was caring for and loving their child, the hardest part was meeting the financial needs of their child. However, despite their admitted failure to meet their own definitions of success (independence), most stated that they were on their way. Additionally, primiparous and parous participants described motherhood as not that hard, describing adjustments to life as an adolescent mother. Understanding these adjustments and their possible implications for repeat pregnancy are essential to foster hope in adolescent mothers as a method to reduce rates of repeat pregnancy.
APPENDIX A
PARTICIPANT INTAKE FORM

To be completed and verified BEFORE the interview or after the focus group

Demographic Information
1) Age: What is your date of birth? _______________________

2) Race & Ethnicity: Please check the box (es) that describes you best. (Check all that apply)
   □ 1 White     □ 2 Native Hawaiian or Other Pacific Islander
   □ 3 Black or African American □ 4 American Indian or Alaska Native
   □ 5 Hispanic    □ 6 Asian/ Asian American
   □ 7 Other________________________

3) School Attendance: Please check the box that describes you best. (Check one)
   □ 1 I go to high school full time
   □ 2 I go to high school part time
   □ 3 I graduated from high school
   □ 4 I quit high school but got a GED
   □ 5 I quit high school
   □ 6 Other: ______________________

3b) If you are in school, how are you doing academically? (Check one)
   □ 1 I get really good grades (As and Bs)
   □ 2 I get ok grades (Bs and Cs)
   □ 3 I get poor grades (Ds and Fs)

4) Work Status: Are you currently working or looking for a job? (Check one)
   □ 1 I work full time
   □ 2 I work part time
   □ 3 I recently quit or stopped working
   □ 4 I am looking for a job
   □ 5 I do not work

5) Sexual Activity: Sexually active is defined as someone who has sex three or more
times in the past month. (Check one)
   □ 1 I am currently sexually active
   □ 2 I used to be sexually active, but not anymore
   □ 3 I am not sexually active, but I have had sex
   □ 4 I have never had sex
6) Pregnancy Status: Please check the box that describes you best. (Check one)
☐¹ I have never been pregnant
☐² I have been pregnant once
☐³ I have been pregnant two or more times

7) Parenting Status: Please check the box that describes you best. (Check one)
☐¹ I have no children
☐² I have one child
☐³ I have two or more children

7b) If you have children, tell me about them.

<table>
<thead>
<tr>
<th>Age</th>
<th>1st child</th>
<th>2nd child</th>
<th>3rd child</th>
<th>4th child</th>
<th>5th child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>1st child</th>
<th>2nd child</th>
<th>3rd child</th>
<th>4th child</th>
<th>5th child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8) Living Arrangement: Please check the box that describes you best. (Answer Yes or No for each statement)
Currently in my home, I live with my …

| Mom only¹ | ☐ Yes | ☐ No |
| Dad only² | ☐ Yes | ☐ No |
| Mom & Dad³ | ☐ Yes | ☐ No |
| Romantic partner⁴ | ☐ Yes | ☐ No |
| Friend⁵ | ☐ Yes | ☐ No |
| Grandmother or grandfather⁶ | ☐ Yes | ☐ No |
| My Child or children⁷ | ☐ Yes | ☐ No |
| Other⁸: ________________________ | ☐ Yes | ☐ No |

9) Living Environment: Please check the box that describes you best. (Check one)
I live in a…
☐¹ House
☐² Apartment
☐³ Mobile Home
☐⁴ Group Home
☐⁵ Other: _____________________________

10) Relationship Status: Please check the box that describes you best. (Check one)
☐¹ Single
☐² Same-sex relationship (less than 6 months)
□³ Same-sex relationship (more than 6 months)
□⁴ Committed Boyfriend (less than 6 months)
□⁵ Committed Boyfriend (more than 6 months)
□⁶ Engaged
□⁷ Other: _______________

Family Dynamics

11a). To the best of your knowledge, please circle your **MOM**’s highest grade in school completed: *(circle one number)*

*Elementary*: 0 1 2 3 4 5 6 7 8
*High school*: 9 10 11 12
*GED*: 12
*College/technical school*: 13 14 15 16
*Graduate*: 17 or more

b. If you live with your mom… is your **MOM** currently employed for pay?
   □¹ Yes, full-time
   □² Yes, part-time
   □³ No, retired
   □⁴ No, disabled
   □⁵ No, looking for work
   □⁶ Other__________________

c. To the best of your knowledge, how old was your **MOM**, when she had her first child? __________________

12a). To the best of your knowledge, please circle your **DAD**’s highest grade in school completed: *(circle one number)*

*Elementary*: 0 1 2 3 4 5 6 7 8
*High school*: 9 10 11 12
*GED*: 12
*College/technical school*: 13 14 15 16
*Graduate*: 17 or more

b. If you live with your dad …is your **DAD** currently employed for pay?
   □¹ Yes, full-time
   □² Yes, part-time
   □³ No, retired
   □⁴ No, disabled
   □⁵ No, looking for work
   □⁶ Other__________________
c. To the best of your knowledge, how old was your DAD, when he had his first child?

____________________

13) To the best of your knowledge, please estimate your household yearly income: (check one box)

□ 1 less than $10,000
□ 2 $10,000 to $19,999
□ 3 $20,000 to $29,999
□ 4 $30,000 to $39,999
□ 5 $40,000 to $49,999
□ 6 $50,000 to $59,999
□ 7 $60,000 to $69,999
□ 8 $70,000 to $79,999
□ 9 $80,000 or more

14) A teen parent is someone who is 18 or younger who is currently pregnant or has one or more children. (Answer Yes or No for each statement)

| My older sister is/was a teen parent | □ Yes | □ No |
| My younger sister is/was a teen parent | □ Yes | □ No |
| My female cousin is/was a teen parent | □ Yes | □ No |
| My aunt(s) is/was a teen parent | □ Yes | □ No |
| My grandmother is/was a teen parent | □ Yes | □ No |
| I do not know of any female relatives who are teen parents | □ Yes | □ No |

15) A teen parent is someone who is 18 or younger who is currently pregnant or has one or more children. (Answer Yes or No for each statement)

| My older brother is/was a teen parent | □ Yes | □ No |
| My younger brother is/was a teen parent | □ Yes | □ No |
| My male cousin is/was a teen parent | □ Yes | □ No |
| My uncle(s) is/was a teen parent | □ Yes | □ No |
| My grandfather is/was a teen parent | □ Yes | □ No |
| I do not know of any male relatives who are teen parents | □ Yes | □ No |

16) Religious Affiliation: I was ‘raised’ in a… (Check one)

□ 1 Non religious/ spiritual environment (I never attended church/temple)
□ 2 Mildly religious/ spiritual environment (I attended church/temple on the holidays)
□ 3 Moderately religious/spiritual environment (I attend church/temple once a week)
□ 4 Highly religious/spiritual environment (I attend church/temple 2 or more times a week)
Peer Relationships
17) *Sexually Active* is defined as someone who has had sex three or more times in the last month. *(Answer Yes or No for each statement)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the girls I know are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of the girls I know are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my girl friends are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my best girl friends are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My very best girl friend is sexually active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18) A *teen parent* is someone who is 18 and younger who is currently pregnant or has one or more children. *(Answer Yes or No for each statement)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the girls I know are teen parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of the girls I know are teen parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my girl friends are teen parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my best girl friends are teen parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My very best girl friend is a teen parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Male Relationships
19) *Sexually Active* is defined as someone who has had sex three or more times in the last month. *(Answer Yes or No for each statement)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the guys I know are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of the guys I know are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my guy friends are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my best guy friends are sexually active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My very best guy friend is sexually active</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20) A teen dad is someone who is 18 and younger who has one or more children, or their girlfriend is currently pregnant. *(Answer Yes or No for each statement)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>None of the guys I know are teen dads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of the guys I know are teen dads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have some guys friends who are teen dads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some of my best guy friends are teen dads</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My very best guy friend is a teen dad</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mastery Scale
21) How much do you agree or disagree with the following statements.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. There is really no way I can solve some of the problems I have.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. I have little control over the things that happen to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Sometimes I feel like I am being pushed around in life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. There is little I can do to change many of the important things in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. What happens to me in the future mostly depends on me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. I often feel helpless in dealing with the problems of life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. I can do just about anything I set my mind to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22) Please tell me how you have been feeling over the last two weeks. Please check the amount of each emotion you have been feeling.

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Very slightly or not at all 1</th>
<th>A little 2</th>
<th>Moderately 3</th>
<th>Quite a bit 4</th>
<th>Extremely 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Interested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Distressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Excited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Strong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Scared</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Hostile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Enthusiastic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Proud</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Irritable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Alert</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. Ashamed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Inspired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O. Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Over the past 2 weeks, how much have you felt….

<table>
<thead>
<tr>
<th>Very slightly or not at all 1</th>
<th>A little 2</th>
<th>Moderately 3</th>
<th>Quite a bit 4</th>
<th>Extremely 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>P. Attentive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q. Jittery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R. Active</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S. Afraid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23) Please tell me how you see yourself. For the following statements, please check the box that describes you best.

<table>
<thead>
<tr>
<th>A. I feel that I am a person of worth, at least on an equal plane with others.</th>
<th>Strongly Agree¹</th>
<th>Agree²</th>
<th>Disagree³</th>
<th>Strongly disagree⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Things never work out the way I want them to.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. I feel that I have a number of good qualities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. At times I think I am no good at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. All in all, I am inclined to feel that I am a failure.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. If something can go wrong for me, it will.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. I am able to do things as well as most other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. In uncertain times, I usually expect the best.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. I feel that I do not have much to be proud of.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. On a whole, I am satisfied with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. I'm always optimistic about my future.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. I wish I could have more respect for myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. I am a believer in the idea that &quot;every cloud has a silver lining.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. I take a positive attitude toward myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O. I rarely count on good things happening to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P. I certainly feel useless at times.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Agree ¹</td>
<td>Agree ²</td>
<td>Disagree ³</td>
<td>Strongly disagree ⁴</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Q. I hardly ever expect things to go my way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R. I always look on the bright side of things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there anything you would like to add? _____________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Thank you for your help!
Please answer the questions below – we will cut off this portion of the survey and keep it separately from your responses.

Name: _______________________________

If we need to contact you in the future…

A. What is your preferred phone number?

B. What is your preferred time of day?

Staff only -- Study ID number: University of Florida
APPENDIX B
NULLIPAROUS ADOLESCENT INTERVIEW GUIDE

Good __________(insert time of day, morning afternoon etc), Thank you for agreeing to participate in this interview. I would like to confirm a few things before we get started.

   a. First, I have listed that you are ______ years old, is that correct? __________
   b. I have listed that you have had no known pregnancies, is that correct? __________
   c. I also have listed you □ are □ are not currently in enrolled in school, is that correct? ________
   d. Finally, I’d like to remind you that this interview is confidential. Nothing you say will be repeated. Your parents, teachers or friends will not see this interview. However, if you choose to tell me about any cases of abuse (physical or sexual) or report any harm to yourself or others I have to report it to the authorities. If there are any questions that make you uncomfortable, you can choose not to answer that question.

Part 1: Life Story

Introduction
1. Tell me about life for girls your age.
   Probe if necessary: Describe a typical day for you.
   Probe if necessary: How does that compare to some of your friends?
   Probe if necessary: What are some things that are going well right now?
   Probe if necessary: What are some things that worry you?
   Probe if necessary: What is life like at home?
   Probe if necessary: (if in school) What is life like at school?
   Probe if necessary: Are you working? Tell me about your job?

Part 2: Future Success and Aspirations

Success
2. I’d like to talk to you all about success. I’d like for you to think about someone you consider successful, tell me about this person.
   Probe if necessary: What is it that makes them successful?
   Probe if necessary: What does success mean to you?
   Probe if necessary: Describe a successful ____ (insert participant age) year old young woman, what about a man?
   Probe if necessary: Describe a successful ____ (Insert participant age + 10 yrs) year old woman, what about a man?
   Probe if necessary: How do you decide if someone is successful? What do use to measure success? (Some measure success by the amount of money they have, cars, or nice things etc.)

Future Aspirations
3. Now I’d like for you to imagine yourself 3 years from now. What would you like to be doing?
   
   Probe if necessary: What is your plan to get there?
   Probe if necessary: Has this always been your goal, or has it changed?
   Probe if necessary: Why has it changed?
   Probe if necessary: What do you think your life will be like in 10 years?
   Probe if necessary: Where will you be living?
   Probe if necessary: What type of job or career will you have? (location, living environment, family, friends, job)

Professional Future
4. Next I’d like for you all to think about your future job or career. Can you tell me your career plans and hopes for the future?
   
   Probe if necessary: What type of job do you want after high school?
   Probe if necessary: What about ________ career interests you?
   Probe if necessary: How did you arrive at that choice?
   Probe if necessary: Has this always been your goal, or has it changed?
   Probe if necessary: Why has it changed?
   Probe if necessary: What is your plan to become a ________?
   Probe if necessary: Is your plan moving ahead the way you want?
   Probe if necessary: What do you think about college?

Personal Future
5. Okay, now I’d like for you to talk about your personal life. Can you tell me about your family ten years from now?
   
   Probe if necessary: Do you see yourself with someone special?
   Probe if necessary: (if they mention marriage) How old do you want to be when you get married?
   Probe if necessary: How old do you think you will be?
   Probe if necessary: What do you think your wedding will be like?
   Probe if necessary: Can you describe your future husband?
   Probe if necessary: What role do children have in your future?
   Probe if necessary: How many children do you think about having?
   Probe if necessary: When do you want to have your first child?
   Probe if necessary: When do you want to be done having children?

Part 3: Past and present relationships

The next few questions are about your past and present relationships. Please keep in mind this interview will remain between us. However, if you choose to tell me about any cases of physical or sexual abuse I will report it. This includes cases about statutory rape (sexual relationship between older boy and underage girl).

Relationships
6. When did you have your first romantic relationship?
   
   Probe if necessary: How did you come about dating?
Sexuality

7. Next I’d like to talk about sex, please keep in mind, this interview will remain between us, and none of your friends, teachers or parents will see your answers. When did you first learn about sex?

- *Probe if necessary:* What do you remember learning about sex?
- *Probe if necessary:* Where did you learn about sex? Was it at school? At home?
- *Probe if necessary:* What did you learn from friends?
- *Probe if necessary:* What were some of the biggest questions you had, when you first learned about sex?
- *Probe if necessary:* From your understanding what is the best way to prevent getting a STD?
- *Probe if necessary:* From your understanding what is the best way to prevent getting pregnant?

8. Tell me about your first sexual experience.

- *Probe if necessary:* “Sexual active” is when you have sex three or more times in a month. Would you consider yourself sexually active?
- *Probe if necessary:* When is the last time you had sex?
- *Probe if necessary:* Are your friends sexually active? What do you think about that?
- *Probe if necessary:* Are you currently trying to prevent pregnancy?
- *Probe if necessary:* What are you doing to prevent getting pregnant?

Part 4: Pregnancy, Motherhood and Media

*Next, I’d like to talk about pregnancy and motherhood. I’d like to hear your story about your friends who are pregnant or mothers. Try not to use your friends’ real name, instead use a made up a name. Please keep in mind your parents, friends and teachers will not see this interview.*

Pregnancy * (For nulliparous adolescents)

9. Next, I would like to talk about girls who have babies in high school. I would like you to think for a minute about a girl your age who has had a baby. Can you describe what you think it is like for girls who have a baby in high school?

- *Probe if necessary:* What are some good things about having a baby in high school?
Probe if necessary: What are some difficult things about having a baby in high school?
Probe if necessary: What are some reasons girls may have a baby when they are still in school?
Probe if necessary: What are some reasons not to have a baby while you are still in school?
Probe if necessary: What is your biggest reason for not having a baby right now?

Motherhood
10. Can you describe what you think it is like for a teen mother?
   Probe if necessary: What do you think are some of the easiest things about being a teen mom?
   Probe if necessary: What do you think are some of the hardest things about being a teen mom?
   Probe if necessary: How do you think motherhood will change a teen moms’ educational plans?
   Probe if necessary: How do you think motherhood will change a teen moms’ personal plans?
   Probe if necessary: How do you think motherhood will change a teen moms’ romantic plans?
   Probe if necessary: How do you think motherhood will change a teen moms’ career or work plans?

Media
11. MTV has two popular television shows about teen pregnancy and motherhood. Have you seen ‘16 and Pregnant’ or ‘Teen Mom’?
   Probe if necessary: What are your thoughts about ‘16 and Pregnant’?
   Probe if necessary: How does the show compare to your thoughts about teen pregnancy?
   Probe if necessary: What are your thoughts about ‘Teen Mom’?
   Probe if necessary: How does the show compare to your thoughts about being a teen mother?
   Probe if necessary: Can you tell me about any other TV shows or movies that discuss teen pregnancy or motherhood?
   Probe if necessary: What are your thoughts about these TV shows or movies?

Part 5 Future and past advice
Okay, we are nearing the end of the interview. I’d like to thank you again for participating in the interview. I only have a few more questions. We are going talk a little more about your goals for the future.

Past Self
12. If you could go back and change one thing about the past related to your personal past what would it be? Why is that?
Probe if necessary: If you could go back and change one thing about your academic past what would it be? Why is that?

Probe if necessary: If you could go back and change one thing about your romantic past what would it be? Why is that?

Probe if necessary: Do you have any advice for your past self?

Future Self
13. Is there any one thing you are excited about, or looking forward to in the future? Why is that?

Probe if necessary: Do you have any advice for your future self?

Conclusion
14. Is there anything else you would like to tell me about being a teenager?

15. Is there anything else you would like to tell me about being a mother?

Worksheet Instructions
Ok, I have two more items before we finish up.

First, I would like to talk about community and success a little more. I am going to give you a handout (hand participant worksheet). On the sheet, please list some characteristics of successful and unsuccessful people in your community. I want you to think of your neighborhood, classmates, friends and family as your community.

Second, I would like you to review the community ladder. The people you described as successful are at the very top of the ladder. Those you described as unsuccessful are at the bottom of the ladder.

A. Mark an X on the ladder where you think stand at this point in your life.
B. Mark two X’s where you think you will be in three years
C. Mark three X’s where you want to be in three years.

Lastly, I’m going to hand you some index cards. (Hand participant cards) I’d like for you to put them order. On the top put the item that is going to most help you get to the ‘top’ rung or level. At the bottom put the item that will help you the least. If there is something not listed that you think is going to help you get to your top rung write it on the card marked ‘other’. Now put the cards in order. What card did you put on top, what will make it easiest to get to the top rung.

(Write order below)

_____ Graduating from high school
_____ Going to college or technical school
_____ Getting a job
_____ Having a baby
_____ Owning something costly; car, home, boat, music instrument
_____ Getting married
_____ Going out more
_____ Having lots of money
_____ Other ________________________

Probe if necessary: I noticed that you put _________ on the top, why is that?
Probe if necessary: I noticed that you put _________ on the bottom, why is that?
Probe if necessary: How did you finally make the decision?

Now with the same cards I’d like for you to put them order of items that are going to make it hard for you to reach your rung. On the top please put the item that is going to make it HARDEST to reach your top rung. At the bottom put the item that is going to make things Easiest. If there is something not listed mark this item on the card marked other. Now put the cards in order. What card did you put on top, what will make it hardest to get to the top rung. (Write order below).

_____ Graduating from high school
_____ Going to college or technical school
_____ Getting a job
_____ Having a baby
_____ Owning something costly; car, home, boat, music instrument
_____ Getting married
_____ Going out more
_____ Having lots of money
_____ Other ________________________

Probe if necessary: I noticed that you put _________ on the top, why is that?
Probe if necessary: I noticed that you put _________ on the bottom, why is that?
Probe if necessary: How did you finally make the decision?
Interview Worksheet

What are some things you think describe successful people at the top of the ladder.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Write some things you think describe unsuccessful people at the bottom of the ladder.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Community Ladder

At the top of the ladder are the people who have the highest standing in your community.

Where would you place yourself on this ladder?

Please place a large an “X” on the rung where you think you stand at this time in your life relative to other people in your community.

Place 2 large “XX”s where you think you will be in 3 years.

Then place 3 large “XXX”s where you think you want to be in 3 years.

At the bottom are the people who have the lowest standing in your community.
APPENDIX C
PRIMIPAROUS/ MULTIPAROUS ADOLESCENT INTERVIEW GUIDE

Good ________ (insert time of day, morning afternoon etc.), Thank you for agreeing to participate in this interview. I would like to confirm a few things before we get started.

a. First, I have listed that you are ______ years old, is that correct? __________
b. I have listed that you have _____ child/ children, is that correct? __________
c. And, their ages are ______________, is that correct? __________
d. Lastly, I have listed you □ are □ are not currently in enrolled in school, is that correct? __________
e. Ok, before we get started, I’d like to remind you that this interview is confidential. Nothing you say will be repeated. Your parents, teachers or friends will not see this interview. However, if you choose to tell me about any cases of abuse (physical or sexual) or report any harm to yourself or others I have to report it to the authorities. If there are any questions that make you uncomfortable, you can choose not to answer that question.

Part 1: Life Story

Introduction

1. Please tell me about life for girls your age.
   Probe if necessary: Describe a typical day for you.
   Probe if necessary: How does that compare to some of your friends?
   Probe if necessary: What are some things that are going well right now?
   Probe if necessary: What are some things that worry you?
   Probe if necessary: What is life like at home?
   Probe if necessary: (if in school) What is life like at school?
   Probe if necessary: Are you working? Tell me about your job?
   Probe if necessary: (if they have/ mention children) Tell me about your daughter/ son/ children?

Part 2: Future Success and Aspirations

Success

I’d like to talk to you all about success. I’d like for you to think about someone you consider successful, tell me about this person.

   Probe if necessary: What is it that makes them successful?
   Probe if necessary: What does success mean to you?
   Probe if necessary: Describe a successful ____ (insert participant age) year old young woman, what about a man?
   Probe if necessary: Describe a successful ____ (Insert participant age + 10 yrs) year old woman, what about a man?
Probe if necessary: How do you decide if someone is successful? What do use to measure success? (Some measure success by the amount of money they have, cars, or nice things etc.)

**Future Aspirations**
10. Now I’d like for you to imagine yourself 3 years from now. What would you like to be doing?
   
   *Probe if necessary:* What is your plan to get there?
   *Probe if necessary:* Has this always been your goal, or has it changed?
   *Probe if necessary:* Why has it changed?
   *Probe if necessary:* What do you think your life will be like in 10 years?
   *Probe if necessary:* Where will you be living?
   *Probe if necessary:* What type of job or career will you have? (location, living environment, family, friends, job)

**Professional Future**
11. Next I’d like for you to think about your future job or career. Can you tell me your career plans and hopes for the future?
   
   *Probe if necessary:* What type of job do you want after high school?
   *Probe if necessary:* What about ________ career interests you?
   *Probe if necessary:* How did you arrive at that choice?
   *Probe if necessary:* Has this always been your goal, or has it changed?
   *Probe if necessary:* Why has it changed?
   *Probe if necessary:* What is your plan to become a ________?
   *Probe if necessary:* Is your plan moving ahead the way you want?
   *Probe if necessary:* What do you think about college?

**Personal Future**
12. Okay, now I’d like for you to talk about your personal life. Can you tell me about your family ten years from now?
   
   *Probe if necessary:* Do you see yourself with someone special?
   *Probe if necessary: (if they mention marriage)* How old do you want to be when you get married?
   *Probe if necessary:* How old do you think you will be?
   *Probe if necessary:* What do you think your wedding will be like?
   *Probe if necessary:* Can you describe your future husband?
   *Probe if necessary:* How many children do you think about having?
   *Probe if necessary:* When do you want to be done having kids?

**Part 3: Past and present relationships**
The next few questions are about your past and present relationships. Please keep in mind this interview will remain between us. However, if you choose to tell me about any cases of physical or sexual abuse I have to report it. This includes cases about statutory rape (sexual relationship between older boy and underage girl).

**Relationships**
13. When did you have your first romantic relationship?
   - Probe if necessary: How did you come about dating?
   - Probe if necessary: What are some things you liked about the relationship?
   - Probe if necessary: What are some things you wanted to change about the relationship?
   - Probe if necessary: Are you currently in a relationship?
   - Probe if necessary: Tell me about that person.
   - Probe if necessary: How long have you been in a relationship?
   - Probe if necessary: What are some things you like about the relationship?
   - Probe if necessary: What are some things you would like to change about the relationship?

Sexuality

14. Next I’d like to talk about sex, please keep in mind, this interview will remain between us, and none of your friends, teachers or parents will see your answers. When did you first learn about sex?
   - Probe if necessary: What do you remember learning about sex?
   - Probe if necessary: Where did you learn about sex? Was it at school? At home?
   - Probe if necessary: What did you learn from friends?
   - Probe if necessary: What were some of the biggest questions you had, when you first learned about sex?
   - Probe if necessary: From your understanding what is the best way to prevent getting a STD?
   - Probe if necessary: From your understanding what is the best way to prevent getting pregnant?

15. Tell me about your first sexual experience.
   - Probe if necessary: “Sexual active” is when you have sex three or more times in a month. Would you consider yourself sexually active?
   - Probe if necessary: When is the last time you had sex?
   - Probe if necessary: Are your friends sexually active? What do you think about that?
   - Probe if necessary: Are you currently trying to prevent pregnancy?
   - Probe if necessary: What are you doing to prevent getting pregnant?

Part 4: Pregnancy, Motherhood and Media

Now I’m going to ask you some questions about your pregnancy and transition to motherhood. I’d like to hear your story about becoming a mother. Please keep in mind your parents, friends and teachers will not see this interview. However, if you tell me about any cases of abuse I will have to report it.

Pregnancy

16. Next, I’d like to talk about your pregnancy and birth. Again, this will remain between us and you can skip any question that makes you uncomfortable. Tell me what it was like when you first found out you were pregnant.
   - Probe if necessary: How did you feel when you first found out you were pregnant?
Probe if necessary: Who did you tell about your pregnancy first? Why did you tell that person first?
Probe if necessary: Who did you tell about your pregnancy last? Why did you tell that person last?
Probe if necessary: How did the father of your child view your pregnancy? How did he feel after you had the baby?
Probe if necessary: How did your parents view your pregnancy? How did they feel after you had the baby?
Probe if necessary: How did your friends view your pregnancy? How did they feel after you had the baby?

Motherhood
17. Can you describe a typical day as mother?
   Probe if necessary: What is it like to be a young mother?
   Probe if necessary: How have things changed since you became a mom?
   Probe if necessary: What are some of the easiest things about being a mom?
   Probe if necessary: What are some of the hardest things about being a mom?
   Probe if necessary: Tell me how motherhood has changed your educational plans?
   Probe if necessary: Tell me how motherhood has changed your personal plans?
   Probe if necessary: Tell me how motherhood has changed your work or career plans?

Media
11. MTV has two popular television shows about teen pregnancy and motherhood. Have you seen ‘16 and Pregnant’ or ‘Teen Mom’?
   Probe if necessary: What are your thoughts about ‘16 and Pregnant’?
   Probe if necessary: How does the show compare to your thoughts about teen pregnancy?
   Probe if necessary: What are your thoughts about ‘Teen Mom’?
   Probe if necessary: How does the show compare to your thoughts about being a teen mother?
   Probe if necessary: Can you tell me about any other TV shows or movies that discuss teen pregnancy or motherhood?
   Probe if necessary: What are your thoughts about these TV shows or movies?

Part 5 Future and past advice
Okay, we are nearing the end of the interview. I’d like to thank you again for participating in the interview. I only have a few more questions. We are going talk a little more about your goals for the future.

Past Self
12. If you could go back and change one thing about the past related to your personal past what would it be? Why is that?
   Probe if necessary: If you could go back and change one thing about your academic past what would it be? Why is that?
Probe if necessary: If you could go back and change one thing about your romantic past what would it be? Why is that? 
Probe if necessary: Do you have any advice for your past self?

Future Self
13. Is there any one thing you are excited about, or looking forward to in the future? Why is that? 
Probe if necessary: Do you have any advice for your future self?

Conclusion
14. Is there anything else you would like to tell me about being a teenager?

15. Is there anything else you would like to tell me about being a mother?

Worksheet
Ok, I have two more items before we finish up.

First, I would like to talk about community and success a little more. I am going to give you a handout (hand participant worksheet). On the sheet, please list some characteristics of successful and unsuccessful people in your community. I want you to think of your neighborhood, classmates, friends and family as your community.

Second, I would like you to review the community ladder. The people you described as successful are at the very top of the ladder. Those you described as unsuccessful are at the bottom of the ladder.

A. Mark an X on the ladder where you think stand at this point in your life.
B. Mark two X’s where you think you will be in three years
C. Mark three X’s where you want to be in three years.

Lastly, I’m going to hand you some index cards. (Hand participant cards) I’d like for you to put them order. On the top put the item that is going to most help you get to the ‘top’ rung or level. At the bottom put the item that will help you the least. If there is something not listed that you think is going to help you get to your top rung write it on the card marked ‘other’. Now put the cards in order. What card did you put on top, what will make it easiest to get to the top rung. (Write order below)

_____ Graduating from high school
_____ Going to college or technical school
_____ Getting a job
_____ Having a baby
_____ Owning something costly; car, home, boat, music instrument
_____ Getting married
_____ Going out more
Having lots of money
Other ________________________

Probe if necessary: I noticed that you put _________ on the top, why is that?
Probe if necessary: I noticed that you put _________ on the bottom, why is that?
Probe if necessary: How did you finally make the decision?

Now with the same cards I’d like for you to put them order of items that are going to make it hard for you to reach your rung. On the top please put the item that is going to make it HARDEST to reach your top rung. At the bottom put the item that is going to make things Easiest. If there is something not listed mark this item on the card marked other. Now put the cards in order. What card did you put on top, what will make it hardest to get to the top rung. (Write order below).

Graduating from high school
Going to college or technical school
Getting a job
Having a baby
Owning something costly; car, home, boat, music instrument
Getting married
Going out more
Having lots of money
Other ________________________

Probe if necessary: I noticed that you put _________ on the top, why is that?
Probe if necessary: I noticed that you put _________ on the bottom, why is that?
Probe if necessary: How did you finally make the decision?
Interview Worksheet

What are some things you think describe **successful** people at the **top** of the ladder.
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Write some things you think describe **unsuccessful** people at the **bottom** of the ladder.
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Community Ladder

At the **top** of the ladder are the people who have the highest standing in your community.

Where would you place yourself on this ladder?

Please place a large an “X” on the rung where you think you stand at this time in your life relative to other people in your community.

Place 2 large “XX”s where you think you will be in **3 years**

Then place 3 large “XXX”s where you think you want to be in **3 years**.

At the **bottom** are the people who have the lowest standing in your community.
APPENDIX D
FOCUS GROUP SCRIPT AND QUESTION GUIDE

Good ___________(insert time of day, morning afternoon etc.), Thank you for agreeing to participate in today’s focus group. The purpose of today’s group is to understand what life is like for girls your age. I want to know your opinion on school, home, sex, teen motherhood, and most importantly your personal and professional goals. Before we get started, I would like to go through some things.

a. Each of you should have handed me a signed consent form for today’s focus group. Those of you that are under eighteen must have parent / guardian consent. (Assess situation)

b. Each of you should have handed me a completed intake form. (Assess situation)

c. Each of you should have a name badge, on that name badge is your stage name for today’s focus group. Please address one another by their stage name. Do not use real names.

d. This focus group will be audio recorded. This is a friendly setting. Everyone will get a chance to speak. Try not to talk over or interrupt one another and be mindful of the digital recorder. Please do not yell, fight or use a lot of curse words.

e. Lastly, I’d like to remind you that this focus group is confidential. I will not repeat anything you say in today’s focus group. Your parents, teachers or friends outside this group will not know what you say here today. I ask that you all respect everyone’s privacy. What is said here must stay here. And again, please do not use any real names in today’s group.

However, if you choose to tell me about any cases of abuse (physical or sexual) or report any harm to yourself or others I have to report it to the authorities. If there are any questions that make you uncomfortable, you can choose not to answer that question.

**Draw Focus Group Set Up and Place Setting**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Focus Group Question</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Part 1: Life Story</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Introduction**      | Tell me about life for girls your age.  
  *Probes if necessary:* Describe a typical day for you.  
  *Probes if necessary:* How does that compare to some of your friends?  
  *Probes if necessary:* What are some things that are going well for you right now?  
  *Probes if necessary:* What are some things that worry you all?  
  *Probes if necessary:* What is life like at home, school, if you are working, tell me about your job?                                                                                                     |
| **Success**           | I’d like to talk to you all about success. I’d like for each of you to think about someone you consider successful, tell me about this person.  
  *Probes if necessary:* What is it that makes them successful?  
  *Probes if necessary:* What does success mean to you?  
  *Probes if necessary:* Describe a successful 17-year-old woman, what about a successful 27-year-old woman. A man?  
  *Probes if necessary:* What are some ways you decide if someone is successful? What do you use to measure success? (Some measure success by the amount of money they have, cars, or nice things etc.) |
| **Part 2: Future Success and Aspirations** | The next set of questions are about your future plans. I’d like to know what you want to do after you turn 18 or finish school.                                                                                       |
| **Future Aspirations**| Now I’d like for you all to imagine yourself 3 years from now. What would you like to be doing?  
  *Probes if necessary:* Describe your plan to get there.  
  *Probes if necessary:* Has this always been your goal, or has it changed?  
  *Probes if necessary:* What are some reasons your goal has changed?  
  *Probes if necessary:* What do you think your life will be like in 10 years?  
  *Probes if necessary:* Where will you be living?  
  *Probes if necessary:* What type of job or career will you have? (location, living environment, family, friends, job)                                                                                      |
| **Future Professional**| Next, I’d like for you all to think about your future job or career. Tell me some of your career plans.  
  *Probes if necessary:* What is your dream job 10 years from now?  
  *Probes if necessary:* what is your back up job 10 years from now?  
  *Probes if necessary:* What role does college play in your future?                                                                                                                                        |
**Part 3: Past and Present Relationships**

The next few questions are about your past and present relationships. Please keep in mind this interview will remain between us. However, if you choose to tell me about any cases of physical or sexual abuse I will report it. This includes cases about statutory rape (sexual relationship between older boy and underage girl).

| Sexuality          | When did you first learn about sex?  
|--------------------|-------------------------------------|  
|                    | *Probe if necessary:* What do you remember learning about sex?  
|                    | *Probe if necessary:* Where did you learn about sex? Was it at school? At home? What did you learn from friends?  
|                    | *Probe if necessary:* What were some of the biggest questions you had, when you first learned about sex?  
|                    | *Probe if necessary:* From your understanding what is the best way to prevent getting a STD (such as the ‘Clap’ or HIV)?  
|                    | *Probe if necessary:* From your understanding what is the best way to prevent getting pregnant?  

**Part 4: Pregnancy, Motherhood and Media**

Next, I’d like to talk about pregnancy and motherhood. I’d like to hear your story about you or your friends who are pregnant or mothers. Try not to use real name, instead use a made up a name. Please keep in mind your parents, friends and teachers will know what you say today.

| Pregnancy         | Let’s talk about girls who have babies in high school.  
|-------------------|------------------------------------------------------|  
|                    | *Probe if necessary:* Can you describe what it’s like for girls who have a baby in high school?  
|                    | *Probe if necessary:* What are some reasons girls may have a baby when they are still in school?  
|                    | *Probe if necessary:* What are some reasons not to have a baby when they are still in school?  

*Future Personal*

Okay, now I’d like for you to talk about your future personal life. Can you tell me about your family ten years from now?

*Probe if necessary:* Do you see yourself with someone special?  
*Probe if necessary:* Can you describe your future partner?  
*Probe if necessary:* Do you want to get married, What do you think your wedding will be like?  
*Probe if necessary:* What role do children have in your future?  
*Probe if necessary:* When do you want to have your first child?  
When do you want to have your last child.  
*Probe if necessary:* How many children do you think about having?
### Motherhood

If you are a mother, or know a young mother, can you describe what it is like for a teen mother?

*Probe if necessary:* How do you think motherhood will change a teen moms’ educational plans?

*Probe if necessary:* How do you think motherhood will change a teen moms’ personal plans?

*Probe if necessary:* How do you think motherhood will change a teen moms’ romantic plans?

### Media

MTV has two popular television shows about teen pregnancy and motherhood. Have any of you seen ‘16 and Pregnant’ or ‘Teen Mom’?

*Probe if necessary:* What are your thoughts about ‘16 and Pregnant’?

*Probe if necessary:* How does the show compare to your thoughts about teen pregnancy?

*Probe if necessary:* What are your thoughts about ‘Teen Mom’?

*Probe if necessary:* How does the show compare to your thoughts about being a teen mother?

*Probe if necessary:* Can you tell me about any other TV shows or movies that discuss teen pregnancy or motherhood?

*Probe if necessary:* What are your thoughts about these TV shows or movies?

### Part 5: Future and Past advice

Okay, we are nearing the end of the focus group. I’d like to thank you all again for participating. I only have a few more questions. We are going talk a little more about goals for the future.

### Past Self

If you could go back and change one thing about the past related to your personal past what would it be? Why is that?

*Probe if necessary:* If you could go back and change one thing about your academic past what would it be? Why is that?

*Probe if necessary:* If you could go back and change one thing about your romantic past what would it be? Why is that?

*Probe if necessary:* Do you have any advice for your past self?

### Future Self

Is there any one thing you are excited about, or looking forward to in the future? Why is that?

*Probe if necessary:* Do you have any advice for your future self?

### Conclusion

Is there anything else you would like to tell me about being a teenager?

Is there anything else you would like to tell me about being a mother?
Ok, we are almost finished with the focus group. Our last activity is a group task. I am going to split you into groups. I am going to hand each group a work sheet and some index cards. (Split focus group into smaller groups of 3-4 people; hand each group a worksheet and index cards).

1. First, list your stage names at the top of the sheet.

2. Next, take the next 5 minutes and write down some characteristics (traits) of **successful** people in your community. Write these items in question 1. Think of your community as your neighborhood, classmates, friends and family.

3. After you have finished with question 1, write down some characteristics (traits) of **unsuccessful** people in your community. Write these items down in question 2.

4. Next, take a minute to look at the community ladder. The ‘successful’ people you described in question one are at the top of the ladder. Those you described in question 2 (unsuccessful people), are at the bottom of the ladder.

5. Using the index cards, put the cards in order from MOST important to LEAST important in helping you (the group) reach the top of the ladder. If there is something not listed in the cards, write that item on the card marked other. When you have finished put the order in question 3.

6. And finally, using the same index cards, put the cards in order using the item that is going to make it HARDEST to reach the top of the ladder. Put the item that is going to make it EASIEST at the bottom. If there is something not listed in the cards, write that item on the card marked other. When you have finished put the order in question 4.

7. Thank you, we are finished with the focus group, before you go please make sure to take a goody bag. If you have any questions or want to talk to me, I am available.
Group Handout

Group Member Names (*Use Stage Names*):

1. List some things you think describe *successful* people at the top of the ladder.

2. List some things you think describe *unsuccessful* people at the bottom of the ladder.

---

**Community Ladder**

At the top of the ladder are the people who have the highest standing in your community.

3. Rank the index cards. On the top put the item that is going to help you the MOST get to the top of the ladder. At the bottom put the item that will help you the LEAST. If there is something not listed that you think is going to help you get to the top, write it on the card marked ‘other’.

*Put the order below:*

- Graduating from high school
- Going to college or technical school
- Getting a job
- Having a baby
- Owning something costly (car, home, boat, music instrument)
- Getting married
- Going out more
- Having lots of money
- Other

4. Rank the index cards. On the top please put the item that is going to make it HARDEST to reach your top rung. At the bottom put the item that is going to make things easiest.

*Put the order below:*

- Graduating from high school
- Going to college or technical school
- Getting a job
- Having a baby
- Owning something costly (car, home, boat, music instrument)
- Getting married
- Going out more
- Having lots of money
- Other

At the bottom are the people who have the lowest standing in your community.
REFERENCES


BIOGRAPHICAL SKETCH

Evelyn received a Bachelor of Health Science in 2005 and Master of Public Health in 2007, both from the University of Florida.

Upon graduating with her master’s degree, she worked as an abstinence-only, and then a tobacco education program manager in two rural North Central Florida counties. Working at a small health department afforded her the opportunity to work closely with other public health programs including Healthy Start. Healthy Start is a service referral and coordination program that aims to improve the health of mothers and babies up to age three. During her tenure at the health department, Evelyn became increasingly aware of the prevalence and consequences of teen pregnancy. She found it especially frustrating to observe adolescent mothers and repeat mothers attending the abstinence only curriculum. She thought the current program did not address the unique needs of adolescent mothers. Evelyn’s dissertation research spun out of her experiences and interactions with adolescent mothers and repeat mothers during her work at the health department.

Following graduation, Evelyn plans to continue to investigate goal aspirations as a prevention/reduction strategy for repeat births. She is particularly interested in working with primary and secondary prevention programs to foster mentoring and success modeling to reduce rates of teen pregnancy and repeat pregnancy. Additionally, she hopes to expand her research to include 1) goal aspirations among minority populations as a method to increase high school graduation and college enrollment; and 2) improving maternal and child health outcomes among impoverished mothers.