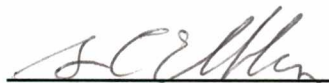


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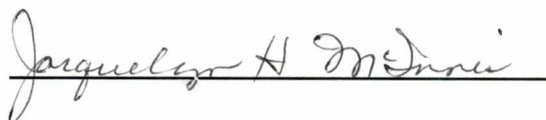
I am submitting herewith a dissertation written by Loretta Pinkard Prater entitled "Rationale for Repeat Term Pregnancy Among Black Adolescents." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Human Ecology.


Greer Fox, Major Professor

We have read this dissertation
and recommend its acceptance:







Accepted for the Council:


Vice Provost
and Dean of the Graduate School

RATIONALE FOR REPEAT TERM PREGNANCY
AMONG BLACK ADOLESCENTS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Loretta Pinkard Prater

December 1990

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This work is dedicated to the memory
of my maternal grandmother and surrogate
mother, Mrs. Lucille Wilson Pinkard.
Although she was very desirous of
educational attainments and denied those
opportunities, she instilled within me an
insatiable yearning for learning.

ACKNOWLEDGMENTS

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My family gave me the love and support much needed to complete this task. I must acknowledge the one who is the ultimate of my source of strength. Thank you God.

ABSTRACT

In recent years, there has been a large volume of quantitative research investigating teenage pregnancy. There were fewer attempts to conduct a qualitative analysis to explain this phenomenon and very little explanations regarding repeat term pregnancy. The micro level of the family systems theoretical framework was the structure for examining the deficit, decision-making, and subjective utilities models. This research used the case study approach through extensive interviews, to examine repeat term pregnancy. Data were collected from 10 participants during the course of a year. The sample consisted of black adolescents, all under the age of 19, who were either pregnant again or were non-pregnant parents of more than one child. The interview questions were derived from trends reported from prior quantitative research. Therefore, triangulation was used in combining quantitative and qualitative methods. Pattern-matching was the process used in reporting the results.

The results indicated that the deficits, believed to be associated with teenage parenting, were more in the minds of researchers than perceived by the young mothers. There seemed to be a distinct difference in how they viewed their

situation in comparison to the larger society. Decision-making was not seen as a rational process for any related activity, except to carry the baby to term and keep it. Whether or not to have sex or contracept appeared to be given little thought. Regarding the subjective utilities model, significant others in their lives patterned a life very similar to their own. Therefore, their behavior was reinforced by the influence of those in their environment.

The study provided implications for program intervention and public policy adjustments. It also provided some considerations when contemplating qualitative research with participants of similar demographic characteristics as these young women. The results indicated that more research should be devoted to explore pregnancy resolution and contraceptive decision-making. It was recommended that future research apply the symbolic interaction approach to determine the meanings adolescents, especially Black adolescents, ascribe to sexual behavior and early parenting.

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CHAPTER I

INTRODUCTION

General Background

Prior to considering adolescent pregnancy as a field of study, it was important to review some of the characteristics which tended to be associated with this particular cohort group. The period identified as adolescence was created by adults. Before the turn of the century, there was no perceived established adolescent sub-culture. In 1900, only 11% of high school aged persons were enrolled in schools(Coleman, 1961). America was basically a rural society. Therefore, the opportunity for groups of youth to congregate did not exist. Only after mandated school attendance went into effect were youth allowed to spend extended periods of time together.

Many view adolescence as a stressful period. If this concept were evaluated, one might discover that restrictions placed by society stimulated much of the ambiguity during adolescence. Society tends to set milestones to delay adulthood. Also, individuality is not considered when enforcing the rules imposed by society. The vices limiting

productivity of adolescents were created and maintained mostly by adults. For instance, many teenagers purchase alcohol and other drugs from adults. The x-rated movies are developed and marketed by adults. The adolescents today are expected to assume a lot of responsibilities. Many are attempting to balance work and school responsibilities. Numerous teenagers are burdened with debts of car payments and insurance premiums. Therefore, adolescents prematurely have responsibilities traditionally reserved for adults.

Overall, the attitude of adults has not been very favorable in relation to adolescents. Teenagers are stereotyped as being irresponsible, troublemakers, wild, and unreliable. Granted, some teens do fit that mold. Like other stereotyped groups, many do not fit that description. Unfortunately, much of the research about adolescents was conducted within a clinical setting. Therefore, the troubled teenager syndrome would be expected to surface. Teenagers who have no history of emotional problems tend to be characteristically different from those in therapy. There are many responsible individuals who happen to be younger than the adult population.

The life span of the individual is dynamic. There are changes during the period of adolescence. It is believed adolescents pass through various developmental stages which may precipitate confusion. There is a desire to establish independence. The teenager is in an ambiguous state.

Childhood is in the past and adulthood represents the future. However, there is a feeling of moving toward adulthood. Often, it is difficult for parents to accept this declaration of independence by the teenager. Therefore, family conflict is common during this period. It is important to remember that conflict is not necessarily bad. Looking into the history of this nation, we see that conflict preceded progress in many instances. The critical element in this instance is the manner in which the family handles differences during this time. In many families, adolescence is occurring at the same time middle age is for the parents. Therefore, there are a lot of changes happening within one household. It would probably be helpful if parents viewed adolescence as a developmental process, and not dread their child's growing up as one would view a plague.

Adolescents are beginning to establish their identity separate from their families. Prior to adolescence, the parents were responsible for the child. Now, the teenager discovers that he/she is responsible for his/her own actions. During the period preceding adolescence, there has been exposure to numerous attitudes, values, mores, and traditions imposed by others. In establishing the identity, it is the task of the adolescent to pick and choose among all of the environmental influences. He/she must decide the person he/she will become and by what measure to be identified.

During this period of time, peer relationships consume

a lot of time. The concept of "Push" versus "Pull" suggested the family was pushing the adolescent at the same time that the peer group was pulling (Smith, 1976). It is comforting for parents to know that research suggested that long term goals were more influenced by parents rather than peers. Present oriented situations, like clothes, music, and where to go on Saturday night were more influenced by peers (Larson, 1972). Although there may be familial conflicts regarding peer attachments, friendship serves an important function in adolescent development. Many "problem" adolescents expressed that they had no friends. Even the short term relationships tend to be better than no relationships at all.

Adolescence may also be viewed in terms of the definitions of age. Family researchers do not all agree on the definition of the chronological age span of adolescence. The developmentalist suggests that it is difficult to have a beginning and ending age to apply to all individuals. Puberty has been used as a yardstick to measure the beginning of adolescence. Biological changes indicate that the body is developing. However, these changes are not consistent chronologically with all individuals. The social age of adolescents is characterized by interaction with members of the opposite sex. Many adolescents begin dating during this period. Some adolescents also experience affectional relationships beyond friendship. Some of these ties are very intense and are identified as love. Another type of age is

mental age. The older adolescent is expected to be in the process of making some plans for a future career or vocation.

Education is a focus during this period. There are some intellectually superior adolescents who could make significant contributions to society now, if given the opportunity. When there is incongruency among or between age definitions, problems usually occur. For instance, a young lady 13 years of age may have the biological appearance of a woman. When this happens, she may be approached by much older men. Cognitively, she may not have the skills to interpret their attraction to her. Junior high school students are deficient in their ability to make valid generalizations, use symbols, to process information with objectivity and engage in formal reasoning (Hamburg, 1986; Peterson & Crockett, 1986). This may partly explain the situation of older men dating and fathering babies of teenagers.

The developmental stage which is of interest in this investigation was the sexual development and socialization of the adolescent. Teenage sexuality and pregnancy is currently a hot topic. It is being recognized that more "nice" girls are becoming sexually active. There are a number of groups and individuals with strong opinions, ideas, and views concerning this topic. Therefore, this issue is very controversial and sensitive.

The root of the concern regarding premarital sexual behavior of adolescents appears to go beyond moral issues.

Pregnancy and pregnancy resolution issues, such as abortion, demand most of the attention. Americans can no longer disregard the fact that every day more than 3,000 girls become pregnant in this country (Alan Guttmacher Institute, 1981). Voluntary pregnancy termination is among historical accounts of illegal actions of society. After the Supreme Court ruled in 1973 that abortion could not be outlawed, the number of persons seeking abortions increased. Nearly 40% of all teenage pregnancies are voluntarily terminated (Hayes, 1987). The "right to life" movement keeps the abortion controversy alive. Another concern, is the act of repeated abortions. In this situation, it appears that there was no attempt to abstain or contracept and that abortion was used as a primary contraceptive.

Contraceptives are readily available in most communities. Of course, there are "over the counter" devices and preparations which teenagers may purchase. However, most health clinics offer free family planning counseling and contraceptives to adolescents. Parents are not informed that their child is a clinic patient. The "squeal rule" attempted to mandate that health clinics had to notify the parents. This did not pass because the lawmakers felt that such a ruling would increase the abortion and teen birth statistics. There was a fear that many adolescents currently getting birth control, without parental knowledge, would discontinue use of the clinic's services if parents were notified. However,

informing parents would not necessarily cause adolescents to cease their sexual activity.

Teaching of sex education and defining the curriculum have stirred more dissension (Fantina, 1983). Less than 1% of parents refused permission for their adolescents to participate in sex education programs (Scales, 1981). Also, according to a 1985 Gallup Poll, the majority of Americans felt that sex education should be taught in the elementary grades. It appears that opposition to the teaching of sex education originates from a few very vocal individuals. The "silent majority" is supportive of sex education as part of the school curriculum.

Adolescents have limited knowledge of facts regarding sexuality. However, they believe in myths. Teenagers probably have a higher perception of the sexual activities of their peers than actually exists. All teenagers are not sexually active. However, there is a tendency for teenage virgins to assume that their situation is unique. Out of 29 million teenagers, about 7 million males and 5 million females are sexually active. Among those who are unmarried and aged 13-14, 18% of males and 6% of females are sexually active. Unmarried and aged 15-19, 56% of males and 41% of females are sexually active (Alan Guttmacher Institute, 1981). The report that young people are having their first sexual experience at younger ages (Zelnik, Kim, & Kantner, 1979), further explains the youth's lack of knowledge about sexuality.

There are other myths concerning pregnancy precautions. These beliefs, including instructions that one cannot get pregnant while standing, are accepted by some as facts. Teenagers confuse love with sexual attraction. Many attempt to act out romantic scenes from movies or television programs. It is interesting that one study reported that sexually active teenagers watched an average of 20 hours of television weekly in comparison to 14 hours viewed by their inactive cohorts. Also, the avid television watchers reported that they believed the portrayals on the screen represented real life (Hamburg, 1986).

Our society is constantly changing. The environment is not static. Therefore, evidence of these shifts will be seen in all aspects of life. Sexuality is no exception. Society is currently involved in what has been described as a sexual revolution. Attitudes toward sex before marriage have become increasingly liberal and the traditional standard of males and females confining sex to marriage has become decreasingly popular (Fox, 1986). It appears that three trends have surfaced as a precipitant of the revolution. More liberal sexual norms for both men and women; more acceptance of self-determination by women in sexual and other matters; and more acceptance of variations in family patterns are integral parts of social change. Emphasis on sex seems to permeate all areas of society. There is no escape. For instance, it is not uncommon to view a television commercial featuring a

subtle mention of sex. If a manufacturer is trying to sell a car, a beautiful woman in a bathing suit may be stretched out across the hood. Tooth paste commercials stress the value of having a sexy smile. Clothing commercials can be very suggestive, especially advertisements for blue jeans. Afternoon television viewing is consumed with "love in the afternoon". In the past, economic depression was accompanied by modesty, more emphasis on morals, and traditional values. Presently, that does not appear to be the case. Possibly, the media has an effect on the reluctance to return to more traditional sexual beliefs. It is believed that in the course of a year, the average viewer sees thousands of scenes of suggested sexual intercourse on prime-time TV.

Years ago, adoption and marriage were considered viable options for pregnancy resolution. Recent statistics indicate that of the teenagers who gave birth, the majority kept their babies. In 1982 it was estimated that of the roughly 261,000 teenagers who gave birth without marriage, 249,000 became single parents while the others resorted to adoption (Hayes, 1987). Marriage was more common among pregnant teenagers in former years. The "shotgun" wedding was the method many adolescents used to resolve the early premature pregnancy situation. Abortion, a present day alternative to pregnancy related marriage, was not legal. Therefore, many couples were coerced into legitimizing the baby through matrimony.

Another important issue concerns the impact of teenage

pregnancy on the family. The family is a system with components which mesh as well as compliment each other. Therefore, any change in the system has a dynamic impact on other elements of the family unit. Teenage pregnancy may cause families to experience a crisis, based on the uniqueness of that family's situation. Of much concern is the role of the family in pregnancy resolution.

Previously, a severe stigma was attached to premarital pregnancy. The family and the girl tried to hide or deny the situation. When Ingrid Bergman became pregnant, without the benefit of marriage, she was banished from Hollywood. Currently, popular entertainers parade the fact of their "without marriage" parenthood status. This tends to glamorize premarital pregnancy. The contemporary woman may decide that she wants to be a mother, but does not invite the combined role of the traditional wife and mother. An increase in the availability of day care facilities makes motherhood more attractive for the career woman.

Culturally, there are some consistent findings related to adolescent sexuality and pregnancy. The United States leads the developed nations in its incidence of pregnancy among girls between the ages of 15 and 19 (Jones, et. al., 1985). Some may feel that this indicated that American teenagers were more sexually active than teens in other countries. However, that is not the case. The difference in the pregnancy rate tends to be related to the fact that

countries with low adolescent pregnancy rates teach their youth about contraceptives (Jones, et. al., 1985). Research indicates that only about one in three sexually active American girls between the ages of 15 and 19 use contraceptives (Zelnik & Kantner, 1979). In many countries, sexual development is viewed as a normal and anticipated stage of human development for youth. Our culture separates sexual development from other stages of growth.

Adolescents need information about sex. Parents can be effective educators of sexuality. In fact, adolescents indicate that they prefer that parents are their major source of information about sexuality. In most families, parents may respond to questions, but rarely initiate conversations about sex. Also, research indicated that fathers were especially avoiding of discussions about sex (Thornburg, 1981). Even for sons, mothers were the primary sex educators in homes where there was instruction. If parents are to effectively communicate on this topic, it is important that they employ honesty, patience, and a listening posture.

There tend to be some barriers to teenagers talking to their parents about sex. Adolescents indicate that many parents condemned them for even inquiring. It is easier for parents to use the "ostrich" approach and believe that their youth are not interested in sex. Many adolescents risk implications of guilt by inquiring about sex. Youth may not talk to parents rather than submit to possible scrutiny.

Parents tend to act embarrassed when answering questions about sex (Winchester, 1983). Adults are more sensitive to certain issues than others. Masturbation tends to be one of the issues parents avoid. However, masturbation is considered to be the most common form of sexual expression by Americans over the life span. If parents are uncomfortable with an issue, the first thing they should do is to merely discuss their feelings with their children, rather than to reprimand the child for asking. Another difficulty parents experience is the reality that their child is maturing. It is not easy for parents to perceive their children as sexual beings. Also, adolescents may have difficulty viewing their parents as sexual beings. This is a reflection of the sexual environment found within the home.

Adolescents who live in poverty are considered to be at risk for sexual involvement and a subsequent pregnancy. One implication is that there are few motivators for not getting pregnant. Alternatives for involvement in "wholesome" activities are limited. Also, many youth of poverty do not see themselves as having an internal locus of control. Fatalism tends to rule their thinking. They may view themselves as mere victims of the environment. Many look at their family situations and see teen pregnancy as the norm. For instance, research has indicated that a high percentage of girls who give birth at age 15 or younger were daughters of teenage mothers (Alan Guttmacher Institute, 1981).

Research has consistently reported that a high percentage of black adolescents were sexually active and became parents prematurely. Related to the incidence of poverty, only 6% of American black families are considered to be middle class (Glasgow, 1980). Single parenting, an indicator of lower financial status, is very common among the black community. In many ghetto areas, husbands are rarely present in the households. Black women seeking husbands discover that the pool of eligibles is low. There are many factors used to explain why 48% of all black families are headed by women. A large number of black men were unemployed, incarcerated, or died at an early age. Mortality rates among black men between the ages of 15 and 30 were three times higher than for their white cohorts (Staples, 1986). Therefore, it becomes more apparent why the pool of eligible black men is limited.

Society has responded to the concerns of adolescent pregnancy by establishing various forms of programs, including workshops and seminars for parents. There are programs which are school, church, and community, and state initiated. In school classrooms, teenage sexuality may be taught through home economics, health, and science classes. There is much variety in the course content and delivery system among these programs. It is important that churches no longer ignore this problem. The research has indicated that there tends to be a lower incidence of teen pregnancy among those individuals reporting that they were regular in church attendance (Moore

& Caldwell, 1976). Community based programs may be numerous, depending on funding. One concern of these programs is that there is a need for more communication among agencies. Instead of "reinventing the wheel", it appears to be more productive if more focus was on the coordination of efforts. Some states have initiated programs. One such current program is in the state of Ohio. The Ohio grads program is focused on assisting the pregnant and parenting teenager to remain in school and prepare for future employment. It is also concerned with teaching parenting skills.

The epidemic of teenage pregnancy affects the nation as a whole. America has always been motivated to seek excellence. Resources for potential greatness are being sacrificed because of early involvement with sexual experimentation. No longer can individuals ignore the problem because they feel that they are not personally touched. Teenage pregnancy affects everyone, indirectly or directly. It is the problem of every American.

Statement of the Problem

Teenage pregnancy has been a focus of research and community concerns in recent years. It is estimated that one million teens will become pregnant this year. The occurrence of teen pregnancies has ramifications which extend beyond the immediate crisis which the individual and her family may experience. The impact on the life of the baby, the adolescent father, and his family is also of concern. Although adolescent pregnancy is not unique to this era, premature parenting has surfaced as one of the major social problems today. The increasing numbers involved and implications for present and future quality of life, affecting all of society, motivate concerns for preventive measures. A single out-of-wedlock pregnancy for an adolescent is of concern. However, the increasing occurrences of repeat pregnancy among teenage mothers compound circumstances which may create and nurture, throughout the life-cycle, a disadvantaged lifestyle for the mother and children. The problem is especially prevalent in the black community. Black teenagers are at greater risk of nonmarital pregnancy than whites because proportionately more Black adolescents are sexually active, fewer are married, more are sexually active at a young age, and they are less likely to practice contraception (Hayes, 1987).

Objectives

The following objectives were pursued in this study:

1. To determine the validity of previously identified psychosocial predictors of repeat pregnancy.
2. To determine if adolescent victims of repeat pregnancy intentionally sought this status.
3. To determine if insufficient support resources contributed to the repeat pregnancy.
4. To determine if client identified factors, which precipitated the initial pregnancy, parallel those of the repeat pregnancy.
5. To develop a framework, based on research findings, for a program to deter repeat pregnancies of adolescent mothers.
6. To develop a composite identifying the characteristics of young adolescent women who are parenting more than one child.

Assumptions

1. Intervention can help to curb the incidence of repeat pregnancies.

2. Repeat pregnancy is an unwanted occurrence for most adolescent parents.
3. There are some established predictors of repeat pregnancy which tend to identify mothers at risk.
4. Explanations for repeat adolescent pregnancy are the same as those for the initial pregnancy.
5. Adolescent mothers lack sufficient knowledge and understanding of contraceptives.

Conceptual Framework

The pregnant adolescent is not an independent entity. There are a number of factors, influences, attitudes, and situations impacting this young woman. Therefore, the systems approach was the conceptual framework used in this study. The home, school, community, and attitudes and policies of society were variables to be considered. Within a system, the elements are in a consistent interactional relationship. Therefore, no element in the system acts independently. There are dynamics within the system and any change in one element causes a change in other parts. The basic element within the system is the pregnant individual. One of the aims of this system is to reach established goals. In this study, the ultimate goal was to avoid a repeat pregnancy.

The eco-systemic approach organizes this conceptual framework into the microsystem, mesosystem, exosystem, and macrosystem. These concepts, as described by Bronfenbrenner (1977) are as follows:

- (a) The microsystem is a pattern of activities, roles, and personal interrelations experienced by the developing person in a given setting. A setting is defined as a place with particular physical features in which the participants engage in particular activities in particular roles for particular periods of time.
- (b) The mesosystem comprises the interrelation among two or more settings in which the developing person participates.
- (c) The exosystem is an extension of the mesosystem embracing other specific social structures, both formal and informal, that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which that person is found, and thereby influence, delimit, or even determine what goes on there.
- (d) The macrosystem refers to the belief systems underlying a culture as well as attitudes and traditions. It includes the economic, social, educational, legal, and political systems operating within a given culture.

Nominal Definitions

It was important that the reader and author have the same understanding of terms. Nominal definitions clarified the author's view of specific concepts.

1. Adolescence referred to a period of time between the age of becoming fecund through 19 years old. Although few in number, there are some young women who experience prenuptial pregnancy before becoming a teenager. These young women were included in considerations referring to adolescent pregnancy.
2. Repeat pregnancy referred to a situation in which a female adolescent had experienced a previous pregnancy.
3. Subsequent pregnancy was understood as having the same meaning as repeat pregnancy.
4. Rapid repeat pregnancy referred to an interval of within 24 months.
5. Knowledge of contraceptives was a term used to describe the level of understanding the adolescent had concerning available contraceptives and the potential for preventing additional pregnancies.
6. Rationale referred to the reasons cited for

specified behavior.

7. The terms client, respondent, and participant all were used to identify an adolescent mother who agreed to be interviewed for this project.

CHAPTER II

REVIEW OF THE LITERATURE

There is a vast amount of literature addressing the issue of adolescent pregnancy. Most of the previous research focused on the initial birth and not on subsequent pregnancies. The more immediate concern of this dissertation was to investigate the prevalence of rapid repeat pregnancy among adolescents. The research efforts were confined to a population of Black adolescents. Research literature specifically related to pregnancy among the general population of adolescents, pregnancy among Black adolescents, and the repeat of that behavior were more closely analyzed.

Although there may be many factors related to premarital adolescent pregnancy, the one universal identifying factor is that adolescent pregnancy results from an act of unprotected sexual intercourse. All of the many reasons given, singly or combined, do not produce pregnancy (Phipps-Yonas, 1980). The circumstances which led to first pregnancies, if unchanged, tend to lead to repeated pregnancies (Dempsey, 1970). Hence, the primary unit of concern was the individual or the micro level of the systems framework. This chapter will explore the interrelationships between the individual and the environment.

To meet the objectives of the review, models used by family scientists, in exploring the behavior of the individual, served as a basis for discussion.

For clarity of discussion, the chapter was divided into four parts. The first three parts will explain initial and subsequent adolescent pregnancy in relation to the Deficit, Decision-making and Subjective Utilities models. These models have been used throughout the literature as a framework for reporting adolescent pregnancy. For each model, the general population of adolescents will be discussed, followed with information specific to Black adolescents and repeat pregnancy. The fourth part will serve as an overview of previously established programs to curtail adolescent repeat pregnancy. The program components will be examined according to the relationship to concepts found within the Deficit, Decision-making, and Subjective Utilities models. The objective of reviewing existing programs was to suggest components of an ideal intervention strategy to prevent or retard the pace of rapid subsequent pregnancies among teenagers.

The Deficit Model

The Deficit Model proposes that specific circumstances prove to be detrimental to the well-being of the individual. In examining adolescent pregnancy, the assumption is that this

situation presents "problems" for the individuals involved. Teenage pregnancy is viewed as being more costly than rewarding. Research has substantiated consequences which allow us to predict, with some accuracy, the future lifestyle and well-being of a significant number of pregnant and parenting adolescent females. Campbell (1968) asserted that 90% of the life script was written for the adolescent who became a mother. Adolescent parents are viewed as disadvantaged in regards to health, education, income, and family structure. Klein (1974) reported that younger adolescent mothers exhibited a "syndrome of failure". This syndrome included failure to fulfill the functions of adolescence, failure to remain in school, failure to limit family size, failure to establish stable families, failure to be self-supporting, and failure to have healthy infants.

Health

Because many female adolescents have a tendency to be nutritionally unsound and their bodies are changing in response to puberty, the addition of a pregnancy complicates matters. Early childbearing may adversely affect the health of mothers and infants (Moore, 1985 & Wallis, 1985). Adolescents experience more problems with pregnancy than women in their twenties, it is supposed. These problems range from excessive weight gain to maternal mortality and include

anemia, nutritional deficiencies, toxemia, prolonged or abrupt labor, and caesarean sections (Hamburg, 1986). Negative obstetrical outcomes were greater among non-white, low socioeconomic groups (Hamburg, 1986), and teenagers less than 15 years old (Geronimus, 1987). This concern is complicated by the fact that adolescents are becoming fecund at earlier ages in comparison to adolescents of the past. Girls generally reach menarche at any time between the ages of 10 and 17, with 12.5 being the average age (Chilman, 1979).

In addition to the concern with the mother's health is the fact that the baby may also be disadvantaged. Babies born to teenagers are two to three times more likely to die in their first year of life than babies born to women in their twenties. Related reports state that a high percentage of low birth rate babies are born to teenage mothers (Beyer, 1983; Garn, Pesick, & Petzoid, 1986). Other negative outcomes evidenced by infants born to teenage mothers included prematurity, congenital malformations, neurological defects, perinatal mortality and childhood growth failure (Hamburg, 1986). These babies have physical and mental health problems that may be continuous, even for those who survive. Unfortunately, during the critical first trimester of pregnancy, many teenagers are experiencing a state of confusion and are without medical assistance.

The mental health status of adolescent mothers has been examined by some researchers. It is hypothesized that the

task imposed by motherhood increases the turmoil of adolescence (Atkins, Protinsky, & Sporakowski, 1982), adding to the already pressing responsibilities of this period of life. This stress is evidenced in various ways. Of major concern is the fact that nine percent of teenage mothers attempt suicide (Beyer, 1983; Polley, 1979). The transition to parenthood can be a challenge for adults, considering most individuals do not experience anticipatory socialization for parenting. The reality of parenthood, with its many demands, may be a culturally shocking experience for a teenage parent.

Education

Research is consistent that education of the adolescent is hindered by pregnancy (Furstenburg, 1972, 1976, ; Hayes, 1987 ; Klein, 1974; Mott & Marsiglio, 1985). Young women who give birth while in junior high or senior high school complete an average fewer years of school, were less likely to earn a high school diploma, and were less likely to go on to college and graduate school than those who delay childbearing until their twenties (Hayes, 1987). This curtailment of education is viewed as the most far-reaching consequence of teen pregnancy (Finkel & Finkel, 1983).

Income

Education has been used as a vehicle to escape poverty. In our culture, the status of poverty is reserved for those with little money. Teenage parents have little success in locating jobs which provide an adequate and secure income. They lack sufficient training to possess skills being sought by employers. The single female parent is the fastest growing poverty group in America today (Moore & Burt, 1982). Delaying the first birth may be the single most important way of breaking out of the cycle of poverty (Morris, 1981). For those who cannot get economic support from a job, their families, or the father of the baby, Aide to Families of Dependent Children (AFDC or welfare) is their major source of income. The welfare roles are significantly filled with single women who first gave birth as teenagers.

Teenage fathers do not escape the situation of lower educational attainment and subsequent job status. Research indicates that men who became fathers during adolescence had lower income earnings than men in their age group who delayed parenthood (Card & Wise, 1978). Of course, many variables would intervene in this situation. One important variable would be the amount of participation and commitment the unmarried teenage father assumes toward the support of the baby. Some adolescent males drop out of school and seek employment, in an effort to fulfill the role of husband and

father. Lack of a high school education limits job opportunities. In the past, many young men in this situation could volunteer for the armed services. Today, a high school education is required for entrance into military service.

Teenage pregnancy is costly to society. In Illinois, state officials calculated that teenage pregnancy cost \$853 million in medical care, day care, welfare, and other social programs in one year. It has been estimated that the United States spends 8.6 billion on income support for teenagers who are pregnant, or who have given birth (Wallis, 1985). Receiving such payments is not found to be a conscious incentive for adolescents to parent outside of marriage (Finkel & Finkel, 1983; Moore, 1985). In fact, being an unwed mother is viewed as a temporary status, since many adolescents perceive that the baby's father will eventually marry them (Scott, 1983).

Family Structure (Family of Orientation)

A female headed family of orientation is a familiar family pattern for many pregnant teenagers (Moore & Burt, 1982). According to a study by Klein (1974), 61% of pregnant teenagers lived in female headed households. This situation may be viewed as dysfunctional in relation to delaying pregnancy. Corroborating that belief, Kantner and Zelnik (1973) reported that girls from father-headed households had

the lowest incidence of premarital sexual activity. Adding to this evidence, Zonker (1977) indicated that two factors, the absence of a male authority figure and reduced parental control, may impact significantly the development and behavior of adolescent girls, providing impetus and opportunity for risky sexual activity. This is a psychoanalytic view which concludes that deprivation of a male parental relationship within the family impels a daughter toward seeking compensatory masculine attention, as through sexual behavior. On a more positive note, Fox and Inazu (1980) reported that mothers who are heads of households were more likely than mothers in male-headed homes to talk frequently with daughters about sex. If a strong mother-daughter bond existed there, adolescent pregnancy was lower (Fox, 1979). It is assumed that this more open communication pattern could diffuse the negative impact of father absence.

Two of the more popular motivational explanations for teenage pregnancy are couched in terms of family system deficits: namely that teens have babies in order to have someone to love, to relate to, to care for, and to compensate for their family's lack of attention to them. The other version is that teens have babies in order to break away, establish their own independence, and force a renegotiation of their relationship with their parents (Fox, 1981).

Family Structure (Family of Procreation)

The completed family of procreation for teenage mothers tends to be larger in comparison to women who postpone motherhood (Moore & Hofferth, 1978). The younger a female is at her first pregnancy, the more children she will have and the closer spaced they will be (Ford, 1983; Klein, 1974; Phipps-Yonas, 1980). Naturally, this places more financial obligations on the parent who assumes the caregiving responsibilities.

Marriage does not appear to be the solution to the problem of a premarital pregnancy for adolescents. Statistics indicate a low probability of marital success for these couples (Card & Wise, 1978; Furstenberg, 1976; Moore & Burt, 1982). In comparison to past times, marriage is not necessarily the natural solution to an early pregnancy.

Repeat Pregnancy

To avoid a repeat pregnancy, it is important to continue schooling. Furstenberg and colleagues (1972) reported that women who returned to school immediately following the delivery of their first child were much less likely to experience a second conception in the 12 month period after the birth of their child. Otherwise they fall into the category of the 17% of all teenage mothers who experience a

second pregnancy within the 12 month time period after the birth of the first child (Ford, 1983). Single mothers with low educational ambitions are more than three times likely to become pregnant again within two years of delivery as their peers who had high educational ambitions during pregnancy (Furstenberg, 1976). Phipps-Yonas (1980) characterized repeaters as having poor academic records and facing the likelihood of dropping out of school. As reported earlier, marriage is rarely the lasting solution when an unwanted pregnancy occurs. According to several studies, marriage affects the rate of repeat pregnancy (Furstenberg, Masnick, & Ricketts, 1972; Klein, 1974; McLaughlin, Grady, Billy, Landale & Winges, 1986; Mott, 1986). Adolescent women who legitimate a premarital conception have the most rapid pace of subsequent fertility. Although marriage may be a good predictor of a second pregnancy, a second pregnancy is not a good predictor of marriage. Gispert, Brinich, Wheeler, and Krieger (1984) found that 83 percent of the adolescents in their study, who became pregnant more than once, did not marry.

Older girls are more likely than younger girls to have sufficient cognitive and psychosocial maturity as well as the appropriate knowledge and experience to function as an adequate parent (Peterson & Crockett, 1986). Unfortunately, the younger adolescents are at a higher risk for a repeat pregnancy. Unmarried women who first gave birth at ages 16 or younger are more likely to bear a second child within the next

two years (26%) than are women who have their first child at ages 17-18 (20%) or at ages 19-22 where 22 percent repeat pregnancy (Mott, 1986). Findings of a New Haven study (Sarrel & Davis, 1988) indicated that in a follow-up of 100 unmarried pregnant women after a period of nine years, only 5 had not repeated pregnancy. Furstenberg (1976) found that 67% of a group of 404 teenage mothers had at least 1 additional child within a five year period. Significant findings by Keeve (1969) indicated that 60% of his sample of girls who delivered before age 17 were pregnant again by age 19. Hutton's data (1968) revealed that more than 8% of his sample of 113 teenage mothers were pregnant again within 6 months after delivery. The prevalence of short birth intervals among young mothers signals further strain on the life circumstances of these young women (Coombs & Freedman, 1970; Bumpass, Rindfuss, & Janosik, 1978).

Black Adolescents

The rate of teenage pregnancy is a concern of all racial groups. However, it appears to be an "out of control" epidemic in the Black community. At the end of the 1950's, only 15% of all births were to unwed Black women. By 1978, the percentage had grown to 53 percent. Significantly, during the twenty-year span from 1947-1967, births to unwed Black women increased 106.3 percent. More strikingly, in 1978, 83

percent of the births to Black teenagers were to unmarried adolescents (Franklin, 1987). The pregnancy rate among Black teenagers ages 15 to 19 is almost twice what it is among whites. In 1980, 48 percent of the first births among Blacks occurred to women under 20, compared to 25 percent for whites (Blinn, 1988). One in four Black 17 year olds has been pregnant, compared to one in 10 whites in the same age category (Moore, 1985). Nearly half of Black females in the United States are pregnant by age 20. Ninety percent of the babies born to blacks in this age group are born out of wedlock (Wallis, 1985). In fact, 55 percent of all black births occur out of wedlock to young Black mothers (Bell-Scott & McKenry, 1986). Because black teens are more likely to be sexually active and less likely to employ contraceptives, they are considerably more likely to become pregnant (Moore, 1985; Mott, 1986).

Early pregnancy compounds the already dismal picture painted of Black adolescents. Such factors as having to drop out of school, supporting the child, hurting one's family, etc. are very real for these girls and most of them struggle with these issues (Ladner, 1971). According to Chilman (1979), Black youth were in a far less advantageous position than other youth. On the average they and their parents had less education, lower incomes, and more unemployment. In fact, Black adolescents have one of the highest unemployment rates of any demographic group in the United States (Bell-

Scott & McKenry, 1986). The authors further reported that 33 percent of Black families lived in poverty with 70 percent of these families headed by females. It is not surprising that Chilman (1979) found them to be more pessimistic about their immediate and future prospects and more dissatisfied with society. Minority youth were also described as more likely, as a group, to espouse increased sexual freedom, to doubt the viability of marriage, and to accept having children out of wedlock.

The Decision-Making Model

For an adolescent to become a parent, it is assumed that there was a decision to engage in sexual relationships, a decision to disregard contraception, and a decision to carry the baby to term, among other choices. There are alternatives in any decision making process. The structure of this process is to identify a problem, list alternatives, consider the pros and cons of each alternative, select a path, and accept responsibility for that decision. It is still uncertain whether some adolescents make decisions regarding sexual behavior or merely allow circumstances to dictate actions.

Decision-Making and Sexual Behavior

Kantner and Zelnik (1973) found that nearly one out of five 15 year old girls admitted having intercourse, as did nearly a third of the 16 year olds and 43% of the 17 year olds (Wallis, 1985). According to research, there are no effective methods of reducing sexual activity among sexually active adults and there are no effective methods found to reduce sexual activity among teenagers with sexual experience (Klein, 1974).

Research has provided explanations for a female adolescent's decision to sacrifice virginity. Seeking pleasure through intercourse did not appear as a motivator for female adolescents to engage in sex. Actually, many reported receiving minimal pleasure during intercourse. They primarily engaged in intercourse because they didn't want to hurt the male's feelings, damage his pride, or because he expected it (Barglow, Bornstein, Exum, Wright, & Visotsky, 1968).

The sexual behavior of the adolescent may be decided by peers. If the peer culture dictates sex, most adolescents will comply (Franklin, 1987). In initiating sexual activity, curiosity, social and/or peer pressures are dominant factors (Franklin, 1987; Scott, 1983).

Most teenagers do not have intercourse frequently, Data for 1979 indicate that four in ten of those who had ever had sex did not have intercourse during the previous month; only

one in five had sex on six or more occasions. Of the 700 adolescents surveyed by Phipps-Yonas (1980) to see why they didn't use contraceptives, 23% said that they had not expected to have intercourse. When sexual encounters were episodic and unanticipated, passion was likely to triumph over reason (Kantner & Zelnik, 1973). Young single girls have difficulty in understanding that the pill must be taken continuously, although they may have sexual experiences at irregular intervals. Therefore, they are faced with the choice of taking the pills when they perceive they do not need them, or deferring sexual activity until they are fully protected (Furstenberg, Masnick, & Ricketts, 1972). It is unfortunate that the "one-night stands" are the most likely to produce an unwanted pregnancy (Phipps-Yonas, 1980).

Decision-Making and Contraception

For the majority of teens who have sex more or less regularly, the probability of pregnancy rests on their fecundity and their use of contraception (Moore, 1985). A sexually active teenagers chances of becoming pregnant during a month is one in seven. Over the course of a year, if no contraception is used, the chances of becoming pregnant are as high as 85-90% (Ashdown-Sharp, 1977). There are some other time variables to consider. Irregularity of intercourse is not effective protection from pregnancy. For instance, coitus

once a month, at random within the menstrual cycle and without protection, would result in a pregnancy rate roughly equal to that associated with intercourse two or three times a week, with contraception at a 90% level of effectiveness (Tietze, 1974). Some researchers believed that the condom was the most appropriate birth control method for the infrequent, sporadic type of sexual activity reported by teenagers (Clark, Zabin, & Hardy, 1984).

Although one-third of the women who seek contraceptive services at clinics are teenagers, many sexually active teenagers are not protecting themselves. Of those who do take preventive measures, persuasion by one's partner emerges as the most powerful influence (Franklin, 1987), with withdrawal being the method most often used during first intercourse. Research indicated that of the sexually active 15 to 19 year-olds, 53% failed to use any kind of contraception the last time they had intercourse. Among the youngest group, those aged 15, the figure reached 71% (Kantner & Zelnik, 1973). On the average, teens waited 12 months after they were sexually active to seek contraception. By this time, pregnancy was a reality for many, considering that 50% of teen pregnancies occurred during the first six months of sexual activity (Wallis, 1985; Zabin, Kantner, & Zelnick, 1979). This attitude toward contraception seems puzzling in view of reports which indicate that most teenage pregnancies and births are "unplanned", and usually, fewer than a third of

respondents intended to become pregnant (Scott, 1983). Of all women aged 15-19 who were exposed to the risk of unintended pregnancy, 48 percent used a prescription method. The rest used either a non-prescription method or no method (Orr, 1984).

The belief that "nice girls" don't is related to the low contraceptive use of teenagers. Some youth perceive that the use of contraceptives indicates the preplanning of sexual involvement. A "nice girl" may be swept away with passion, but not leave home planning to have intercourse. The "nice girl" construct, according to Fox (1981), required that a woman be irresponsible sexually with regard to contraceptive use.

Some research has indicated that peers are more likely an influential source of contraceptive information and use than parents (Thompson & Spanier, 1978). However, the impact of parents regarding this decision should not be discounted. Other research has indicated that regular use of contraception of young mothers was associated with a positive relationship between the girls and their mothers and with the presence of the girls' fathers in the home (Gispert, Brinich, Wheeler, & Krieger, 1984).

The attitudes of obstetricians and gynecologists impact contraceptive behavior of teenagers. A majority of doctors are willing to prescribe contraceptive methods to adolescent women. However, only 59% are willing to serve unmarried

minors without parental consent. Therefore, most adolescents will not go to a private physician for this service. The fear of physicians telling their parents and the expense of private care are reasons cited (Orr, 1984).

Although most teenagers did not plan to get pregnant, there are some who planned the event. These adolescents, male and female, decided against contraception because they desired parenthood as a passage into adulthood. Many young ladies are enthusiastic about pregnancy because motherhood is highly valued throughout society (Inerchen, 1986). This factor is among those considered for adolescents seeking pregnancy. According to Cattanach (1976) and Phipps-Yonas (1980), other reasons given were (1) to attempt to escape an unpleasant situation at home; (2) to get even with the parents; (3) to get away from school which they disliked; (4) to trap a mate; (5) to create a captive love; (6) to receive recognition from authority figures; (7) to prove womanhood and achievement; (8) to receive dollars for delivery; and (9) to compete with the mother.

Decision-Making and Pregnancy Resolution

Adolescents who carry their baby to term or more likely to have discussed pregnancy resolution with parents than or those who decide on abortion. Peers are also involved in this decision. Term girls reported a greater number of friends who

had babies and abortion candidates mentioned a greater proportion of friends who had abortions (Gispert & Falk, 1976). A number of pregnant adolescents select abortion clinic services as an alternative to parenting. More than one million teenagers become pregnant every year. Of that number, approximately 325,000 pregnancies are terminated through abortion, 100,000 end in miscarriage, and the remainder are carried to term (Evans, Selstad, & Welcher, 1976; Schinke, Gilchrist & Small, 1979). About 30% of all abortions are performed on teenagers. Abortion patients are more likely to come from intact families, have fewer siblings, have a higher socioeconomic status, and more education than term clients (Olson, 1980). Many poor pregnant adolescents simply cannot afford abortion (Wallis, 1985). Some may wonder if abortion is considered as a birth control procedure. Research indicates that those who have abortions do not come to rely on the procedure as a method of contraception (Evans, Selstad, & Welcher, 1976; Kantner & Zelnik, 1973; Steinhoff, Smith, Palmore, Diamond & Chung, 1979).

More teenagers are keeping their babies as opposed to giving them up for adoption. In fact, approximately 97% of unmarried pregnant teenagers, carrying their babies to term, will decide to keep the baby (Colletta, 1983). There are speculations concerning the motivation for this decision. Vincent (1960) found that unwed mothers who kept their babies

manifested a need to have someone dependent upon them who made it safe for them to receive and return love.

Decision to Repeat

It is proposed that some teenagers make a rational decision to become pregnant again soon after the index pregnancy. Young mothers who wanted their first child at the time of conception were generally more likely to repeat than were mothers whose first births were unwanted (Mott, 1986). Twenty percent of teenagers who became pregnant in the year following their first birth planned the second pregnancy (Ford, 1983). The sexual behavior of many of the other 80% suggested that they were not consciously avoiding a repeat pregnancy. Unless these young mothers begin to practice effective contraception, they are likely to experience a second pregnancy soon after the first, especially since many of these adolescents return to having sexual relations prior to their six-weeks postpartum checkup (Furstenberg, Masnick, & Ricketts, 1972). An analysis of data from the National Survey of Family Growth found that 82% of sexually active teenage mothers were using contraceptives in the year following the birth of their first child. The majority of those who practiced contraception used the pill (Ford, 1976). However, if there was a belief that the pill is unsafe,

unmarried adolescents will act consistently with that belief (Kantner & Zelnick, 1973).

A significantly large number of single adolescents who had already delivered gave as a reason for becoming pregnant again as the lack of convenient availability of contraception (Evans, Selstad, & Welcher, 1976; Inerchen, 1986). Among a sample of 102 teenage mothers, Inerchen (1986) found that only two-thirds had ever used contraception, although only a quarter of the pregnancies were planned. Some of the reasons for not taking the pill were they forgot it, had not started back after taking a break, just didn't like them, and encountered unpleasant side-effects like weight loss, depression, stopped menstrual cycles, backaches and nausea. Parental support of contraception plays a more important role in preventing repeat pregnancies than does the adolescents' reported attitudes toward contraception (Gispert, Brinich, Wheeler, & Krieger, 1984).

Some repeat pregnancies end in repeat abortions. Repeat abortions account for approximately half of subsequent pregnancy experience within five years after a first induced abortion (Steinhoff, Smith, Palmore, Diamond & Chung, 1979).

Black Adolescents

Black female youth tend to initiate their sexual careers at an average age of 15.6 years (Franklin, 1987). Because

Black teens are more likely to be sexually active and less likely to employ contraceptives, they are considerably more likely to become pregnant (Moore, 1985; Mott, 1986). If contraception is used, the condom is the method most often used among unmarried black adolescents (Kantner & Zelnick, 1973). Contraceptive behavior significantly impacts the pregnancy rate. Zelnick and Kantner (1979) calculated that the difference between "no use of contraception" and "always use of contraception", by those who do not want to conceive, is roughly one million pregnancies.

Most Black adolescents do not fit the mold of the abortion patient described by Olson (1980). Religious and moral reasons, superstitions, and finances may influence the black mother's likelihood to carry the baby to term. The idea that the child should not be punished for the mother's mistake is deeply entrenched in the culture of the community (Ladner, 1971). Therefore, abortion or adoption is not usually a viable option for Blacks, especially poor Blacks.

Staples (1976) reported another characteristic of sexually active black mothers which may add to the explanation to not consider abortion. He found that while Black adolescent women were relatively permissive, they were not generally promiscuous. They tended to require affectionate relationships as a basis for sexual behavior. In her qualitative study of adolescent Black mothers, Ladner (1971) found that most often girls stated that these pregnancies

resulted from their involvement with a boyfriend with whom they were in love or cared a great deal. Ladner (1971) further explained that it was not uncommon for a girl to break off with the child's father and take another boyfriend, thus creating the potential for a subsequent pregnancy. Since a child was conceived by the previous boyfriend, there may be a feeling of wanting to validate the new relationship by having a child for him. Therefore, this emotional attachment to the father may be a factor in deciding against abortion.

The Black community may have some unique attitudes which serve to discourage the use of contraceptive services. In the 1960's, when Black adolescents were identified as "high risk" in that they had higher birthrates than other groups, special programs were developed. Large amounts of federal dollars were channeled into the Black community, providing inner-city women and teens with hospital and clinic based perinatal care, sex education, and contraception. The attitude of many in the Black community was that the federal government was committing genocide and that this assistance was a plan to decrease the percentage of Blacks in the nation (Franklin, 1987).

Sometimes, a belief in "old wives' tales" and "folk tradition" may facilitate the process of misinformation and non-usage of contraceptives. Ladner (1971) found that some Black adolescents seemed to be resigned to a destiny of premarital pregnancy. They felt that they were powerless and that one of two of two alternatives would occur: either (1)

engage in sexual relations and accept whatever consequences might follow; or (2) abstain from premarital sex. This indicates a very weak internal locus of control and a very strong alliance with fatalism.

There are important racial differences in the likelihood of rapid repeat childbearing. Among whites, age at first birth has little effect on the proportions who have a second birth quickly; but among Blacks, it has a significant inverse effect, with younger women more likely than older women to have a second child quickly (Mott, 1986). For whites, data suggests that pregnancy leads to better contraception in the future, but the effect of pregnancy is not as strongly evident among Blacks (Kantner & Zelnik, 1973). Further, Ford (1983) reported that the proportion of Black teenage mothers using no method of birth control was higher than that for white teenage mothers, and it increased over the course of the year following birth. Rates of non-use were particularly high among Black women younger than eighteen.

Subjective Utilities Model

The is subjective utilities model proposes that there are significant elements in the adolescent's environment which serve as a model for behavior. The key precipitant is the individual's perception of significant others as influential elements.

Individual's Perception of Self

One of the predictors of teenage pregnancy is low self-esteem. Some have suggested that many teenagers use pregnancy to compensate for the feeling of being unloved and worthless (Franklin, 1987; Gispert and Falk, 1976; Phipps-Yonas, 1980). Zonker (1977) reported that girls who exhibited poor personality integration and deviant self-concept became susceptible to numerous forms of disordered behavior, including unplanned pregnancy. Other psychodynamically-oriented research further suggested that the pregnant adolescent was often acting out an unconscious wish, suffering from a weakened ego, was extremely dependent, or was expressing a need to gratify the oedipal wish (Bieber & Bieber, 1968; White, 1981). For these type of reasons, some teenagers actually planned the pregnancy (Klein, 1974). This may be a disappointing experience. Pregnancy may compound the negative feelings.

Many adolescents are unprepared to accept their rapidly changing appearance during pregnancy. Whereas the young adolescent female is striving to be comfortable with her changing body image, the pregnant adolescent also has to deal with the body distortions, and her feelings of lowered self-esteem (Schneider, 1982).

Influence of Mothers

One area which often remains constant is the intergenerational effect of adolescent pregnancy. Women who parented as teenagers tend to have daughters to repeat this behavior (Moore, 1985). According to one study, 82% of girls who give birth at age 15 or younger were daughters of teenage mothers (Wallis, 1985).

Influence of Siblings

Research has indicated that siblings as significant others is a factor in adolescents pregnancy. Hatcher (1973) found that three out of five of the pregnant early adolescents in his sample had older siblings who had a "shotgun" marriage.

Influence of Friends

For the young adolescent girl, there is a strong identification with the same-sex friend (Hatcher, 1973). There appears to be a difference between male and female adolescents peer attachments. Girls tend to be influenced more by peers because their relationships are characterized as being more intense. Boys tend to have a number of buddies, whereas girls have a few very close friends (Brown, 1982). In view of this, it is not surprising that pregnant girls who

carry their babies to term report a greater number of friends who were mothers (Gispert & Falk, 1976; White, 1981).

The teen years represent a period for testing of relationships with members of the opposite sex. Dating is a common expectation for most adolescents. The perception of the value of those relationships vary. Some unwed mothers between the ages of 15-17 romanticize love relationships (Hatcher, 1973). Pope (1967) in a study of over 900 unwed mothers found that four-fifths of whites and three-fourths of Blacks said they were or thought they were in love with the sex partner. In another study, it was found that 89% of whites and 80% of Blacks reported being in love their sex partner at the onset of pregnancy (Scott, 1983). Even after the birth, the mothers are likely to associate with the baby's father and anticipate marriage as a definite future possibility (Furstenburg, 1970); Klein, 1974; Pope, 1967). Childbirth tended to give cause for continued social-sexual, economic and psychological interest in one another.

Family Communication Pattern

The communication pattern within the family system has been investigated as a possible indicator of the likelihood of out-of-wedlock births. A high level of confiding in parents and degree of connectedness are negatively associated with sexual experience (Barglow, Bornstein, Exum, Wright, &

Visotsky, 1968; Fox, 1973; Jessor & Jessor, 1975; Kantner and Zelnik, 1973). Open communication between parents and children is believed to decrease the incidence of premarital pregnancy. The closer the ties to home, regarding parental values, the less the likelihood of becoming premaritally sexually experienced (Jessor & Jessor, 1975; Shah & Zelnik, 1981).

Influence of Religion

Religious beliefs and attitudes influence the incidence of adolescent pregnancy. Frequency of church attendance is associated with a diminished likelihood of sexual experience for adolescents (Kantner & Zelnik, 1973). To add credibility to that finding, Fox and Inazu (1980) reported a strong positive association between family religiosity and early sexual communication. They identified family religiosity as participation in family-based religious practices such as singing hymns, Bible reading, family prayers, and saying grace. This finding is important because, as mentioned earlier, family communication is negatively related to early premarital sexual experiences.

Repeat Pregnancy

An adolescent mother's physically leaving the family circle can be a predictor of repeat pregnancy. The new mother who chooses to leave her parents, in the absence of a husband, also may be pursuing a lifestyle which will lead to subsequent pregnancies, Jekel, Klerman, & Bancroft, 1973). Her life may be void of continued nurturance and support, which parents could have provided. In seeking to fulfill certain needs, other sources are substituted and utilized. Kantner and Zelnik (1973) found that intercourse prevalence was highest among teenagers who lived by themselves. However, sometimes a young woman may move in with a friend or an older sister. This situation was also viewed as less than ideal, in relation to pregnancy avoidance. The poorest record of consistent use of contraceptives and the greatest amount of risk-taking at least intercourse was found among young women living in a family headed by a woman other than the mother, according to Kantner and Zelnik (1973).

Black Adolescents

Although Zonker (1977) reported that school-age mothers exhibited poor self-esteem, we don't know this to be a fact with the Black adolescent. In reporting self-esteem, Black youth tend to use blacks within their environment as a

reference group. In this regard, they may view themselves as having a high level of self-esteem, whereas the majority population may assume otherwise. If crystallization of the self-concept is established early and is relatively stable (Engel, 1959) and if Black youth are socialized early for an active sexual role in adolescence (Bell-Scott & McKenry, 1986), then pregnancy doesn't have to be a negative impact. In Black families Furstenberg (1981) observed that pregnancy elevated the status of the young mother. She was accorded greater recognition by parents and siblings. To have a child represented fulfillment of the womanly tradition in the Black community. The ultimate test of womanhood, then, was one's ability to bring forth life (Ladner, 1971). Nearly one-third of Black teenage mothers who have one baby will have another by the time they are 20, thus increasing the opportunities for more recognition.

Black family life, especially that of lower socioeconomic groupings, has been characterized by elaborate kinship patterns. The socialization and subsequent identity formation of Black adolescents is likely to be shared by several relatives, older siblings, neighbors, and friends (Bell-Scott & McKenry, 1986). These kin networks, according to Hamburg (1986) begin with childbearing. In Furstenberg's 1981 study of low income Black teenage mothers, 90% lived with a parent or close relative. These adolescents were more likely to advance educationally and economically than were those who left home.

Traditionally, Black families tend to warmly accept the child. According to Ladner (1971), there are no "illegitimate" children in the low income Black community because there is an inherent value that children cannot be "illegally" born. These are "unauthorized " births because these children are not born within the limitations and socio-legal context defined by legislators and other people in the majority group who create and assign labels to the minority group.

Overview of Program needs to Curtail Repeat Pregnancy

In recent years, an increasing number of localities have begun to provide family planning services to pregnant adolescents and to teenage parents in the hope of preventing early repeat pregnancies (Furstenberg, Masnick, & Ricketts, 1972). In fact, most programs addressing the problem of teen pregnancy are directed at the group easiest to identify and help: adolescents who are already pregnant or have given birth. The goals are to ensure that the girls obtain adequate prenatal care, continue their education, and learn how to be good parents (Finkel and Finkel, 1983); Wallis, 1985). However, the prevention of adolescent pregnancy is for less expensive, economically and psychologically, than the alternatives of birth or abortion (Finkel & Finkel, 1983). Since adolescence is considered to be a unique period,

contraceptive programs must be specifically tailored for this youthful group (Jekel, Klerman, & Bancroft, 1973).

An effective prevention program would have to address the need for information, services, and motivation. Young people are not getting enough information about birth control (Evans, Selstad, & Welcher, 1976; Juhase, 1974). Part of this is the unsupported belief that providing birth control information at an early age encourages sexual involvement (Finkel & Finkel, 1983; Francome, 1983). However, Francome (1983) further explained that 90% of teens seeking contraceptive advice were already sexually experienced. Unfortunately, in the past, teenage girls had difficulty obtaining effective methods of birth control unless they first became pregnant (Finkel & Finkel, 1983).

An intervention program, the Teenage Interconceptional Care Clinic (ICC) was established in Atlanta. The purpose was to provide continuing services for approximately 15 months postpartum for teenagers aged 16 and under at the time of delivery. The ICC provided birth control services, counseling, health care, and assistance in establishing an atmosphere in which a young sexually active teenager can develop an acceptable self-image as a contraceptive (Klein, 1974). It was found that young girls would not return to a typical adult "examining table" birth control clinic at regular intervals, nor would they return to a clinic whose sole interest was their sexual activity and birth control use.

Klein's study (1974) reported that during the period of 1971-72, eighty-six percent of the 932 patients aged 12 to 16, who delivered at Grady Memorial Hospital, returned for postpartum examination. Of that number, more than 97 percent accepted a method of contraception despite their young age. Findings indicated that the clinic was successful in that repeat unwanted pregnancy occurred significantly less often among patients who participated in the program. Providing an advocacy role and supportive attitudes toward birth control was viewed as the catalyst for clinic success to reducing unwanted repeat pregnancies.

Furstenberg, Masnick, and Ricketts (1972) studied the Adolescent Family Clinic (AFC) at Sinai Hospital of Baltimore. This was a special program offering prenatal and postpartum care to adolescents who were pregnant for the first time. The program included an intensive effort to encourage contraceptive use in the postpartum period. During the prenatal period, the participants received medical examinations, nutritional information, social counseling, training for parenthood, and instructions in birth control techniques. Following delivery, most of the young mothers elected to use birth control pills. By the end of the third month, more than four percent of program nonparticipants, who delivered at Sinai, were pregnant again as compared to less than two percent of the participants. The differential reaches its maximum at 15 months where the cumulative results

are about 35 percent for nonparticipants and 25 percent for participants. After that time, the differentials narrow. By thirty-six months, approximately half of each group, according to the research, could expect to experience a repeat pregnancy. According to interview results, it does not appear that many of the second pregnancies were intentional. This research suggests that the long time effects of providing birth control pills postpartum is minimal, in relation to avoiding premarital repeat pregnancies. Possibly, program efforts should be focused on those factors related to contraceptive use. For instance, White (1981) reported that demographers found employment opportunities more effective birth control measures than pills, IUD's, or pastel condoms.

Continuing multi-service programs, aimed at keeping adolescent mothers in school, may be a needed program strategy to combat rapid subsequent adolescent pregnancies. A study of New Haven school-age mothers reported that only school status at registration was correlated significantly with subsequent pregnancy. Those in school were less likely to become pregnant again by 15 months postpartum (Jekel, Klerman, & Bancroft, 1973). Furthermore, 30% of the 73 poor attenders (those who attended less than 60% of the time) were pregnant again by 15 months, whereas none of the 24 with good attendance (80% or better) were pregnant by that time.

As expected, school attendance was found to have a significant impact on birth control use. Jekel, Klerman, &

Bancroft (1973), found that of the 57 girls who had dropped out of school, only 18 were using a method of birth control. In contrast, of the 75 who had been prescribed contraceptives and who were still in school or had graduated, 57 or 76% were still using birth control. These significant differences strongly suggested the possibility that the mere prescription of birth control was not sufficient to prevent subsequent pregnancies. Curtailment of education seemed to produce an environment which encouraged repeat pregnancies (Klein, 1974). The motivation and/or ability needed to remain in school also may be a crucial factor in the continued use of oral contraceptives. These findings suggest that either the motivation to achieve an education or the information and values received in school, or both, influence the girls toward avoiding an early additional pregnancy. If the motivation to avoid pregnancy is missing, services and programs will be ignored (Moore, 1985).

In programming, there is some value in including education in the consequences of early marriage (Mott, 1986). Some adolescent mothers may perceive marriage as the answer. It has already been established that remaining in school is positively correlated with avoiding additional rapid pregnancies. However, those young mothers who marry because of pregnancy are more likely to curtail schooling than are her unmarried counterparts (McLaughlin, Grady, Billy, Landale, &

Winges, 1986). This factor is especially disturbing given the likelihood of marital dissolution among such couples.

Programs should be designed to include adolescent males (Klein, 1974). The interest shown, by at least some males, in acquiring contraceptives before starting sex suggests a potentially useful component of a family planning program's efforts at pregnancy prevention. There is a proportion of adolescent males who are willing to tolerate unprotected sex and who are too embarrassed to buy any kind of protection. Increasing the proportion of young men who obtain condoms while still virgins is one strategy worth implementing (Clark, Zabin, & Hardy, 1984).

Interventions that are aimed solely at sexually active adolescents, exclusive of parents, may miss an important part of programming. Research has reported that adolescents who were able to seek and receive support from their parents during the crisis of a first pregnancy were less likely to become pregnant again than were those who found little support at home (Gispert, Brinich, Wheeler, & Krieger, 1984). In programming, emphasis should be placed on the family system and its impact. Fox (1979) suggested that policies that ignore the familial context of teenage sexual behavior, that fail to discern and enlist the familial support base of the teenager, and that undermine rather than supplement the efforts and effectiveness of parents, were likely to yield programs that are wasteful, inefficient, and ineffective.

One barrier to effective programming is the division between political and religious leaders over what the primary mission should be: the eradication or discouragement of sexual activity among young unmarried people, or the reduction of teenage pregnancy through promotion of contraceptive use. If reduction of pregnancy is the primary focus, programs established by countries with low teen birth rates should be examined. Although teenagers begin intercourse at early ages in Sweden, this country has been the most active among other nations in developing programs and policies to reduce teenage pregnancy. These efforts include universal education in sexuality and contraception: development of free clinics closely associated with the school: widely available and confidential contraceptive and abortion services: widespread advertising of contraceptives in all media: frank treatment of sex: and availability of condoms from a variety of sources (Jones, et. al., 1985).

Family planning for adolescent mothers must be broadly based to include attention to both short and long term goals. Long-term programs offering initial and continuing family planning care have the best prospect of achieving long-term results with adolescents (Furstenberg, Masnick, & Ricketts, 1972). Research has indicated that even when contraceptive services were exemplary, pregnancy rates do not necessarily decline (Franklin, 1987). Understanding causal phenomena can be the first step in developing effective interventions.

Summary Statement

Adolescents are couched in a developmental stage which is dynamic and somewhat ambiguous. Youth are expected to assume many more responsibilities during this period, obey the rules established by the adult population, and conquer the confusion of society's double messages. The dichotomy of these instructions is especially apparent regarding sexual behavior. American teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: Movies, music, radio and TV tell them that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are likely to be divorced or separated but involved in sexual relationships. Yet at the same time, young people get the message good girls should say no (Jones, et. al., 1985). The religious community sends messages that sex is sinful. Peers say that everyone, except you, is engaging in premarital sex. Adding to this maze, the biological time clock indicates that the body is ready for sex.

A consequence of adolescent sexual involvement is teenage pregnancy. Parenthood is one alternative to pregnancy resolution. According to the timeline of life events established by society, parenthood should not be a role for an unmarried adolescent. However, many adolescents are

attempting to balance the roles of parent, student, and dependent child. At best, these roles are in conflict. By middle class standards, it is difficult to isolate advantages for teenagers faced with this dilemma.

Of all teenagers in the developed world who become pregnant, Black American adolescent females have the highest birth rate (Timberlake & Carpenter, 1986). When one considers the already disadvantaged state of Black Americans plagued by racism, this sexual behavior of Black adolescents is of special concern. The fastest growing black family formation today, according to authors Timberlake & Carpenter (1986), is the single teenage mother. It appears that economic stability within the Black community becomes more out of reach by this family form. Not only is pregnancy a concern, but a more crucial concern is the repeat pregnancy of these young unmarried mothers.

There may be some rational motives for repeat pregnancy among Black adolescents. Research literature has reported characteristics of mothers at risk for such an occurrence. There is also a body of knowledge describing the consequences of such behavior. However, there seems to be a void in the literature to explore the "whys" of this behavior at the individual level and if the reasons are consistent with those previously reported. There may be a tendency to stereotype these young repeaters and assume that they were too lazy to use birth control or that they desired more welfare payments

as motives for their behavior. This may not be an accurate perception. It is still puzzling if there are some rational motives for Black teenage mothers to rapidly continue childbearing, if this is a result of irresponsible decision making, if this occurred by default, and if intervention strategies could be designed to successfully discourage such behavior.

CHAPTER III

METHOD

The major objective of this study was to determine if a rationale existed for repeat full-term pregnancies of unmarried black adolescents. Qualitative research techniques were used to compare with findings of quantitative investigations; that is the qualitative investigation was used as a clarifying follow-up to traditional studies. It is believed that, once a trend has been identified via statistical methods, the life events from which that trend derived can be explored qualitatively. In doing so, there is an indication of whether the quantitative findings extend to broader samples. It was hoped that results, of this particular study, would provide clues to explain the phenomenon in question and guidelines for establishing effective prevention measures.

In family research, gathering of quantitative data has dominated the methods of choice. Social scientists have been using indirect quantitative methods rather than starting with the actual experience of the subject. Researchers have come to realize that practical and effective ways must be considered for understanding the world that individuals

construct and maintain within a given society. Such strategies must allow access to other's meanings in a reasonable amount of time (Schwartz & Jacobs, 1979). Qualitative measures, along with information obtained from quantitative data, may be used to meet that objective.

The blending of the two approaches can enhance the quality of the investigation by benefitting from the advantages of both. Rank (1988) reported that the strength of qualitative data was in the richness and depth of the data of small samples, whereas, quantitative data was ideal for describing the characteristics of a large population. Fox (1988) translated this as the superior reliability and generalizability of quantitative methods and the greater validity of qualitative approaches. Qualitative and quantitative methods should be viewed as complementary approaches rather than rivals. By bringing together both quantitative and qualitative data in an analysis, insights are gained which may have been unattainable by one method alone. Quantitative data analysis often answers the questions of what, where, and when. Qualitative data analysis is ideal for answering the questions of why and how (Rank, 1988). It provides the investigator the opportunity to explore the unknown. In this study, results of quantitative studies served as a reference point in identifying the need of a more intensive personalized approach. According to Van Maanen

(1983), qualitative work aimed to disclose and reveal, not merely to order and predict.

Systematic phenomenological or qualitative research, which seeks to classify and describe circumstances and experiences, offers two major advantages over statistical research. First, phenomenological descriptions reveal what the situation is like from the perspective of actors in that situation. The findings are closer to life than the variables and constructs of statistically oriented research. A weakness of the statistical approach is that even though its constructs are initially formulated from life, it is difficult to translate it back to life. Phenomenological studies of life situations, on the other hand, permit policy makers and service providers to see concrete points of intervention into the lives of communities and individuals. Such findings can be communicated directly to the public and persons can see the extent to which the findings match their own experience. Also, results may be helpful in planning appropriate interventions.

Another advantage of phenomenological studies is that it represents the process of lived events, including critical points of transformation. In the qualitative view, according to Schwartz and Jacobs (1979), it is crucial to discover the daily activities, the motives and meanings, and the actions and reactions of the individual "actor" in the context of his daily life. Qualitative methods are best at gaining access

to the life-world of other individuals in a short time. The life-world includes motives, meanings, emotions, and other subjective aspects of the lives of individuals.

Triangulation is broadly defined as the combination of methodologies in the study of the same phenomenon. More than one method used ensures that the variance reflected that of the trait and not of the method. Thus, the convergence or agreement between the two methods, qualitative and quantitative research, enhances the belief that the results are valid. The effectiveness of triangulation rests on the premise that the weaknesses in each single method will be compensated by the counter-balancing strengths of another. Perhaps the most prevalent attempts to use triangulation have been reflected in efforts to integrate fieldwork and survey methods (Van Maanen, 1983). Four advantages of triangulation were identified by Van Maanen, (1983): (a) It allows researchers to be more confident of their results, (b) it can stimulate the creation of new ways of capturing a problem to balance with conventional data-collection methods, (c) it can lead to enriched explanation of the research problem, and (d) it may also help to uncover the deviant dimension of a phenomenon.

Techniques under the canopy of qualitative research are varied and include participant observation, content analysis, formal and informal interviewing, videotaping, the discovery and use of unobtrusive measures, life history construction,

archival data surveys, historical analysis, and various formal sociologies such as dramaturgic analysis, frame analysis, ethnomethodology, and conversational analysis (Van Maanen, 1983). Although qualitative research covers a number of techniques, the principal strategies are observation, interviewing, and documentary analysis (Punch, 1986). This study used intensive interviews to gain information for case studies, one of the most difficult techniques of research to conduct (Yin, 1989).

Case studies can also be another vehicle for theory development in the social sciences. According to George (1979), intensive analysis of a few cases may be more rewarding than a mere superficial statistical analysis of many cases. In general, the problems of reliability and validity may be smaller for the investigator working with the comparable-case approach. The investigator can analyze his smaller number of cases more thoroughly and is less dependent on data that he or she cannot properly evaluate. One reason why single case studies in the past contributed so little to theory development was that the studies either lacked a common focus or a common approach to the study of a given type of problem. In this investigation, there was commonality with both the focus and approach of the study.

Regardless of criticism by some scientists, field research is not a soft option. Several accounts of field research touch on the stress, the deep personal involvement,

the role-conflicts, the physical and mental effort, the drudgery and discomfort, the potential danger for the researcher, and the time-consuming nature of this method (Punch, 1984). Regarding the consideration of time, Fox (1988) reported that qualitative research can be done by one scientist alone with limited resources of everything except an abundance of time.

In exploring phenomena, there is sometimes a mistaken tendency to combine clinical and ethnographic methods under the broader label of qualitative research. In many accounts of qualitative research, the journalistic, ethnographic, case analysis, fieldwork, and clinical approaches were all lumped together. No clear distinction was being made between these various approaches and the "clinical" perspective. The essence of the clinical method was to draw out of the client "deeper" levels of data that could be obtained only by intensive listening and the creation of a psychologically safe and supportive environment. Using the clinical method, as a tool, is the clinician, a member of those helping professionals who get involved with individuals in a helping role. The purpose of the ethnographer has much more to do with how to obtain valid information without influencing or disturbing the system being studied any more than is necessary. Typically, the ultimate goal is to obtain valid data for science, not to change, help, or in other ways influence the system being studied (Schein, 1987).

Sometimes it is difficult to separate the role of the ethnographer from that of the clinician. In trying to build up trust, ethnographers are often thrust into the role of clinician. They are sometimes asked to give advice and actively help to solve problems. The clinician's role requires an "in-depth" analysis in an area of agreed upon pathology. However, in pursuing this goal of insight, questions may be asked to solicit the same type of information sought by an ethnographer. Clinicians have to observe, develop relationships with clients and subjects, listen attentively, elicit information in conversations and interviews, and use structured devices for gathering information (Schein, 1987). This process is also used by the investigator using interviews to gather information for case studies, the technique used in this research. McCracken (1988) promoted the long interview as the method of choice when cultural categories, assumptions, and themes were objects of investigation, and when total immersion in the studied scene was impractical or impossible.

Although the case study is an empirical inquiry, there have been some major concerns regarding its validity. The greatest concern, voiced by those reluctant to use this technique, has been over the lack of rigor of case study research, citing that the investigator was biased in reporting conclusions. Another criticism was that case studies provided very little basis for scientific generalization. A persuasive response

is that case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes (Yin, 1989). Also, those opposing case study research cited that the process was time consuming and the report was difficult to read. Despite these reservations, case studies are generally the preferred strategy when "how" or "why" questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context (Yin, 1989).

In considering the variety of research methodologies available, this investigator chose the case study approach for qualitative inquiry. There have been many quantitative studies reported about adolescent pregnancy. Certainly, trends have already been established. There seemed to be little value in re-examining those trends when there were still the unanswered "how" and "why" questions. This author agreed with Rank (1988) in that these questions were best addressed through phenomenological means. The case study technique was selected over other means of qualitative investigations because of its significance as described by Yin (1989). As reported by Fox (1988) and Punch (1984), the drawbacks of stressful personal involvement and time commitments were pondered. However, the anticipation of interaction with these young mothers to elicit a high level of sharing was far greater than any warnings against using this technique.

Research on adolescent issues is conducted by adults. Therefore, when quantitative measures are used, the implications and conclusions are reported from an adult world-view. This author sought to solicit the feelings, thoughts, beliefs, and motives of the adolescents. So often, unsuccessful social programs are designed by persons having a different frame of reference from the people for whom the program is developed. Despite the many efforts, the failed attempts by society to control teenage pregnancy may stem from the fact that few programs are based on qualitative research, aimed at the adolescent mother's perception of the situation. This investigator sensed a need for a "first-hand" account to serve as a catalyst for suggested intervention.

What is the subjective expected utility of repeat pregnancy? The only way to answer that question is to ask the adolescent affected. The subjective expected utility weighs the expected negative or positive consequences of behavior (Bauman & Udry, 1981). Quantitatively, the anticipated negative consequences of repeat pregnancy, among unmarried adolescents, have already been reported by middle-class oriented researchers. Whether the adolescent mother's view coincided with the researcher's conclusions was a matter of concern. Therefore, the case for talking directly to adolescents, who had experienced the phenomenon, grew even stronger.

Although George (1979) reported on the rewards of using a few cases, analysis of interviews from 10 participants would have very little strength in generalizing to other populations, but had value in generalizing to theory (cf Yin, p.21, pp43-45). It was important to review and include findings of quantitative research. This was a way of gaining knowledge obtained from larger samples. This author felt that combining quantitative and qualitative measures would provide the best opportunity for seeking the desired information and validating responses. As described earlier, there are advantages and disadvantages of each method. By using both, this allowed each to complement the other, thus, enhancing the chances of a more reliable and valid research piece.

Hypotheses

1. Adolescent mothers who experience repeat full-term pregnancies have similar psycho-social characteristics.
2. Knowledge of contraceptive methods through family planning programs will prevent a repeat pregnancy.
3. The decision to repeat a full-term pregnancy is a rational process for black adolescents.

Design

The research design is the logical sequence that connects the empirical data to a study's initial research questions, and ultimately, to its conclusions (Yin, 1989). This project used a single focus, multiple-case design. The topic of the project was the single focus of study, but there was more than one individual in the sample. With this type of case study design, it was important that selection of individual cases was guided by replication. When this suggestion is carefully followed, one expects similarities of results. For a case study, according to Yin, (1989), five components of a research design are especially important, [questions, propositions, unit of analysis, linking data to propositions, and the criteria for interpreting the findings]. Each component will be discussed in the paragraphs to follow.

Questions

The investigator develops an interview schedule with emphasis on open-ended questions. The interview guide, or instrument, provides topics or subject areas within which the interviewer is free to explore, probe, and ask questions that will elucidate and illuminate that particular predetermined subject. The basic purpose of the standardized open-ended interview is to have each person interviewed asked essentially

used a single focus, multiple-case design. The topic of the project was the single focus of study, but there was more than one individual in the sample. With this type of case study design, it was important that selection of individual cases was guided by replication. When this suggestion is carefully followed, one expects similarities of results. For a case study, according to Yin, (1989), five components of a research design are especially important, [questions, propositions, unit of analysis, linking data to propositions, and the criteria for interpreting the findings]. Each component will be discussed in the paragraphs to follow.

Questions

The investigator develops an interview schedule with emphasis on open-ended questions. The interview guide, or instrument, provides topics or subject areas within which the interviewer is free to explore, probe, and ask questions that will elucidate and illuminate that particular predetermined subject. The basic purpose of the standardized open-ended interview is to have each person interviewed asked essentially the same core of questions. This format also makes data analysis easier because it was possible to locate each respondent's answer to the same question rather quickly and

because they appear relevant or important. Making interviewing recursive allows the researcher to treat people and situations as unique and to alter the research technique in light of information fed back during the research process itself (Schwartz & Jacobs, 1979; Patton, 1980). Patton (1980) supported this strategy by reporting that a number of basic questions may be worded precisely in a predetermined fashion, while permitting the interviewer more flexibility in probing. The investigator is free to determine the timing for exploring certain subjects in greater depth, or even to undertake whole new areas of inquiry that were not originally included in the interview instrument. It is also possible to adopt a standardized open-ended interview format in the early part of an interview and allow the interviewer to pursue any subjects of interest during the latter parts of the session.

For purposes of qualitative measurement, good questions should be open-ended, neutral, singular, and clear. Multiple questions tend to create tension and confusion and asking questions which are understandable is an important element in establishing rapport. It is crucial that the interviewer uses language that is understandable and part of the frame of reference of the person being interviewed. Leading questions

are the opposite of neutral questions and should be avoided. Leading questions give the interviewee hints about what would be a desirable or appropriate kind of answer.

Assumptions

Each of the assumptions listed in Chapter 1 was examined within the scope of the study.

Unit of Analysis

In each situation, the individual person was the case being studied. Qualitative sociology proposes that the individual and his interpretive process is important to real understanding. Furthermore, the individual is best understood by reference to his place in society (Schwartz & Jacobs, 1979). Therefore, the individual adolescent mother was the primary unit of analysis.

Linking Data to Propositions

The approach of "pattern-matching" was used, whereby information from each case was related to some theoretical proposition. For an investigator, the association is between an entity being studied and some analogy, interpretation, or

abstract pattern that seemed to capture the essence of that entity (Van Maanen, 1982).

The Criteria for Interpreting the Findings

The method of interpretation used was to analyze each case in relation to the "'pattern-matching" results and to conduct a cross-case analysis of trends, indicators, and predictions. Under these circumstances, the method of generalization was "analytic generalization," in which previously developed theory is used as a template with which to compare the empirical results of the case study (Yin, 1989). If two or more cases were shown to support the same theory, replication was claimed. Only replication will truly validate ethnographic research (Schein, 1987). The empirical results may be considered yet more potent if two or more cases support the same theory, but do not support an equally plausible, rival theory (Yin, 1989). In the time consuming analysis of the results, findings were presented primarily in a narrative which identifies consistencies and differences among respondents' experiences. Qualitative analysis encourages social scientists to draw from their own experiences in understanding the subjects. Therefore, although one strives to be scientific, the approach is somewhat subjective. Punch (1986), warned that qualitative

work was blatantly interpretative, which explains why critics attack its validity.

George (1979) reported some useful information when seeking to analyze case studies and strengthen validity of the conclusions. In each case, the investigator employed the historian's method of causal interpretation, which differed from the mode of causal inference in statistical-correlational studies. The causal interpretation gains plausibility if it is consistent with the available data and if it can be supported by relevant generalizations for which a measure of validity can be claimed. This is why the inclusion of quantitative results was so important in this study. Furthermore, the plausibility of an explanation was enhanced to the extent that alternative explanations were consistent or inconsistent with the data and previously reported generalizations.

Sample

The traditional perspective of much family research is based on a view which considers adolescents to be cognitively and socially immature and unable to understand and describe their experiences (Deatrick & Faux, 1988). This author choose to disregard this view in seeking first-hand accounts of the adolescent's definition of the situation. The sample consisted of 10 unmarried Black adolescent mothers who ranged

in age from 15 to nineteen. Participants were adolescent females who were, at the time of the study or had been, students of East Side Day School, a school for pregnant adolescents in Chattanooga, Tenn. and adolescent mothers who were present or former clients at Alton Park Community Health Center. The health center clients were part of the Black Infant Mortality Project, a state funded program targeted at decreasing the rate of Black infant mortality in the Chattanooga community. Selection was based on teacher and health administrator recommendation and subject compliance. All of the research participants were already mothers of more than one child through a repeat pregnancy or were currently pregnant for the second time.

Instrument

The literature review of quantitative research in Chapter Two was used as the basis for formulating questions. From the review, three theoretical models emerged. The sequencing of questions was deliberate to match the models discussed in Chapter Two. The investigator designed the instrument (See Appendix C) to examine phenomena within the deficit (Questions 12-21), decision-making (Questions 22-33), and subjective utilities (Questions 34-46) models. Questions 1 through 11 were designed to elicit demographic data, following

McCracken's (1988) recommendation to make opening questions simple, informational ones.

Five different types of questions, as described by Patton (1980) were included in the instrument. Questions described below were asked in the present, past, or future tense, although future-oriented questions are typically less reliable than questions about the present or past:

1. Experience/behavior questions which were aimed at eliciting descriptions of experiences, behaviors, actions, and activities that would have been observable had the observer been present.
2. Opinion/value questions aimed at understanding the cognitive and interpretive processes of people. Answers to these questions tell what people think about the world. They tell about people's goals, intentions, desires, and values.
3. Feeling questions which were aimed at understanding the emotional responses of people to their experiences and thoughts. There is an implicit assumption of spontaneity about the origin of emotional responses. Feelings occur inside people; they are their natural, emotional responses to what happens around them or to them.
4. Knowledge questions which were asked to find out what factual information the respondent had.

5. Background/demographic questions which were concerned with identifying characteristics of the person being interviewed.

In qualitative research, the investigator serves as a kind of "instrument" in the collection and analysis of data. This metaphor is useful because it emphasizes that the investigator cannot fulfill qualitative research objectives without using a broad range of his or her own experience, imagination, and intellect in ways that are various and unpredictable (McCracken, 1988). The "interviewer" constitutes a special kind of stranger in our society, one who can ask about many personal matters without being perceived as breaching another's right to privacy. Because the interviewer is a socially irrelevant person, the interviewee does not face the personal consequences of telling this information to a significant other. As a result the interviewer can ask almost anything, and in turn, can be told almost anything he or she wants to know (Schwartz & Jacobs, 1979). In seeking information, the investigator should keep a "low" and unobtrusive a profile as possible.

It is important that the respondent feels comfortable talking during the interview process. The interviewer should convey respect for those persons willing to share their time and their world. A reciprocal regard for one another must be established. Rapport is built on the ability to convey empathy and understanding without judgment. If practical, the

interviewer can get to know the interviewee over a period of time before attempting to acquire or access his or her personal accounts. However, there may be a danger of becoming too familiar, which might bias the process. In this study, rapport between the investigator and respondents was quickly established. Like the participants, the investigator was a Black female. This fact could have facilitated a comfort level for both parties. McCracken (1988) noted that when an investigator had a long-lived familiarity with the culture under investigation, there was an advantage of having an extraordinarily intimate acquaintance with the object under study.

Procedure

Prior to any interviews, the investigator met with a focus group of eight adolescent mothers ranging in ages 13 through 17, to field test potential questions for inclusion in the study. None of these adolescents were selected as participants in the actual qualitative study. For a summary of this meeting, see Appendix A.

To initiate this research, the investigator met informally with a group of alternative school students who qualified for the research. This meeting was a get acquainted session to allow potential participants to meet informally with the investigator. During this meeting, the investigator

discussed the project and invited participation by anyone desiring to be interviewed. Some of the participants in that group elected to become a part of the study. For participants not available for the previously described group session, the program administrator discussed the project with each, before the participant met with the investigator. Since students at the alternative school enrolled at different times during the school year, some of the later participants did not qualify when the first participants were interviewed, considering the interview process spanned a 12 month period. The procedure of using the program administrator to initially introduce the project was also used to gain access to the participants from the health agency.

In order to protect both subjects and the profession, codes of ethics are drawn up to regulate the conduct of research. A central plank here is that of "informed consent." There exists an understandable desire to protect vulnerable groups from research. These embody principles related to the dignity and privacy of individuals, the avoidance of harm, and the confidentiality of research data (Punch, 1984). The respondent in a qualitative interview is subject to several risks. Participation in this process can be time consuming, privacy endangering, and intellectually and emotionally demanding in ways foreign to quantitative measures (McCracken, 1988). Each participant was given an "informed consent" document (See Appendix B) to read and sign. This was

witnessed by another individual and a copy was given to each participant for future reference.

The fundamental principle of qualitative interviewing is to provide a framework within which respondents can express their own understandings in their own terms (Patton, 1980). The semi-structured interview was the qualitative technique selected. The interviewer assumed that the questions contained in the structured questionnaire or interview schedule were relevant to the topic of concern, that the questions were phrased unambiguously, and that the interviewee would understand the questions and find them unthreatening. Structured interviews are organized so as to elicit, through a set of pretested, predetermined questions, what the respondent thinks about or what he thinks he would do about a variety of hypothetical questions or situations. The respondent, knowing his or her own life history, decides what to say to the interviewer and assigns the precise meaning and significance of what he is saying. It is recommended that the respondent is asked a series of detailed ethnographic questions about the main issues covered in the interview (Schwartz and Jacobs, 1979).

For this qualitative research, three intensive interviews with participants were planned by the investigator. The first two sessions, each an hour in length, used the structured interview schedule, interspersed with questions generated during the interview process. The third session varied in

length and was to follow-up on any questions or concerns which were generated from the previous interview sessions. This session was more individualized because each question was unique according to the participant's responses during the two previous meetings. The first two sessions were in neutral settings. The follow-up sessions were face to face meetings in the homes of the clients, at the school setting, or via telephone.

It was essential to retain and retrieve information provided from the interviews. There are two basic procedures for doing this. One can take notes during the interview or one can tape-record and later transcribe the interview. Tape recording allows the investigator to concentrate on the interview without distracting the respondent and still retain all that the respondent related. However, the tape recorder may be intimidating to the respondent and may bias the account. For this research, the investigator decided to tape record the sessions. A microcassette tape recorder was purchased in an effort to lessen the threat which a big machine might pose.

There are some disadvantages in using a tape recorder. For instance, there is a hazard in taping that the interviewer, knowing there is a spoken record of all that transpired for future analysis, may become relaxed and fail to pay sufficient attention to what is being said. This investigator was very sensitive to this possibility and

careful to maintain eye contact with the respondents. When taping, another disadvantage is that there may be some unindexed material which is valuable and difficult to retrieve. This includes unobstrusive measures such as nonverbal communication. For instance, the interviewer may consider whether the participant is frowning, crying, shouting, or whispering. A good deal may be inferred from body language. Also, what is said may have different meanings to the interviewer at different times. Therefore, it is important to record such information immediately at the conclusion of each interview. Regardless, the retention of vital information and the lack of distortion that taping provides may more than outweigh the potential drawbacks (Schwartz & Jacobs, 1979).

All of the interview sessions were tape recorded, with the exception of the telephone follow-up sessions. Since the raw data of interviews were quotations, the most desirable data to obtain was the full transcription of interviews. Unfortunately, the ratio of transcribing time to tape time is typically 4:1, on the average. It takes about four hours to transcribe one hour of tape. Despite these costs, full transcriptions are the most desirable data to obtain. Transcripts can be enormously useful in data analysis and later in replications or independent analyses of the data (Patton, 1980).

The data were created from full transcriptions of the tapes of face-to-face interviews and field notes of telephone follow-up sessions. All data were kept securely confidential. The tapes were erased after completion of transcriptions. The written data were void of any names or other information which would intrude on the confidentiality of the interview or, otherwise, jeopardize the privacy of the respondent.

During the interview process, probes were used. Probes elicit a deeper response to a question, increase the richness of the data being obtained, and give cues to the interviewee about the level of response that is desired. As such, probes are conversational, offered in a natural style and voice, and used to follow-up initial responses (Patton, 1980). Therefore, probes are seldom written out in an interview schedule. The follow-up interview questions with each participant were actually a series of probes, resulting from responses during the two structured sessions. These follow-up sessions provided for clarifying any inaudible responses from the tape, identifying patterns across the different cases, and determining if initial impressions, from analyzing the previous interviews, were accurate.

Problems Encountered in Methodology

Availability of Clients

Most of the clients were initially seen at their school site. However, because of the uncertainty of their baby-sitting arrangements, the child's health, or the illness of pregnant participants, they were not always there as expected. Most appeared to have no regard for commitments or appointments or any knowledge of pre-planning. They would say that they were going to be at school on a certain day, the investigator would arrange schedules to be there, and they would not arrive. They never telephoned the investigator to report a change of plans. During visits at the homes, the client's attention was divided between the interview and child care responsibilities. On some of the tapes, crying of babies was interspersed with the responses. There were problems encountered with some of the follow-up telephone interviews. The clients would say to call at a certain time, but when the investigator followed their instructions, they would often not be there or were unavailable to talk. Some of the clients did not have telephones and the investigator would just "show up" at the home, hoping the client would grant an interview. Some of the clients lived in very depressed areas and in communities stereotyped as "dangerous drug infested havens."

Therefore, the investigator felt a risk of safety when making those visits.

Data Collection

During the data collection process, this investigator realized why case study research was described by Yin (1989) as one of the most difficult of qualitative techniques. One drawback was that the investigator was not gathering information in a controlled laboratory environment. For this research effort, most of the interviews were in a pleasant and comfortable conference room setting. However, availability of participants sometimes necessitated a variety of interview settings. One interview was conducted while sitting on a bed shared by the respondent and a baby. On another occasion, the investigator spent an afternoon, with the client, at a neighborhood health clinic in order to talk with her after her appointment. The appointment actually occurred 2 hours later than the client had originally been scheduled. A third uncomfortable interview setting was in a non air-conditioned living room on a day when it was 100 degrees outside. These situations illustrate the diversity of arrangements an investigator encounters when collecting data in the field.

The investigator was a secondary school guidance counselor and home economics teacher by training. Therefore, consistent with the warnings of Schein (1987), it was

difficult to separate the role of the clinician and the ethnographer. There was a tendency to want to help the clients to avoid an additional pregnancy, rather than merely collect facts. Also, in reviewing the first few interviews, it was apparent that the investigator's presence was too evident. The investigator had more to say than the respondents. In some instances, the investigator may have a whole paragraph of dialogue to ask or explain a question, and the respondent's reply was a brief "yes" or "no". That situation did improve as the interview process continued.

Another obstacle in data collection was the language barrier. The investigator and respondents operated on a different level of vocabulary usage and grammatical understanding. As McCracken (1988) reported, the interviewee's intellect influences the process. There were instances where the investigator and the respondents had difficulty understanding each other because of the language used. As an example, the investigator asked, "Did you have any complications during pregnancy"? The respondent's reply was, "Yes, well, it was like...I couldn't even go to the store without him going with me." The investigator had to go back and rephrase the question to indicate the inquiry was concerned with health complications.

The investigator encountered problems in writing up the data. Qualitative research generates volumes of written data.

The taped interviews produced over 250 single-spaced typed written pages of data and consumed over 100 hours of transcription time. It was important that transcriptions were accurate accounts of the taped sessions. The investigator had much difficulty in spelling such terms as un huh for "yes", unh un for "no", yep, nope, shoulda, and nayun for "not one", to name just a few. Punctuating the transcriptions was also a challenge. There were so many pauses in the clients' responses. Another drawback in writing up qualitative studies was that, with some exceptions, (Patton, 1980; Van Maanen, 1983; & Yin, 1989) there were few guidelines to assist researchers in this task. In writing quantitative analysis, there are many resources, including books, articles, and statistical computer packages, which give explicit instructions. In the writing of qualitative case studies, there is still much ambiguity in the field.

Time Investment

This investigator agreed with Winchester (1986) in his discussion of time lag or time expenditures. According to Winchester(1986), in unsupported dissertation research, the doctoral candidate usually performed all tasks involved in the research process, including research design, measurement decisions, data collection and data analysis. This is the student's advantage in gaining "first-hand" experience with

the process, but there is considerable stress involved due to the simple lack of "personpower" in carrying out the project. The research design in this study required an enormous amount of time, as indicated by Fox (1988) and Punch (1984). At one time, the investigator considered hiring someone to help with the transcriptions, but decided that data quality may be sacrificed. Since the investigator conducted all of the interviews, listening to hours of tapes while transcribing tended to recreate the sessions. Body language, facial expressions, and voice intonations were all occurrences of which the interviewer had knowledge. Therefore, it was felt that a more reliable report would result from one person performing all of the tasks the research required. Consideration of this significant factor made the investment of time worthwhile.

Limitations

The role of respondent was very powerful, since the study relied primarily on the self-reporting of participants. The investigator had to assume that the responses were accurate. There was no way to validate many of the answers, as they were derived from the adolescent's subjective view. There were times when the investigator felt that the respondents were saying what they believed to be socially acceptable. In many ways, the participants were "calling the shots". They could

discontinue the interview if they desired, refuse to answer questions or give a non-committal response. The investigator was sensitive to this and felt placed in a very vulnerable role. Yin (1989) encouraged case study researchers to use more than one source for data input. This investigator chose not to seek interviews from significant others because the adolescent mothers' perceptions of themselves and their environment were the focus of concern.

Despite the problems and limitations discussed, this investigator felt that the method used was best for researching the "how" and "why" of the phenomenon in question. The advantages of qualitative research, as discussed earlier in this chapter, tended to minimize any inconveniences which may have occurred.

CHAPTER IV

RESULTS

Three approaches were used in the analysis of case interviews. First, a pattern-matching process was used to examine each of the theoretical models in detail. Next, the three hypotheses were assessed in light of the data gathered in this project. Finally, to provide an overall summary of the data, a composite sketch was drawn of the prototypical adolescent mother with a repeat pregnancy.

Participant's Responses Compared to Theoretical Models

A cross-case analysis of the 10 cases was reported as related to each theoretical model. This was the pattern-matching process as described by Yin (1989). For a review of each case report, see Appendix D. To give depth to the analysis, excerpts of actual selected responses from clients were included in the text of the results.

Deficit

In the deficit model, one is seeking to uncover disadvantages of a teenager repeating a pregnancy. This behavior is expected to precipitate certain problems for the adolescent mother. Of significance is to consider the frame of reference of the adolescent in question. The deficit model, contrasting what is socially acceptable, is anchored within a set of beliefs and standards characterized. The guidelines for this model have been established by middle class researchers. These adolescent mothers in this study were not members of the middle class. Therefore, their orientation was somewhat different. Who can place a moral judgement of right or wrong on one's beliefs? This was the question which caused this investigator to more closely examine conclusions from prior research. A review of actual comments by selected participants further supported the belief that some didn't view their situations as having far-reaching consequences in years to come. Middle class researchers, seeking to identify the deficits of adolescent parenting, may anticipate client responses to support their perceived premise that repeat pregnancy is a problem. For instance, one might naturally assume that the role of mother would change the lifestyle of the adolescent. However, actual participant comments illustrated that the adolescent mothers'

definition of the situation was independent of middle class prescriptions.

Interviewer: How were things different for you after becoming a mother as opposed to before you had a baby?

Client: Well, I had someone to go somewhere with me. Because I used to hate going by myself. It was alright because I had my mama and she used to always help me, and I didn't go out much anyway. I love babies and I didn't mind taking her with me.

Client: It really didn't change my life. I never liked to go anywhere anyway. I was mostly at home. It hasn't been any different.

Client: It changed my life a lot. For one thing, when I had to drop out of school, I changed then. I wasn't really ready to have any children at that young age. It just happened.

Client: I felt like I was more needed when I became a mother and stuff. My daughter, you know, if something happened, she would come to me. That made me feel good. I wasn't childish like I used to be and I wasn't routy like some of these girls are now. I felt like I was needed and I should, you know, show her an example of what she should be. She changed me a lot.

Client: It didn't change it at all, because I already knowd how to change diapers and feed them and all that. I used to raise my sister nem. I helped my mama raise them. (This Client was the oldest of 11 children)

Client: I couldn't go nowhere like I used to do. It just seemed like...responsible, real responsible. I can go out, but I just can't go out regular like I used to. I have to come back at a certain time, because I know my baby be there. My mama told me to not take advantage of her keeping the baby, because she has things she wants to do. But, I don't really like going anywhere. I just like staying at home with the baby. It didn't really change, just I hate getting up at night.

Some clients didn't view being disturbed in the middle of the night as a significant inconvenience. All lived with parents, siblings, or others who could help them with the

physical care of their infant. In reference to getting up during the night, three clients responded:

Client: Well, my baby didn't wake me up, she waked my mother up. It seemed like they picked her up every time when she first cried, and I never heard her when she first cried. And then when I do hear her, I hear them coming in the room to see about her. I know they are going to take care of her, so I just turn on back over and go back to sleep. My sister and everybody used to come and get her.

Client: My baby sleeps all the way through the night.

Client: I used to hate getting up at night, at first. Now, I'm used to it.

Since these adolescents became parents when they were so young, most had only stopped playing with dolls in recent years. Therefore, their memory of that experience was still vivid when they became pregnant. They were socialized for motherhood through role playing with dolls. When clients provided descriptions of their perceived reality of motherhood, it was apparent that these expectations were based on their childhood play experiences. As one mother reported:

I thought it would be like...I just thought it would be fun, but it ain't fun being no parent. It's like, you know, I don't know how to put this. It's like, it ain't really fun at all, but its something you gotta do. So, I just see it as something I got to do. So, I sit there and got the baby, so I'm gonna take care of it. I'm going to cut out almost all my extra-curricular activities and stay home with my child. Cause, I know that that's my responsibility. I just gotta do it.

Prior to the actual interviews, the investigator assumed that clients would report being overwhelmed by parenting more than one child. However, client perceptions of having more than one child varied in terms of difficulty.

Interviewer: How has being the mother of more than one child been different from parenting one child?

Client: Well, you have to buy twice as much of everything.

Client: You have to find a baby sitter and it is hard to find one. You have to worry about dropping out of school.

In the short-term, some clients admitted that they would rather be without children at this time in their life. The investigator did not get a sense that these clients conceptualized any far-reaching consequences of repeat pregnancy. The fact of their early parenthood status was accepted. In fact, some viewed their whole being in reference to motherhood. Implications of how parenthood permeated their lives was evident by some of the responses to the question, "If you had the power to change anything in your life, what would you change"?

Client: I guess I would change that I wouldn't have had no children, but I love both of them.

Client: I would make a way for me to have a baby sitter all the time so I could go to school.

Client: One thing my mama always complained about is money. I wouldn't make us rich, but I would make us comfortable. I wouldn't change myself getting pregnant. I regret it, but it happened. I wouldn't change that. You know, I would change the way people act towards me. You know, they act like I done something to them or something.

Client: Well, I don't know how to put this to say what I want to say. I love my children and I'm glad that they are here, but if I could change, I would just have them later. You know, after I'm older. I would try to make it better for them, so when they do get here, it wouldn't be so hard to try to get them what they need.

Rather than to ask them if they were happy to be parents, the investigator used a less threatening question.

Participants were asked, "Would you recommend parenthood to other teenagers?" Some replies were:

Client: I think it would be better if they waited. They are just too young to have children now.

Client: The way I see it, if you ain't got naun, (referring to a child) keep you life together. Children just slow you down. I think you should live your life, set your goals, and don't think about one, cause its hard.

Client: I would try, you know, like tell them, but these folks these days don't want to listen to nobody.

Client: I wouldn't like them to end up like I am, with a child and another child on the way. I would like for them to finish school. I have girlfriend who says, "I want a baby," I say, "No you don't." I say, "Cause it ain't all fun."

Client: I'll say, "Girl, you just don't want to have no children." Its hard, you know, trying to raise a child, especially if you are a single parent, you're not married, and you're young. Getting on welfare just won't take care of it. It will help, but it won't take care of it for the rest of the month. You usually spend the money right at the first.

Client: Not really. I was gone try to wait until I was round about...until I got a little older. My mama had me when she was 16, and I was gone wait...try to, you know.

Even after receiving warnings, teenagers are still getting pregnant. One of the reasons that some teenagers don't delay pregnancy is because they want a baby. As reported in Chapter II, there are various reasons for this decision. Some of the clients in this project desired to become adolescent mothers, or knew of others seeking pregnancy as teenagers. Sample explanations for their desiring a premarital pregnancy were:

Client: I was happy. I felt like I would have something that's mine now.

Client: My friend, she said that she was going to have a baby. She was 16 when she got pregnant. She said, "Honey,

I'm going to have a baby." I said, "Don't do that." I didn't have no children then. She threw away her birth control pills and then she had a baby. Her mama is raising him now.

Client: My sister says that she is ready to have children. I told her, "Don't do that, just go on and have fun and when you find somebody stable and you really love them, then you can talk about having children."

Client: I guess they want to be like their friends. They see their friends with babies and they want to be like them. They think that it is so easy, you know. After they have that baby, they gone see that its not as easy as they thought it was.

Client: With the first one, I wanted to have a baby. I used to like babies a lot, and I used to like keeping them.

Adolescence has socially defined characteristics which are unique to that period of the life cycle. It is viewed as a stage in which identify formation is being refined, independence from parents is being expressed, and social interaction among peers is enhanced. In terms of societal expectations, parenting is reserved for married adults. Therefore, one might expect unmarried parenting adolescents to experience a lifestyle different from that of their non-parenting cohorts. Some participants were able to conceptualize what might be different about their present lifestyle if a pregnancy had never occurred.

Client: It wouldn't be so hard trying to go to school, first of all. I would have the freedom to do a lot more things, and that's all. I would have the chance to go to college.

Client: I would be graduating this year, and I wanted to be a model. I probably would have took up modeling school. I'd have a good job. Then, I would have been ready for some children in about 2 more years.

Client: I have to worry about my little daughter. If I didn't have her, I would probably just worry about what am I going to wear the next day, or something like that.

Client: I could date more, you know. I could go out more. I could have had things that I wanted, like a car. But my children, my child is in the way. I have to take care of my child first. I could go to school things, like basketball games and things like that. I could have more goals for myself, but I have to think about my child first.

The question was asked, "What is the best thing about being a mother at your age?" Some representative client responses were:

Client: There ain't nothing good about it, not really. Well, I guess...well, there ain't nothing good about it.

Client: Sometimes it is fun going shopping for the baby.

1. Health

The deficit model would propose that these young mothers experienced pregnancy complications. Since infant mortality is such a problem within the Black community, one might expect that, at least one of the participants, experienced the death of an infant. Contrary to the report of some authors (Beyer, 1983; Garn, Pesick, & Petzoid, 1986; Hamburg, 1986; ; Moore, 1985; Wallis, 1985), all of these young women had healthy babies. Their successful physiological pregnancy experiences enhance the research findings of Geronimus (1987). One young lady had two caesarean sections, but that procedure is not uncommon among other women who give birth.

Client: I had a caesarean with Child 1 and I had one with Child 2 too, but I asked for that one. Child 1, she was just too big. They tried everything, but she just wasn't going to come out. I mean they tried everything. I got on my knees and everything in that hospital.

Social programs intervened to assist these young women in prenatal care. They were all enrolled in a school or health center program which helped to monitor their progress during pregnancy. As participants in these programs, they also received additional instruction and counseling concerning their health and the implications for their baby's well-being.

The emotional state of these adolescents was also a factor to consider. Atkins, Protinsky, and Sporakowski (1982) investigated concerns of mental health and adolescent mothers. Interestingly, all of the respondents in this study reported that they were happy. All appeared happy with the exception of three, although they didn't admit to being unhappy. Their facial expressions and tone of voice were indicative of sadness rather than happiness. One mother of two defined a happy person as someone who didn't have children, but still insisted that she was happy. Participants expressed positive feelings about their lives and love for their children. Regarding whether self-esteem is impacted by pregnancy, one client explained:

I was scared to go places when I was pregnant. I just stayed in the house cause I thought people were going to be laughing at me. Cause I thought, I used to tell people, "I'm not gone get pregnant," but I got pregnant.

2. Education

When one considers the various reasons a student may drop out of school, teenage pregnancy is a primary reason for adolescent girls. However, nine of the ten clients were continuing their education and had plans of graduating from high school. This result was influenced by the source of the sample population. The alternative school for pregnant adolescents was the referral agency for most of the participants. Therefore, they were enrolled in school. The investigator observed that while most of the clients had a strong desire to "get an education", few, including those about to graduate, had even mastered grammatical skills. Only two clients had received any type of vocational training. This raised the question of their understanding of educational objectives. It appeared that they equated receiving a high school diploma, a piece of paper, as being educated rather than having mastered specified skills. Their decision to continue in school, refuted Frustenberg's (1972) findings that women who returned to school immediately after the first child, were less likely to experience a second pregnancy within 12 months. That might be valid for the general population of teenage mothers with one child, but it was not applicable to these young women. After the birth of a child, most of them immediately returned to school. As reported by the participants, they did not anticipate dropping

out of school. Having babies was not viewed as a barrier to graduating. Explaining their rationale for continuing in school, some clients said:

Client: I didn't want to just sit around and do nothing. I wanted an education, so I decided to stay in school. I want to be able to take care of myself and my children.

Client: I want to make something out of myself for me and my kids, so I won't have to wait on no welfare check monthly. When my children need something, I don want to say, "Well, I have to wait until the first of the month." A lot of girls drop out because they can't get no baby sitter. It used to be the law when you couldn't drop out until you were 17, but now they don't care no mo.

Client: I told everybody that I don't care how many children I have, as long as I finish school, and I have, almost. (This client is a senior) I just want my education. Maybe I can find me a good job or something. If you drop out, you really don't be having no good jobs, you know. You depend on your mama and stuff. I be just wanting to get out and get my own place and stuff and try to help her out with the bills and stuff.

Client: I feel like I got to do things for my children, so I want to stay in school. There ain't nothing out there if you just quit school. It ain't nothing out there but restaurant jobs, and they don't pay much when you got two children. So, I'm gonna work hard for my children.

After becoming pregnant with her second child, one client reported the encouraging words her mother gave her regarding finishing school.

Client: She said (in reference to her mother's comments) maybe God put me on this earth to have children. You know, like at a young age. So, she felt happy and I sort of felt happy. She just said, "Finish school". That's all she worry about. I thought she was going to be mad or something, but she was happy. Then she said, "All I want is for you to stay in school." My mama told me don't end up like her. She was going to high school, but she got pregnant with me. So, she didn't finish school and she had to end up working in a plant. She don't want me to end up like her, but mama had one child. This will make my second child. She said, "You can have two children and finish school." My mama's mama wasn't there for her, but she's there for me.

One participant dropped out of school in junior high when she had her first of three children. That was three years ago. Although she expressed a desire for an education, she had not returned to school. Explaining the reason for that decision, she said:

Not having a baby sitter. Cause, I don't trust people with my children.

Clients, who continued in school, did admit to some inconveniences and hardships in pursuing their high school diploma. Securing affordable, dependable child care was a major problem. Baby sitters are difficult to find for one child. It is especially difficult for those with more than one. Some clients discussed the frustrations of the dual roles of mother and student:

Client: I got to get up and get both of them ready, then I got to get myself ready. That makes it like 2 hours earlier than the time I would usually get up. I got to get them ready and den I have to get together the pampers and milk. It's a lot of extra stuff to do in the mornings.

Client: I'm constantly stopping what I'm doing to get up and see what she wants. Then, while I'm doing whatever she wanted me to do, she'll climb on the table and tear up my homework and I have to start all over again. Its kinda hard, cause I have to set certain times for me to be with her and stuff. I have to do my homework when I get home from school. When I bring her home from daycare, I have to try to get her to use the potty. She'll just mess up the house and I'll have to clean up after her. Then I'll be up until about 10, cause her bedtime is 9 o'clock. I have to get my bath, after I get her in bed. Its just that I don't get that much sleep. Its pretty hard trying to go to school and attend to your child. Some schools don't understand, like if you have detention at school. You say, "I can't serve my detention cause I have to pick up a child." They say, Well, that's not my problem, that's yours. You shouldn't have gotten pregnant." Its just certain things that they do to try to make us upset and I just try to not pay attention and stuff like that. The teachers be saying, "She is such and such, and she has such and such,

and why doesn't she go to the alternative school." When you have a child, the teachers whisper back and forth and stuff. It hurts, it hurts to know the people...well, they suppose to be your teachers and should set an example of what you should be. Instead, they stand around and gossip.

Client: All you hear is that you are going to drop out. Well, the first of the year I did, because I couldn't find no day care. Then I heard about this place I could take her. So, I took her to this place and now I'm here.

Client: Sometimes I have to stop doing my homework and then start back doing it later.

Client: It messes up the grades that I am making. Its because of my children. They be up all the time.

Client: Teachers, I believe they make the people not want to go. You know, you have kids...I guess it ain't their fault that you got children, like some teachers say. The point is, when you are at home, you don't be having time to do homework. Your children, if you ain't cleaning up or doing this, the children are hollering. How do you expect someone to do homework? Like when you are out having a baby, you can't be doing all that make-up work. A lot of people have two, but even if you have one, you have to still keep your household chores. Then you have to do all that work. You don't even have time. That's why so many people be flunking and they flunk, so they just drop out. I had said that if I flunk, I'm dropping out.

Client: Everybody always says how hard it is going to be and stuff like that. After I had her and everything, I felt that it wasn't all that hard, but it was hard. I had to try to figure out who I was going to get to keep her while I was going to school, and stuff like that. I went through, I don't know how many baby sitters. Finally, I put her in day care. That was hard, trying to come up with the money.

Client: Places like Human Services say that they will help you find a baby sitter, but that's a lie. It seems that they (referring to Human Services) hurry up and find a home for White children. For Black children, its hard to find one. The way I see it, they find places for children of people that work. Well, if they work, they can pay someone to keep their children. For the students who want to go to school, they can't find nobody for them. Human Services always say that you can call on them. You can't call on them, because they don't help you. I don't know nobody that you can call on for help when you need it. They might give you welfare or food stamps, but that still ain't helping you.

Client: I called the Department of Human Services. I asked them if they had a program where you could get day care and you wouldn't have to pay for it. Every time I called, they were trying to be a little bit smart and stuff. So, after that, I called and I left my name and number, so I could go and apply. They never did call me back. So, I don't know. I guess I'll try to do that again.

3. Income

An estimated cost of raising one child in an urban setting ranged from \$95,867 to \$111,439, depending on the part of the country in which one resided (Deacon & Firebaugh, 1988). This figure might startle employed adult couples. Considering the age, level of education, and marital status of these single young women, one would expect that their incomes were inadequate. By the standards described above, not only could they not afford to parent two or three children, they didn't have the financial resources for one child. The clients all had incomes below the poverty level. They were unemployed, which was a function of age, lack of educational preparation, or constraints of school obligations and baby-sitting requirements. Money received was from a government stipend, the non-custodial father and his mother, or family members of the clients. Some of the young women received no assistance from the fathers of their babies. It appeared that these clients had entered the poverty cycle fueled by single female parents. As one young mother stated:

Sometime with the little money you get, you can't even give them (referring to the children) some of the things that they need. Its hard, its true, but I try.

As mentioned previously, some fathers were not providing any financial assistance for their babies. It was interesting that many of these adolescent girls expected their boyfriends to behave in this manner. They didn't anticipate that he would help or planned any type of shared financial arrangement which included him. Illustrating this point were the following comments:

Client: I wasn't planning on him helping to take care of the baby or nothing, I was just planning to take care of it myself.

Client: I don't see them (referring to the baby's father and his family) at all and now he has moved out of town to California.

Client: Like my mama always told me, "Mama's baby and daddy's maybe." The boy can do what he want to do. You the one who got to be stuck with that baby for the rest of your life, not him. He can go on about his business.

Client: I really won't ask him to do anything for them. I ain't never asked him to do anything for my children, but one time. He acted like he couldn't do it. So, I just said, "Forget it." (This client had all three children by one man)
Client: He comes around when he wants to. I just say, I can't have that. I say, "My baby needs a full-time daddy." He say, "Well, I ain't gone be there for her." He'll say he is gone come over and I get her ready and stuff, and he don't even show up. He use to call me all the time, but he don't call no more. I told him, "Just don't call me no more if its going to be like this." I can be a mother and a father. I told him, "I'm not gone beg you to take care of her."

Realizing that she would get no assistance from the fathers of her three children, one mother explained her money management process for using the \$238.00 monthly AFDC check and food stamps.

Most young mothers drink and smoke, so they spend that as soon as they get it. I like buy pampers or something like that. I have to stretch my money. I don't just go out and spend it. I don't spend money on me, I spend it on them. I know how to get by, you know. I'm stingy in some things. I try to buy something really cheap. When I go shopping, I try to get the lowest thing. I learned from my mother how to grocery shop. I can come out with two buggies full of food and still have food stamps left over. Some people go in and try to buy all of this name brand food and stuff. They don't understand that the food with the white paper with the black name, its the same food. You can eat it just the same.

One client, in particular, appeared to understand the difference between her financial situation and being middle class. She desired to be middle class and expressed that she wished her mother had been middle class. The question was asked of her, "What do you consider middle class?" She responded:

You know, having money, but not being too poor or too rich. Having money to give me this when I ask for it, or something like that. Being able to keep the lights on, keep the house up pretty good, keep the rent paid and the phone on, and stuff like that.

4. Family Structure

Family structure is couched within the deficit model because so many parenting teenagers are from one parent, female headed households. In this research, only one client resided in an intact family environment. All other participants were from a female headed household, created by their parents separating or divorcing, or never marrying. Even in two situations, where the fathers were deceased, their

mothers were never married to them. Klein (1974) found that the majority of pregnant teenagers lived in female headed households. The results of this investigation concurred with his findings. All female headed households do not necessarily produce adolescent parents. There are some conditions within some single parent households which could serve to discourage teenage pregnancy. For instance, Fox (1979) suggested that adolescent pregnancy is lower if a strong mother-daughter relationship existed in a female headed household. Of course, that wasn't true for some of the participants in this study. Interestingly, some of these clients experienced uniquely weak bonding attachments to their mothers. This point was illustrated during the later pattern-matching discussion of the subjective utilities model.

Decision-Making

The investigation was concerned with whether there were any attempts by the clients to make a decision regarding their sexual behavior, contraceptive use, or pregnancy resolution. Also, the researcher was interested in whether participants realized there were choices available to them and, if so, what lead them to select a particular alternative. The decision-making model exposes that there is a rational process which leads one to choose a specific behavior.

1. Decision-Making and Sexual Behavior

The interviewer was interested in knowing what precipitated the transition from virginity to becoming sexually experienced. Participants, with one exception, were sexually active before they reached the age of fifteen. This indicated that there was a decision made fairly early in adolescence. Two factors surfaced as significant motivators in this decision. Consistent with the literature, the decision to become sexually active was a result of desiring to please peers or the boyfriend (Barglow, Bornstein, Exum, Wright, & Visotsky, 1968; Franklin, 1987; Scott, 1983). For example, two clients explained:

Client: I wasn't even thinking about having no baby. I wasn't thinking about that. I guess it was just pressure from those boys.

Client: I kinda felt pressured. I really didn't want to, but he wanted to.

Client: If I had a chance to talk to some of those girls in junior high, I would tell them, "Don't think about what the boy wants, its what you want." You have to be aware of whats going on, because some boys really don't care how they do you. They'll just treat you any kinda way. They'll take advantage of you and stuff. They'll tell their other friends, "She let me do such and such, you can do it too man, that's how easy she is." You have to tell them straight, "No, this is not what I want to do." You just have to tell them how you really feel, cause if you don't, then they will try to take advantage of you.

In the media, sexual affairs are portrayed as highly enjoyable. Realizing that adolescents are exposed to mass communication, one might assume that pleasure seeking was a

factor in premarital intercourse. Also, it could be theorized that after beginning a sexual relationship, the enjoyment prompted young women to repeat that behavior. This idea was not supported by participants' responses. The clients reported not having enjoyed their early sexual experiences. Therefore, personal pleasure was not a motivating factor. As one mother of two stated:

I feel ain't nobody ever made me feel good, ever. I didn't like it naun time. That ain't no lie.

The client's decision to become sexually active appeared motivated by the unselfish alternatives of pleasing significant persons in their lives or not pleasing them. In explaining why young girls engaged in premarital sex, selected opinions were:

Client: I guess because everybody else is doing it or they are crazy and think they can keep their boyfriend or something.

Client: Cause everybody else is doing it. That's what I thought. It seemed that everybody else was doing it, so why not me? It seems that your friends be talking about you if you don't. They call you names and stuff...virgin of the school. Cause, that's how they was doing when I was in school.(This Client dropped out of school in junior high) Well, you would not want the whole school to know and be laughing and stuff, talking about you still a virgin.

Client: People tend to say, "Well, it ain't peer pressure, peer pressure don't make people do this or that." But, I see a lot of girls who were so smart and so sweet, just like me, who went to junior high school and let their friends talk to them and tell them what to do.

Client: My friends, they were saying, "Girl, gone, gone, it doesn't hurt." You know, so I believe it was that. I didn't never think I would get pregnant though. A good friend of ours, she did, and then I did.

Client: To please the boy. Like, I've been in situations where the boy don't come back to me. I hated that, but its in the past. The boy just talks them into it.

A part of the decision-making process was to consider the results of selecting one alternative over another. The consequences of the behavior of these clients were viewed in terms of short-term expectations, such as losing the friendship of peers or the emotional attachment to a boyfriend. Consistent with Staple's findings (1976) the participants were not promiscuous, but were permissive because of their emotional attachment to their boyfriends or their intense need of acceptance. As one client stated:

Some of them were like one night stands. If I had known it would be like that, it wouldn't have happened. I done had some that tell me things and then get my head all filled up, but I done got hip to their game now. Its just...its just that I ain't never had nobody to really care about me. I haven't had nobody to really care about me, at least male wise.

To further explore feelings about premarital sex, clients with daughters were asked to explain what they would tell their daughters about sex. Two clients, with three daughters each, stated:

Client: I would tell them that if they decide that they want to have sex, make sure it is with somebody that they really care about and that they can come to me and we will go and get the pill.

Client: Well, I really can't say at this time, because they are not that old, but I'm going to try when they get older. They need to be old enough to know what I am saying. Most girls get active around nine. I think they may really be able to understand around seven or eight or something like that.

2. Decision-Making and Contraception

Contraceptive measures are very assessable to adolescents today. Within the community, in which these clients resided, there were health clinics available to them to receive contraceptives free of charge. The cliché "Experience is the best teacher" did not appear to have the impact on these young women as one would hope. In terms of dissemination of information, the participants were aware of contraceptive measures. Some of them had used the pill, but discontinued because of physical discomforts. Other methods, such as the condom and foam, had been used irregularly by a smaller number of respondents. Their decision to stop using contraception was based on their dislike for a particular method, inconvenience, or refusal of their sexual partners.

When contraceptive use was discontinued, abstinence was not substituted to replace the lack of external birth control measures. In making this choice, the risk of pregnancy and its long-term consequences did not appear significant. Since these girls all experienced more than one pregnancy, one would think that the prior pre-marital pregnancy experience would influence their future behavior. This was not the case. Clients merely made the same "mistake" again and gave excuses for their behavior, although they reported an undesire for additional children during their teen years. The question was

asked, Did you want to get pregnant again? A typical client response was:

Client: No, I just wanted to wait until I got out of school.

Client: No, but after my first child...I wanted a girl, but I didn't want it so soon.

Who is at risk for a repeat pregnancy? For one answer, Mott (1986) found that younger adolescent mothers were at greater risk for repeat pregnancy than older adolescent mothers. This investigation supported that premise. The mothers in the study with 3 children started their parenthood experience at an earlier age than those with fewer children. One explanation for this was related to communication skills. Younger girls appeared to be very shy and less likely to take charge of decision making. Communication with sexual partners about contraceptives was practically non-existent, even after the first pregnancy. For instance, one young mother's boyfriend just stopped using the condom. She had no idea why he made that decision, because she never asked him. She merely continued having intercourse with him until she became pregnant with his second child. Attitudes about contraceptives and contraceptive behavior were reflected in the following responses:

Client: I don't like taking it. They make me sick.

Client: I was taking those birth control pills, even though they were making me sick. I just stopped taking them and I got pregnant.

Client: I was taking birth control pills and I ran out. I just didn't go back and get them.

Client: I used birth control pills, but it didn't work out. It hurt my breathing. When I walked down the hall, I would be out of breath.

Client: I used Emco, you know, with that syringe thing. I don't like it. It was just messy like. I just stopped using it.

Client: We were using condoms and I remember one time that it burst. I just knew that I was pregnant, but it wasn't my fault.

Client: I liked birth control pills and I was taking them. I wasn't thinking that you had to take them the same time everyday. I was taking them for about 2 years. It took me two years before I got pregnant.

Client: When my grandmama first said that she wanted to put me on birth control, I wasn't doing anything. Then I got older and I wouldn't take them because they were making me sick and stuff. Then she started giving them to me, but that still didn't help because she would forget to give them to me.

Client: I took some for about a month. They started making me sick. I wanted to change, but the doctor wouldn't change them. So, I just stopped taking them.

Client: Well, for me, they make you sick. I tried different kinds, but they still won't work. They gave me foam, you know, to put up in me right before I had sex. Sometimes I would just forget to do it. After I have this baby, I'm going to get something else. It is something you can stick up in you if you really don't want to have a baby.

One client did try to responsibly contracept. She had secured and was using birth control pills until her mother discovered her actions. The client reported that her mother made her throw them away. She had no idea why her mother was opposed to her taking the pill. She stated:

Right to this day, I don't know why she made me throw them away, but she did. She tried to keep us from going together, but I just kept on going with him. After I had the baby, she tried to keep us from seeing each other.

3. Decision-Making and Pregnancy Resolution

When an unmarried teenager realizes that she is pregnant, there are some legal alternatives to consider in deciding how to respond to the situation. She can abort the child, carry to term and parent, carry to term and give the baby up for adoption, or she can cease to remain unmarried. The reality is that some pregnant adolescents don't see all of these options as being viable alternatives. In fact, depending on their personal beliefs and preferences, and the response of the male partner, these proposed options may not be perceived as choices. For example, although these mothers were of low-income and probably could not afford an abortion, most participants were opposed to the idea of their having the pregnancies terminated. This reaction was not surprising, considering these young women were not white, middle-class, highly success oriented, nor from intact families, typical characteristics of abortion patients. One client desired to abort, but waited too long to seek one. Most clients held very strong views opposing abortion, as determined by these sample responses:

Client: I can't do that. I can't kill no person.

Client: I couldn't do that. I couldn't have no abortion. That's killing a human being.

Client: My mother nem, they were pushing me, trying to get me to have an abortion. I didn't want that. There was something about that, that I didn't want. They took me down to that place and stuff, but the doctor told them that I was too far along to have one. He said that they could take me

to Atlanta. I said, "no"! I just kept on crying and stuff. That's not right to try to push your child into doing something that they don't want to do, especially abortion.

Client: If you have an abortion, you have a beautiful baby and you are just destroying life. I think you should give somebody a chance. I think I would have regretted it, doing that.

In the Black community, babies born out of wedlock have traditionally been accepted lovingly and the mother has been given support. The extended family network, a source of strength for Black people, perpetuated that pattern. As a member of the Black community, the investigator believed there would probably be more of a stigma resulting from giving a child up for adoption, than parenting a child as a single adolescent mother. After carrying their babies to term, none of the respondents considered adoption. Typical responses are illustrated in the following examples of clients' attitudes:

Interviewer: What were some of the reasons you decided to keep your babies?

Client: I wasn't gone carry it no nine months and then give it away. Going through all that pain and stuff, and then give it to somebody who ain't even went through the pain.

Client: With my first baby, I didn't even think about giving it up for adoption. With my second baby, I had thought about giving it up, but I realized, you know, like they say...God don't put no more on you than you can bear. Its hard, I mean its hard with two children. Its hard with one, but you'll make it. You think it ain't gone happen, but, sooner or later, ita work out for you.

Client: Putting them up for adoption...you be hurt when you give it to them. About a year later, you be probably wanting it back and stuff. I couldn't do that.

Client: After laying down and getting it, I can keep it. If you lay down and get it, you might as well keep it.

Client: When you see it, and its so little, you think about all you been through to have this baby. After all those months, I finally get a chance to see my baby and hold it. So, I guess its the baby who kinda does it to you. When they look at you, you look at the eyes and the fingers,...You think, "Just think, I made half of this person." I think that I wanted to keep it because I was thinking about there was so much I wanted to teach it and do for it.

Client: I would hate myself if I gave my child up for adoption, cause its just...its just brutal. If I gave my child up for adoption, I could see my child on the street, but I wouldn't know who she is.

Since all had friends or close relatives who were unmarried mothers, their decision, regarding pregnancy resolution, was the "norm" in their environment. Also, findings in this study concurred with those of Gispert (1984) and his associates, that most of the adolescents who became pregnant more than once did not marry. In most instances in this investigation, there was no discussion or consideration of marriage as an alternative. Dialogue between interviewer and client further explained the considerations regarding pregnancy resolution.

Interviewer: Did you ever think about marrying first before you had children?

Client: No, not being young. Maybe when I get old I probably will.

Client: I'm not ready to be committed to anyone right now.

Client: He asked me when I first got pregnant. He said, "I love you and I want to marry you and my mama thinks its only right." I said, "Well, I don't know." It kinda scared me. I just wanted to have something of my own right now, until I get ready to settle down.

Subjective Utilities

This inquiry sought to identify significant influences in the client's life which served as a model, or encouragement, for a certain pattern of behavior. In other words, there were certain persons who had referent power over the decisions of these young women. Referent power is a concept used to describe a situation whereby power is given to one because an individual holds one in high esteem. When the cases were analyzed as a group, there were similarities among the roles identified as significant. Persons assigned to these roles were very influential, hence very powerful. Also, many intergenerational, social, and environmental factors were in common. Therefore, the participants may have been assimilated into a particular cultural pattern based on association.

1. Individual's perception of self

Symbolic interaction looks at how one interprets symbols within the environment and what meanings are assigned to them. Basic to this understanding is how one perceives the self. In describing themselves, the clients all stated that they were happy persons. However, when explaining the characteristics of a happy person, some descriptions were unique to their life circumstance and experiences. Most were

slow to identify positive things about their personalities. Indeed, a few could not think of anything good about themselves to report. In determining their desirable qualities, motherhood was used as a frame of reference. As one mother explained:

I think I'm a good mother. I do alright. I do take care of my children. I can be a good friend, and that's all.

In identifying the characteristics of a happy person, motherhood was again a focal point.

Client: Getting to have fun, go and do things you want to do, but, you know, having fun at the games and stuff. I'm happy with my babies. My children are my pride.

Client: Yes, I'm happy. You know I got kids, so I'm happy.

Another factor in considering how one views the self is aligned with the extent to which one feels loved and has an object of affection. In identifying persons who loved them and persons whom they loved, all mothers mentioned their children. As one mother beautifully expressed:

Client: When you are hurting inside, you can look at your baby. You feel warm. You know you got that love.

2. Influence of parents

With the exception of one mother, the mothers of the other clients were unmarried parents as teenagers. This explained why the age range for clients' parents was middle thirties to early forties. In some instances, the intergenerational cycle of teenage parenting went as far back

as grandmothers. For example, one client described the relationship of her maternal grandparents:

Client: They were never married. He went off to the service. When he came back, mama was already born. She (referring to her grandmother) used to tutor him cause he was dumb in school. The way she told mama, I guess that's how she got pregnant. When she was tutoring him and helping him with his books and stuff. My mama looks just like him and he was denying her. She looks just like him. I hate when somebody, they look just like they daddy, and the father denies them.

Single, female-headed households were the norm for participants' families of orientation. Not only were the fathers absent from the home, but some of the clients had, virtually, no contact with their biological fathers. When asked about the relationship between them and their fathers, the following responses indicated the nature of those associations.

Client: I don't see much of him. He used to come around all the time, but now he hardly ever comes around. I haven't talked to him a lot since I was little. He is no good.

Client: He didn't help out with me. He didn't buy my baby a Christmas present...and not even me. I just don't have nothing to do with him. I'm going through what my mama went through with my daddy. He used to say that I wasn't his. If he had stayed with her, she wouldn't be in the good shape now that she is in. He is the type of guy...he will bring you down. Let me put it this way, all my daddy care about is finding him a woman. He's into the party life. He just likes to party.

In the families where single parenthood resulted from divorce, the marriages were so short that the clients didn't recall ever having lived in an intact family situation. When asking one client if she remembered living with both parents before the divorce, she replied:

I don't remember a lot of it. It may have been 6 or 7 years that they were married, cause I don't remember hardly nothing about it.

In single mother headed households, the level of bonding between mother and daughter is significant in relation to averting teenage pregnancy (Fox, 1979). This emotional cohesiveness was not present in some of the mother-daughter relationships of these clients. Strained interpersonal interactions between respondents and their mothers were commonplace for some. This assessment was determined based on the following client replies:

Client: I know she don't love me (in reference to her mother). I'm serious, that's the way I feel. She picks between me and my sister. I feel that she don't care nothing about me. I feel that she just had me just to be having me, cause she got pregnant by my daddy, that's all. Like I say, "Look how you be treating me". She say, "Well, I'm grown, I'm the mother and you are in my house." I just leave it at that. I don't say nothing to her. She argues about everything. Every word come out of her mouth is a cursing word. I just don't see how she do it. Other people, like your friends, they talk to their mama sometimes. They can talk to their mamas about any litty bity thing. I used to think, "Why can't I talk to my mama like that?"

Client: She act crazy sometimes. When she gets to drinking, she be all up in folks face talking crazy. I don't want people to even know she my mama. She be saying, "That's my daughter", but I don't be wanting folks to know that she my mama. When people ask about my mama, I always say that my mama is at home in the bed or at work, but I be talking about my grandmama.

Client: My mama, she never has really been there for us or anything like that. With me anyway, she never has really been there. My mama, she never really paid any attention to me. I don't talk to people that much, because I never did understand why my mama did me the way that she did. I always had to turn to my father. He always, you know, would take care of me and stuff. She never really cared. So, I guess that's what made me go stay with my boyfriend and stuff. He said that he didn't think it was right the way she was treating me and stuff. She would like, take her boyfriend

over us, as far as what she would do for us. If he said, "Don't give her this", she would do what he said. That kind of hurt a lot.

3. Influence of siblings

Related to Hatcher's (1973) findings, participants with older sisters followed a pattern set by those siblings. Their sisters became unmarried mothers as teenagers. One client reported that her teenage brother was a father and had custody of his daughter. In two instances, participants and their adolescent sister, or sisters, were pregnant at the same time. In reference to the age similarities of one client's three children and those of her year older, unmarried adolescent sister, she explained:

They all are along right there together. My oldest and her oldest are 5 months apart, and the second babies are 5 months apart and the third are 1 month apart.

4. Influence of Friends

During adolescence, it is anticipated that peers will have a great impact on the behavior of their cohorts. This belief was supported by participant responses that their friends had lifestyles similar to their own. Of the participants who reported having friends, all had some who were unmarried adolescent parents. Two clients responded that they had no friends. Some of the friends of the other clients

were also parenting more than one child. Among their peer environment, teenage pregnancy was a common incident. Also not unusual was the fact that these participants and their friends carried their babies to term and were accepting the dual role of mother/father. To illustrate this point, typical responses were:

Interviewer: Do you have any friends who are also parents?

Client: Yeah, one of my friends, she is 18 now, but I guess she was 16 when she had her first baby. Her baby is 2 years old and now she has another baby. I'm not sure how old that baby is, I guess about 4 or 5 months.

Client: Not close friends. I don't really get involved with no friends. They trouble. I have one friend, I call my good friend. She's pregnant. That's about the only friend I got.

5. Influence of male partners

Some of the participants were impregnated by persons for whom they had little regard. The boyfriends, when participants pregnancies occurred, ranged in age from 14 to twenty three. At the time of their sexual involvement, clients felt an emotional attachment to their boyfriends. However, with the exception of three clients, their babies had different fathers. Interestingly, in most instances, the description of their ideal man contrasted the descriptions of the fathers of their babies, as evidenced by the following:

Interviewer: If you had to describe the man of your dreams, what would he be like?

Client: He'd be kind, love me and my children. He'd have a good job, not no dope man. He'd have a good job, cause I

want...like where I can give my children all the things they need and some of the things they want. You know, have a job and not be going out there messing around with everybody.

Client: He would be like...he would bring you to school and come and pick you up. He don't have to be cute or ugly, it don't really faze me. As long as he keeps himself neat. I don't care what kind of car he drives. I don't care if he's walking. He will treat me like a young lady and give me money, you know. I wouldn't ask him for nothing, because I don't want him to feel that I just want his money. He would give me money when he thinks I need some. He would come and take me to the mall and stuff. He would spend time with my child. That's what I want.

Client: I want somebody who's gone settle down and not nobody who's going to be the wild type. I need somebody who's going to stand by me and support me in going to school, you know. I want somebody who is going to stay with me and not run off or be part-time.

Unfortunately, some participants had been very disappointed in the reactions of their boyfriends to the idea of fatherhood. In fact, some of the fathers didn't even acknowledge paternity.

Client: My little girl's daddy, he go with this girl now. Everybody know he the daddy because, when I was pregnant, he was right with me at first. Then, him and this other girl got back together.

Client: I see him, but he rides up and down my street. He don't speak or nothing. He see me sitting on the porch and he don't say nothing. He once asked me if I was going around saying that I was pregnant. I said, "No, but I am though." He said, "Its not mine." I just felt kind of bad. I just feel sorry for myself sometimes, getting in a relationship like that. I just feel funny, that I had a relationship with him and then he gone do like this when I get pregnant.

Because of the criminal and deviate nature of the lifestyle of some of the fathers, the participants had elected to discontinue the relationship. One young mother got pregnant with her third child when her boyfriend came home on a weekend pass from jail. He has since served his time and

been released. In another instance, the father was still incarcerated. Some participants had already curtailed their associations with the fathers, although their babies were still pre-schoolers. Related to this, clients reported:

Client: I don't want him nowhere near my baby. When I was going with him, he was different. I see how he be. He got babies by other girls. He be beating them up and stuff while they be trying to hold their babies. I ain't with that. No one is going to be beating me.

Client: They got arrested (referring to the fathers of her babies) before for dope, but that's all. Oh, yes, my little boy's daddy went to jail for killing his mother's boyfriend. He out now though. He didn't do much time.

Client: I don't want to have nothing else to do with him.

6. Religion

Billingsley (1989) reported that 70% of all Black women held church membership and 85% considered themselves to be religious. The young ladies in the study were all members of Protestant congregations. They joined church and attended regularly as children, but had curtailed active church participation in more recent years. For most of them, the onset of pregnancy coincided with their decrease in church attendance, because of their perceptions of church members' attitudes.

Client: They don't bother them, (referring to boys who get girls pregnant), but for the girl, they be talking about you and everything.

Client: When you go, the folks get to talking, "Oh, you mean she is pregnant." "I can't believe her grandmother let her get pregnant." I just stopped going. My grandmother told me

not to, but I did. That's how folks are. They be saying that I'm too young. That be the first thing that come out of they mouth."

Client: After I got baptized, I used to go all the time. When I got pregnant with my little girl, I didn't go that much. Well, I guess it was my grandmother, she was kind of ashamed of me.

It might be assumed that, because these unmarried girls continued to have babies, that they were void of any sense of morality. This did not prove to be the case. From the opinions given, implications were that the clients had formed some opinion of the morality of premarital sex and pregnancy.

Interviewer: Did you have any feelings about your pregnancy related to your religion?

Client: Un, huh (yes), I know I did something I shouldna did.

Client: I know the Bible says its wrong. I think its wrong, but, you know, they say you ask God for forgiveness. Sometimes, you can't help it.

Interviewer: What did you learn in church about sex and pregnancy? Was there anything taught in church?

Client: My uncle, he's a preacher. I talked to him. He says, "Its not wrong getting pregnant, but don't make a habit of it." He told me to just find somebody who is going to be good to me. He said, "Don't make sex every weekend," which I don't.

Client: I don't remember anything about sex before marriage. I do remember something about living with a guy before marriage. I believe its wrong, but I just can't say that I haven't done it, you know.

Client: I learned that you shouldn't have sex until you get married and all that. You shouldn't have children until after you get married.

Interviewer: Did you believe that? (Referring to the church's ban on premarital sex)

Client: Nawl, I didn't believe that. I believe that you can have sex if you love somebody.

Assessment of Hypotheses

Hypothesis I

Adolescent mothers who experience repeat full-term pregnancies have similar psycho-social characteristics.

Based on the evidence found, this hypothesis was not rejected. All of the young women, except one, were from homes where there was an absence of the father. Their parents were either divorced, separated, or never married. Their family structures included half-brothers and half-sisters. They were all from a low socio-economic level. Of the ones who answered the related question regarding their mothers' early sexual experiences, eight had mothers who had her first pregnancy as an unmarried teenager.

Hypothesis II

Knowledge of contraceptive methods through family planning programs will prevent a repeat pregnancy.

This hypothesis was rejected based on the fact that all had knowledge of contraceptives and reported using some form at one time or another. Because of the environment in which most of these girls resided, they did not perceive pregnancy, even repeat pregnancy, as a tragedy. Other than being a slight inconvenience, most saw no major difference in their lives resulting from pregnancy.

Hypothesis III

The decision to repeat a full-term pregnancy is a rational process for Black adolescents.

This hypothesis was not rejected. On the surface, it might appear otherwise. However, most participants reported they did not desire pregnancy, the first or subsequent. There was no decision-making evident in regard to becoming pregnant. However, the rational process did enter into pregnancy resolution. They more or less allowed themselves to get pregnant without any rational thought process, but they had reasons for not considering other options. Therefore, the decision to carry the baby to term and accept the parenting role resulted from a rational process.

Composite of Clients Interviewed

As a summary device, a composite was developed by reviewing similar characteristics of unmarried teenage girls who repeat pregnancy. In compiling characteristics of adolescent mothers who repeat, information was drawn from interviews with participants in this project. From this investigation, the typical unmarried adolescent mother who repeated pregnancy came from a single, female headed household. Her mother, sisters, and friends got pregnant when they were adolescents. She loved her children and desired to

complete school in an effort to better provide for them. Her financial assistance was from the state or from her relatives. The father of the baby was providing no consistent support. She was a shy young woman, seemingly, easily influenced by peers. She had a desire to please men to gain their affection. Her actions had been motivated by the desire for male affection, rather than any sexual gratification or pleasure seeking for herself. Although her grades may have been good in an alternative school, her verbal skills indicated that she was academically deficient. Her world view was very narrow and her goals were short-term. She had not projected that her behavior would have far-reaching consequences. She was content with her life. By examining Table 1, additional insight may be gained.

TABLE I

SUMMARY OF CLIENT RESPONSES

	Client									
	1	2	3	4	5	6	7	8	9	10
Age of Client	18	17	17	17	18	15	17	17	17	19
Age at first intercourse	15	15	14	13	15	14	15	14	16	15
Age at first pregnancy	15	16	14	14	15	14	16	15	16	15
1 child and currently pregnant		X	X	X		X	X	X	X	
2 children			X							
2 children and currently pregnant	X									
3 children					X					X
Lived with both biological parents							X			
Lived with mother & stepfather								X		
Lived with single mother		X	X	X						X
Lived with single grandmother					X				X	

TABLE I (continued)

	Client									
	1	2	3	4	5	6	7	8	9	10
Lived with boyfriend	X					X				
Enrolled in school	X	X	X	X		X	X	X	X	X
Planned 1st pregnancy							X		X	
Planned other pregnancies										
Uncomplicated pregnancy and vaginal delivery		X	X	X	X	X	X	X	X	X
C-section	X									
Would not recommend parenthood to other adolescents	X	X	X		X	X	X	X	X	X
Described self as happy	X	X	X	X	X		X	X		X
Engaged in sex because of peers				X	X	X				
Engaged in sex because of boyfriend	X	X	X					X	X	X

TABLE I (continued)

	Client									
	1	2	3	4	5	6	7	8	9	10
Had knowledge of birth control	X	X	X	X	X	X	X	X	X	X
Had used birth control pills	X	X	X	X	X		X	X	X	X
Had used foam	X	X						X		
Boyfriends had used condoms	X	X	X			X		X	X	
Were using birth control pills			X		X					
Against abortion	X	X		X	X		X	X		X
Against adoption	X	X	X	X	X	X	X	X	X	X
Would like to have married father of baby/babies	X	X								
Mother was a teen parent	X	X	X		X	X		X	X	X
Had siblings who were unmarried parents	X			X		X	X			X

TABLE I (continued)

	Client									
	1	2	3	4	5	6	7	8	9	10
Had friends who were unmarried parents	X	X	X		X	X	X	X	X	X
Believed premarital sex was morally wrong			X				X			X
Believed sex is OK if you were in love	X	X								
Felt loved by mother	X	X		X	X		X	X	X	X
Desired to be childless at this time	X		X		X	X		X		X
Had half-sisters and/or half-brothers	X	X	X		X	X	X	X	X	X
Felt loved by biological father	X		X			X	X			
Experienced child care problems	X	X	X		X	X		X		
Received AFDC	X	X		X	X			X		

TABLE I (continued)

	Client									
	1	2	3	4	5	6	7	8	9	10
Received social security check			X						X	
Received financial aid from child/children's father/fathers	X	X				X	X			
Received help from children's paternal relatives						X	X	X		
Received financial help from own family		X			X		X	X		
Received help with parenting responsibilities from family	X	X		X	X		X			
Felt loved by current boyfriend	X				X	X				
Would like to have had tubes tied	X	X				X				X
Parents were divorced	X			X						X

TABLE I (continued)

	Client									
	1	2	3	4	5	6	7	8	9	10
Parents were separated		X				X				
Parents were never married			X		X			X	X	
Admitted to shyness	X	X				X				X
Expressed pride in motherhood	X		X		X	X				X
No contact with at least 1 of the fathers	X	X						X		X
No contact with either of the fathers			X		X			X		
Currently intimately involved with at least on the fathers	X	X		X		X	X		X	
Had attended church, but not now		X	X		X		X		X	X

CHAPTER V

DISCUSSION AND CONCLUSIONS

Discussion

In the discussion which follows, there was a return to the three models guiding the research on adolescent childbearing: the deficit, decision-making and subjective utilities models. The goal of this chapter was to assess the findings of this research to determine if the results were consistent with, or fail to fit these models.

Deficit Model

The deficit model proposes that adolescent parenting is a disadvantage to young mothers. Early parenting is detrimental to the mother and her children, especially in terms of family structure, income, educational attainment, health status, and overall quality of life. In all considerations, adolescent pregnancy is viewed as more costly than rewarding. Because of the perceived deficits, there is a high opportunity cost for premarital parenting. These costs are compounded by having more than one child as an unmarried,

adolescent parent. This research found the deficit model to be valid from a social scientist's frame of reference, but far from the perception of the young mothers. From prior research, it was assumed that the family of orientation was deficient and characterized by a female headed, father absent structure, a prediction supported by this research. With the exception of a mother/stepfather arrangement, there was only one client living with both parents. Throughout the literature, there were suggestions that a precursor to teenage parenting was to be a member of a female headed household in poverty. One might question the nature of the relationship between female headed households and early coitus. Why is this viewed as a deficit? What is the connection between family structure and early childbearing? While the exact nature of the father's involvement in the sex education of his daughter remained undefined, it is believed that father presence was positively related to his daughter's delayed sexual involvement. One explanation is that in father absent homes, it is probable that adolescents bear greater responsibility for household tasks and care of younger siblings, than do adolescents from intact families. The early assumption of adult responsibilities may lead to the adoption of adult sexual behaviors as well (Robbins, Kaplan, & Martin, 1985). When only one parent is present in the home, there are fewer opportunities for parental rules to be enforced. Miller, McCoy, Olson, & Wallace (1986) found that

the highest attitudinal permissiveness and sexual intercourse experience were associated with a lack of parental rules and strictness. Furthermore, parents who had few, if any, rules for dating appeared to be most likely to produce children who were sexually permissive and at risk of early pregnancy. This study found that parents seemed to exercise little control over the daughter's dating patterns or behavior. The permissive attitude of parents, as well as the behavior modeled by parents, could be interpreted as approval by the adolescents. Fathers were absent from the home and involved in their own sexual affairs. Most of the mothers were involved in their own courtship and dating relationships, sometimes to the extent of a live-in boyfriend. When this happened, there was not as much time to focus on the child's social activities. Also, an unspoken message was being sent to the child. That message was that sex, outside of marriage, is acceptable.

Although the clients reported some inconveniences as an adolescent mother of more than one child, long-term disadvantages were rarely identified. In understanding this, one must consider the environment from which these young mothers emerged. All around them were significant others who were single mothers of multiple children. In most cases, that family structure was all they had ever known. Therefore, as long as they finish high school, they felt that premarital pregnancies were of little negative consequence. The measure

of educational deficit was mostly defined in terms of the high school diploma. The vision of striving to acquire a lot of money and other material resources, comparable to the "American dream", was not owned by them. That vision is owned by those who buy into the middle-class concept of success. For these girls, there was little motivation to direct behavior in a manner which didn't impede the acquisition of higher education, a high paying job, or a higher quality of living. For them, having a beautiful baby may have paralleled another person's sense of accomplishment in being named the CEO of a large business. Other than what they viewed on television as fiction, they had few opportunities to interact directly with families different from their own. Hence, the only standard for comparison was a family situation closely resembling their own household.

Fathers of out-of-wedlock children generally play a minimal role in providing social and economic support (Presser, 1980). This previously reported finding, of a decade ago, was still found to be true. The investigator's perception of the fathers, referred to in this project, was that they applied a totally different meaning to fatherhood than the general population. Becoming a father may have been viewed as a rite of passage to manhood or some natural spin-off from having sex. It was interesting that the adolescent mothers appeared to anticipate this response from the fathers of their babies, especially when one considered that some

clients had all of their children by one man. His behavior was passively accepted. After all, his actions were "normal", in comparison to the other men of that environment. He didn't support the first child, yet the young mother continued to have children by him. One might speculate that, since most of these client's fathers were non-participatory parents, they had no basis for understanding the concept of shared parenting or fatherhood. Using the behavior of their mothers as a standard, it seemed typical for them to assume the sole responsibility for the children. It would have been atypical if the fathers had willingly accepted the socially delegated financial responsibilities of parenthood. This far-reaching lack of help has assisted the continuance of a cycle of poverty for the adolescent parent and her children. Thus, these young women seemed forced to rely on hand-outs, welfare, or become a member of the working poor.

The deficit theory was supported in terms of client income or worth of assets. Using that as a guide, all were within the poverty level, with most on welfare. Poverty can also be considered as a state of mind. There was a sense that these mothers, while admitting difficulty in purchasing items, had not internalized that they were poor. Working was the preferred method of acquiring money, rather than receiving welfare checks. Actually, adolescent mothers comprise a small number of welfare recipients compared to the total welfare population (Boxill, 1987). Therefore, the "brood sow" theory

was rejected. That theory proposed that Black adolescent mothers had children in order to qualify for welfare, and continued to have children to increase welfare allotment (Dunston, Hall, & Thorne-Henderson, 1987). This author felt that young adolescent parents were in a "domino effect" situation. Early parenting triggered the fall of the first domino which knocked down everything in its path, including high educational attainment, well paying jobs, financial security, time for personal growth and development, and all other advantages which these things might offer. Having multiple births, as an adolescent, only accelerated this deficit process. The prevalence of short birth intervals signaled further personal strain for these young women.

Participants in the study perceived that money had no influence on whether or not an adolescent was sexually active. While the researcher concurred with that observation, there was no denying that probably pregnancy resolution could be predicted based on socio-economic status. The recurring question, of whether there is a culture of poverty, still haunts social scientists. The culture-of-poverty theory proposes that the social structural conditions to which poor are exposed give rise to distinctive patterns of community and family disorganization. These, in turn, produce a distinctive set of beliefs, attitudes, and values, including feelings of marginality, helplessness, and inferiority, weak ego structure, lack of impulse control, and inability to defer

gratification and plan for the future. All of which could be applied to the group of Black adolescents of repeat pregnancy in this study. Although observers may feel that these young women exhibited a syndrome of failure, the adolescent mothers may feel successful.

Health factors are not necessarily devastating for pregnant adolescents. Although Black infant mortality is a serious health concern in the Black community, none of the research participants experienced any serious complications for themselves or their babies. It is well to note that these clients were not representative of the general population of pregnant Black adolescents. They were all involved in some form of educational or social service support program which assisted in monitoring their condition during gestation. Therefore, it is reasonable to assume that the highest problems with pregnancy are concentrated in situations where prenatal care is minimal. In fact Geronimus (1987) reported that, for Black adolescents, the chances of having a healthy baby were greater than for Black mothers aged twenty-four to thirty-four. However, considering the other factors couched within the deficit model, encouraging Black adolescents to parent early is not recommended.

Traditionally, the majority of Black people in the United States have functioned within the constraints of poverty. Whether it was a nuclear family, or a single mother with children, all had inadequate resources on which to live.

Therefore, having children out-of-wedlock didn't seem to be a particular disadvantage. Because of the extended kin network, these women were able to feed, clothe, and shelter their children, just like other families. Possibly, attitudes expressed reflected some of those earlier times of adjustment and family management within the Black community. These young mothers showed a remarkable strength and belief that they could make it. Their view of "making it" may not correspond to the expectations of others. However, through their life experiences, they had been taught survival skills. This research was approached from the micro level in order to objectively seek meanings these young mothers ascribed to their situation. This investigator sensed that there was no feeling of being locked in a cycle of poverty, but rather that they would make adjustments and continue.

Decision-Making Model

This model examines behavior in relation to the subject's identifying a problem, considering options, making a choice among alternatives, and taking responsibility for the consequences. For an adolescent to become a parent, there have been several decisions made. The decision to become sexually active, the decision to have sex without contracepting, the decision to carry the baby to term, and the decision to keep the baby all are involved in the process

which led to teen parenting. Although the decision-making process is a rational, cognitive exercise, a non-decision can be a decision by default, void of intellectual input.

The decision to begin coitus as an unmarried teenager seems to be one made by peers or dating partners. The adolescent merely reacts to the suggestion of others, especially if she is very young and easily influenced. Although untrue, the perception is that everyone is having sex. Therefore, a virgin teen feels isolated and embarrassed. Researchers continue to search for the meaning of sexual experimentation for young Black females. In most instances, reported in this research, sex was seen as a means of sealing an intimate relationship by pleasing the partner. It was as though the girls didn't realize that they had a choice. They merely responded to requests of partners and encouragement by peers. Seeking personal pleasure and fulfillment was not considered. During adolescence, it is very important to be accepted and aligned with cohorts. This may especially be true for Black adolescents who may be subject to rejection by the majority community, hence, strengthening the need for acceptance by their own.

Regarding contraception, this researcher was in agreement with Nathanson and Becker (1986) that peers were an attractive reference group regarding contraceptive behavior. The attempted guidance of parents and health care professionals was overshadowed by the persuasion of peers and sex partners.

Overwhelmingly, the parents in this study were in favor of contraception. In fact, parental approval for contraception is markedly higher among Blacks than among White parents (Miller, McCoy, Olson & Wallace, 1986). Black parents may have some selfish motives for wanting their children to use contraception. It has already been established that more Black than White adolescents will carry their babies to term and remain unmarried. Therefore, most of these girls remained at home. This decision placed more responsibilities on their parents to share in the caregiving of the grandchildren. Not only did this entail sharing their home and sacrificing rest and relaxation, but included sharing their financial resources as well. Lamanna and Langworthy (1989) found that contraception was not very salient, even to sexually active teens in social groups characterized by frequent premature pregnancy. Rationalizations about the perceived inconvenience of contraceptives and the "feeling sick" from birth control pills were more primary in the minds of these young women than was the fear of repeat pregnancy. Avoiding pregnancy was not a strong motivator to use birth control measures. This author felt that approaches to combat these attitudes must be employed. Merely informing adolescents on birth control methods does little to motivate their use. Because of immature cognitive functioning, some adolescents are unable to consciously connect sexual behavior with the consequences of pregnancy.

Having experienced one pregnancy didn't seem to impact their decisions regarding contraceptive use. The clients most determined to use birth control correctly and consistently were those with 3 children. It took 3 pregnancies before they saw the value of birth control. Another way to view that is, 3 children later, they were older and wiser. This explained why the younger girls were more at risk for a rapid repeat pregnancy than the girls who were older at index pregnancy. Possibly, public policy changes could be initiated to address this situation. For instance, Medicaid will not pay for a patient to have her tubes tied prior to her twenty-first birthday. An 18 year old mother of three or four, who is on Medicaid and desirous of the procedure, is denied surgery. She cannot afford non-covered medical services. Therefore, she is forced, by default, to rely on other methods of birth control. The government's position is not cost effective. Tax dollars allotted to pay for possible additional children will far surpass the cost of the surgery. Understandably, there are concerns when reports cite officials for coercing single parents to have this surgery. Some people are much opposed to that practice on the basis of ethics. However, when young mothers of several children voluntarily seek such a service, granting such a request may be the better long-term choice.

Pregnancy resolution decisions involve choosing to abort, carry to term, and, for some, whether to marry the father.

As mentioned in previous reports, the decision to have an abortion is not common among girls of low SES (socio-economic status). Unfortunately, a large number of Blacks are within the low-income population. Birth rates are exaggerated by race and SES effects on adolescent pregnancy (Robbins, Kaplan, & Martin, 1985). Therefore, it appears that so many poor and Black girls are getting pregnant and, proportionally, not very many whites. White and higher SES girls are having more abortions than Blacks in poverty. One report was that among unwed White adolescents, 41.5% terminated and 48.9% carried to term. Correspondingly, the figures for Blacks were 5.8% terminated and 81.5% carried to full term (Taborn, 1987). The family structure for these girls, poor, large, and less educated, was opposite the characteristics of those girls seeking abortion, including other Black girls. Middle class Black girls tend to behave similar to middle class whites.

By carrying the baby to term and keeping it, the girls felt that they were accepting the responsibility for the consequences of deciding to have unprotected premarital sex. Avoidance of marriage was also a way to insure that they accepted their responsibility. Historically, this was the pattern which had been portrayed in their environment. Black women who had babies out of wedlock would try to keep them. Often having a child gave the Black adolescent a sense of self-worth (Gibson, 1980). These girls knew that their mothers, neighbors, and sometimes grandmothers had children

and raised them without a husband. There was little perception that the responsibility should be shared with the babies' fathers. These women accepted their responsibility and now, these adolescent mothers felt that it was their turn. This may be considered as a rite of passage to womanhood. If there was one common standard for becoming a woman that was accepted by the majority of Black people, it was the time when girls gave birth to their first child (Ladner, 1971).

Subjective Utilities Model

The subjective utilities model proposes that there are significant elements in the adolescent's environment which serve as a model for behavior. The key to this model is the individual's perception of significant others as influential elements. Once these persons are elevated to the status of significant others, they possess a certain ascribed power over the adolescent. Personal goals, standards of behavior, and wishes became secondary to those of significant others. There was a high level of agreement between the subjective utilities model and the findings of this project, strongly evidenced by the consistent intergenerational pattern of teenage pregnancy and single parenting.

It was very likely that the clients perceived significant persons in their immediate family to be supportive of premarital sexual involvement. If there were older siblings

to look up to, they were likely admiring unmarried parents. Also, most of the research participants were the result of an out-of-wedlock conception. They were aware of the sexual behavior of their mothers as adolescents. Evans (1987) suggested that adolescent females, who perceived their mothers as somewhat approving of sexual activity, were more likely to try sexual intercourse. For instance, in one case, the project participant had a three month old sibling, because her mother was still having children out-of-wedlock. In another example, the father's girlfriend had an infant. An indication of parental attitudes regarding sex outside of marriage was illustrated by the fact that most of the participants had half-brothers and half-sisters. Therefore, prima facie evidence of parental participation in nonmarital sex, with a variety of partners, was readily available to the participants in this study. It was obvious that most of the mothers had several sex partners over their childbearing years. In contrast to research stating that leaving home indicated the likelihood of additional pregnancies, staying at home was just as strong a predictor for some girls. The home modeled single parenthood of more than one child, thus diffusing guilt, shame, and determination to be different.

For adolescents, friends greatly influence their behavior. Having a female friend who supported sexual involvement seemed to be highly correlated with being sexually active (Evans, 1987).

As most of these participants admitted, sexually experienced friends encouraged them to become sexually active. Many of their friends were parents. This is especially true of pregnant girls who decide to carry the baby to term. Like most adolescents, they want to be like their friends. Therefore, a stigma may be attached to the girl who is a virgin rather than a young mother. Young unmarried mothers are rewarded by the self-esteem which comes with being able to accomplish the same feats as friends. Even acquiring the motherhood status of enemies is a motivator. For instance, some girls want to have a baby for a certain young man, because other rival girlfriends have given him children.

Like most other people, these adolescents felt a need for love and acceptance. Since only two clients lived with a father figure, they tended to seek male affection from a boyfriend. There was great confusion between love and sex, with the two terms fusing in the mind and hearts of these girls. Their young age was likely to preempt conceptually sophisticated analytic reasoning skills. "Deprived" was the word which probably best described their situation regarding love of father or a father figure. They sought that reassurance outside of the family bond. Unfortunately, there were males waiting to prey on the vulnerability of these girls. These men told them things they wanted to hear, that they were beautiful and loved. These were things that should have been said and nurtured by their fathers. Since families

in these girls' neighborhoods were demographically similar, there were a lot of girls seeking this attention. Therefore, the competition for these males increased. As competition increased, so did the level of intimacy in which the girls were willing to participate. If it is sex that he wants, then they are likely to accommodate, especially because they fail to see serious long-term consequences.

Program Implications

Across the country, programs to serve adolescent mothers have increased from about 250 in 1970 to 1,500 in nineteen eighty seven (Dunston, Hall, & Thorne-Henderson, 1987). Many improvements are needed within the delivery system. Although the needs of adolescent mothers are multi-faceted, services tend to be narrow in focus. Coordinating services may be helpful, especially considering the age and educational level of these young parents. It is frustrating for them to go "agency hopping". Currently, the adolescent mother must go to several places to meet her needs. Some of the employees at these agencies are insensitive and unresponsive to these mothers' problems, as evidenced by respondents' comments in this study. Some programs help the mother during pregnancy, but fail to provide follow-up services after delivery. This creates tantamount to abandonment and a greater likelihood for

a repeat pregnancy. Adolescent mothers greatly need continued nurturance and support.

Whereas, program evaluations indicate success in meeting medical and educational outcome goals, most programs have failed to reduce rates of repeat pregnancy. This suggests that certain program components can be quite effective, but that intervening in the child bearing process is much more difficult. Indeed, some clients in this study were a part of a community program aimed at reducing Black infant mortality. During the three year program period, Black infant mortality dropped. However, some of the adolescent mothers were re-enrolled in the program because of subsequent pregnancies. One of the motivations of this research was to generate suggestions for programs implementations to reduce repeat pregnancy among adolescents.

There is a need for comprehensive sex education programs in the schools and churches. The school district, within which the participants reside, adopted Tennessee's K - 12 Family Life Education curriculum. Among other concepts, the curriculum has a sex education strand. However, adopting a strand by a school board doesn't guarantee the teaching of the material. Just as the other systems of the body are studied beginning at an early age, the reproductive system should be studied. There is no logical reason to wait until students are teenagers to start talking about reproduction and the

reproductive organs. Judging from the reports of early sexual involvement, by the time educators feel comfortable talking about sex, many students are sexually experienced. Indeed, some have already experienced a pregnancy.

Concurring with Furstenberg's (1980) suggestion, sex education should do more than provide students with knowledge, but equip them with what to do with that knowledge. For instance, the only school programs that have been effective are those that include on-site clinics that prescribe contraceptives and provide family-planning counseling (Sherman, 1986). There is still confusion over the when, what, and where regarding sex education. Somehow, in the teaching of these concepts, one must go beyond the knowledge level to synthesis and application. There must be some consideration of affective learning coupled with the cognitive. Many people think of teaching values when addressing the affective domain. This sends out a red flag for many groups. Therefore, we reach a stalemate situation. Politically, it may be unpopular to take a firm stand on instructing adolescents in pregnancy prevention through techniques other than abstinence.

Our communities need teen pregnancy prevention programs fashioned after those developed in Sweden. Swedish teens begin coitus before teens in the United States, and have fewer problems with teenage pregnancy. Therefore, it is reasonable to assume that their programs are successful. Efforts in

Sweden include the development of special school based clinics, a critical point of intervention.

Some of the advantages of school based clinics are, first of all, a captive audience. Also, when family planning services are delivered within a context of comprehensive health care, young people can be assured of getting contraceptives without being identified as sexually active. Another advantage is that contraceptive continuation can be enhanced by frequent contact and regular follow-up (Dryfoos, 1985). There are presently 136 such clinics opened or planned across the United States. Obviously, that number is inadequate. In the southeastern community, in which the research gathering took place, there were no school based clinics. However, the teenage pregnancy rate in that county was among the highest in the state.

This study occurred in an area within what is commonly referred to as the "Bible Belt." The sex education strategy proposed by some churches is to inform young people that premarital sex is a sin. The reasoning is that if they are "believers", then they will preserve their virginity. If they are sinners, they will indulge in premarital sex and "go to hell," unless they repent. This technique is not working. As evidenced in this study, most of the Clients had been exposed to some form of church teachings against sex and some of them believed premarital sex was a sin. However, they still participated and became pregnant. Indeed, the church's

strategy may be driving young members away, just when they need community support the most. For example, many of the clients dropped out of church activities after becoming pregnant because of their perception of condemnation and guilt on the part of congregations.

This author has no single answer as to how the church should restructure its sex education instruction and ministry to adolescent parents. One recommendation would be to design a series of classes for parents to help them deal with sex education in the home. This type of program was established in a Black church in Syracuse, New York. It was found that the community was supportive and parents were eager for the program. The program developers experienced a need for printed and audiovisual materials in the area of sexuality, which are developed for Blacks (Timberlake & Carpenter, 1986). Another possible program format is to have family retreats focused on the topic of sex education with interaction between parents and youth. Such an activity might prove helpful. It is clear that the "fire and damnation" scare tactic is not working. The biggest concern may not be restructuring a sex education program, but developing one.

Traditionally, in the Black community, the church has been the center of social change. Currently, this author believes that the Black church is losing its impact to influence change within the community. This is especially true in terms of Black youth, particularly in homes where the

parents are inactive church members. The church must reach out to these young women if there is any opportunity for religion to be viewed, significantly, as an intervention strategy. Rather than to recite scriptures telling these adolescent mothers of how they have sinned, churches should be addressing some of the needs of these parents and their children. For instance, the church could establish a financially supplemented church day care center, which would allow young mothers to return to school or work. If money for an individual church is a problem, a cluster of churches could join in sponsoring such a project. This affordable service would probably be of more assistance in delaying additional pregnancies than some of the other techniques the church has used. Another resource of back-up support could be based within established organizations of the church. Mission groups and circles, for instance, could provide support in providing information on childrearing techniques and household management.

Community based support programs for adolescent mothers should include provisions for affordable day care or baby-sitting service. These mothers can not return to school or consistently attend school if they do not have dependable alternatives for child care. Family members may be an option for some, but "built-in" baby sitters are not an option for all. Some grandmothers may be willing to care for one grandchild, but unwilling to care for two or more. Another

consideration is that the extended family, so prevalent and strong in past decades of Black families, has weakened in recent years. Mobility has caused family members to become more scattered. Economic constraints have caused family members to be more concerned with self-survival rather than survival of the group. Also, the intergenerational pattern of early teenage pregnancy is producing grandmothers at much younger ages than in the past. These young grandmothers are very active themselves, and may not have the time, or desire to stay at home and baby-sit.

Educational Implications

In reviewing Chapter IV, a number of implications surfaced for intervention within the educational setting. Students, teachers, school administrators and policy makers can have an impact on developing programs to address this problem. There needs to be a peer counseling programs established with older adolescent mothers helping younger mothers. The reality of parenting more than one child could be shared with young mothers with one child. The participants in this research discussed what they would say to younger adolescents, if given the opportunity. In fact, one client suggested that she may not have been in her situation today, if a parenting teenager had told her what motherhood was like as an adolescent. A peer counseling program of that nature

was the one technique she felt would have made a difference in her behavior.

It clearly evident that a need for teacher in-service training exists. The level of teacher insensitivity reported by project participants was appalling. Regardless of the personal attitude a teacher may have about premarital pregnancy, the teacher should be committed to provide pregnant and parenting teens with an equal access to education. Based on client perceptions, teachers have little knowledge of the range of responsibilities these young women assume. If teachers were aware, there appeared to be no empathy for the situation. Teachers need to be informed of the role they play or can play in the lives of these young women. Indeed, some adolescent mothers may drop out because of the lack of support at school. The school must be "user friendly" for these young women. The competing roles thrust upon young parenting students place them in a situation unique to their non-parenting age cohorts.

Educational administrators could engage in decisions to assist adolescent mothers. For instance, research participants discussed the difficulty of completing homework when there were children to care for in the evenings. A study hall for parenting students could be a part of their regular schedule. In that way, some of the homework could be completed at school. Also, disciplinary techniques, exclusive of after school detention, should be used with these young

women. They have to pick up children after school. Therefore, they may not be able to serve an after school detention. However, they get in more trouble at school if they don't serve detention. School administrators could also assist in the development and availability of school based sex education workshops for parents in the school community. Education is an influential vehicle which may be used to break the intergenerational cycle of adolescent parenting.

Policy makers have the power to recommend the creation and funding of school based health clinics and school-site day care centers. Both of these services have the potential for greatly reducing initial and subsequent pregnancy. Also, lessening the drop-out rolls is an anticipated possibility if dependable, affordable child care were available at school. More specifically, policy makers serving on state boards of education make decisions impacting curriculum across the state. Implications are that sex education should be taught beginning at the elementary grade level. Also, specialized instruction should be targeted to each gender. For instance, this research indicated a crucial need for young girls to become educated in assertive training. They don't know how to "say no" or to take charge of decisions about their own bodies. Boys need to be taught their responsibility as a sexual partner and become sensitive to the need to use contraceptives.

Research Implications

Birth rates do not reflect rates of sexual behavior. Differences in adolescent sexual behavior, are much less pronounced when race is a variable. In comparative studies of Black and white adolescent's pregnancy rates, there needs to be a distinction between term pregnancies and terminated pregnancies. Often, in previous studies, the investigator defined teen pregnancy by considering the proportional number of Black teens who became parents in comparison to the number of white adolescent parents. Adolescents who became pregnant and aborted or miscarried were not considered. Only the teens who had term pregnancies. This same type of misleading research is reported comparing sexual activity between Black and white teenagers. The measure of sexual participation is often pregnancy, but all teens who are sexually active do not become pregnant. There are some who are more responsible contraceptors than others. Also, there are a few sexually active teenagers who do not become pregnant because of "luck" and others who medically cannot conceive.

This research indicated a need for inquiries into the sexual revolution of adolescents. In other words, the symbolic interaction approach should be applied to the study of adolescent sexual behavior and decision making. By using this strategy, the meanings adolescents ascribe to sexual behavior could be explored. This would especially be valuable

in examining the sexual behavior of Black adolescents, since it is often speculated that Blacks are unique in their view of sexuality and sexual behavior. However, there is no reason to believe that Black teens are engaging in sex any more than white teens, that poor adolescents are any more sexually promiscuous than rich adolescents, or that one can predict sexual activity among youth by using any demographic identification. As with adolescent drug use, it appears that all are vulnerable for participation and involvement has nothing to do with social or racial strata. The difference appears to be in contraceptive behavior and pregnancy resolution.

More research is needed to seek reasons why some adolescents are more responsible for contraceptive behavior than others. There are already implications that the level of parental involvement is a factor. However, this author found that, even when parents favored contraceptive use and provided such, there were still irresponsible actions on the part of the adolescent.

Possibly, the level of cognitive functioning should be more closely examined when pursuing such an investigation. Some people don't demonstrate formal reasoning capacity by age fifteen (Peterson & Crockett, 1986). Hence, before some adolescents are capable of making informed choices, they are already sexually active and pregnant.

Since pregnancy resolution among Black adolescents is very predictable, more inquiry into this phenomenon would be useful. Possibly, by going back into the history of Afro-Americans and comparing those archival records and findings with current data, more knowledge could be gained concerning the strong aversion to abortion and non-family adoption within the Black community. It is understood that, in the past, the strength of the extended Black family nurtured an informal adoption agency. However, through the years, the structure of the Black family has changed. Therefore, it should be investigated as to why attitudes have remained constant, while environmental circumstances have been dynamic. Possibly a key to this investigation would be to examine the value system of Black families, and Black adolescents in particular. It would be especially significant to explore their attachment to the idea of motherhood and fatherhood.

Since most of the clients cited emotional factors as motivators for sexual involvement, more research should be designed to investigate the correlation between feelings of emotional deprivation and sexual activity. Interestingly, some project participants entered into a repetitive pattern of involvement without satisfying the need for love. For instance, after one mother had three children by the same boyfriend, she still felt emotionally detached from him. Whatever the exact nature of the emotional need, it appeared that their babies could not fill that void.

Clearly, it would be valuable to conduct a companion study of young men who have fathered more than one child. Their insight could assist in structuring effective program intervention. After all, most of the young women in this study had a strong desire to please their boyfriends. Therefore, he was in charge of the decision to have sex and whether or not he would contracept. The question remains of whether there were reasons, other than purely physical, for these young men to have sex. Were they trying to become fathers to satisfy some perceived rite of passage? Did they receive a higher position of status in their community based on the number of babies they father? These are the type of questions which could be answered in a companion study.

Some Black girls in similar demographic situations do not become mothers of one child or more children. A comparison of Black girls who do not become pregnant at all as adolescents, those who have only one child, and others parenting more than one child would add much to the literature. All things being equal, including family characteristics, there would be a possibility of revealing some characteristics unique to adolescent mothers who repeat pregnancy. Since qualitative investigations allow much depth in looking for the "how" and "why", a research design similar to the one this investigator used would be recommended.

Conclusions

The reported conclusions and discussion were with the understanding that an analysis of 10 case studies cannot be used to generalize to all Black adolescent mothers. However, strong implications were reported based on the common responses by clients and the support of a vast body of previous research. The comments in this chapter were within that context. The similar psycho-social environment for Black adolescent mothers, who repeated term pregnancies, was one which nurtured that behavior. Surrounded by sisters, friends, mothers, and sometimes grandmothers who modeled comparable lifestyles, these adolescents saw no long-term negative consequences of their situations. Having strong feelings opposing abortion, adoption, and even marriage, the Black adolescent more often elected to parent the child. Becoming pregnant again doesn't seem to change the outcome of pregnancy resolution, just as having one child didn't appear to alter contraceptive behavior. The decision making for the rationale of repeat term pregnancy appeared to focus on the alternative of having the baby. Alternatives were considered in deciding to carry the baby to term and parent the child.

If society is to successfully intervene, the challenge is to alter the Black adolescent mother's cognitive view of subsequent parenting. The realization that having subsequent children increases chances of a lifetime of poverty must be

internalized by these mothers. Also, the concept of poverty must be clarified. Only when, and if, Black adolescent mothers determine that it is to their advantage to delay additional pregnancies, will this situation improve. The frame of reference, for these low-income young mothers, was not molded by middle class values. The motivation for change must come from their significant others. Floyd and Smith (1972) described a reference group as a symbolic representation of any collectivity of persons, real or imagined, envied or despised, whose perspective is assumed by the actor. Therefore, change in sexual behavior of Black adolescents must be prompted by these individuals. Society's role, therefore, is to identify those persons and facilitate a structure for them to serve as change agents. In any comprehensive community program addressing these concerns, there should be a concerted effort to include family members, friends, and partners.

Research Objectives Revisited

Objective 1. To determine the validity of previously identified psychosocial predictors of repeat pregnancy.

The validity of research is substantiated if the results may be applied to other populations. Factors reported from previous research, such as the intergenerational cycle of

repeat pregnancy, surfaced as predictors in this study. The psychosocial environment of young women in this study, including family members and friends, was similar to that found throughout the literature.

Objective 2. To determine if adolescent mothers who repeated pregnancy intentionally sought this status.

It was determined that the majority of young women do not consciously intend to repeat pregnancy during their adolescence.

Objective 3. To determine if insufficient support resources contributed to the repeat pregnancy.

Insufficient support, such as lack of dependable child care, made it more difficult to continue in school. Although the service was not used consistently, contraceptive support services were available in the neighborhoods in which these clients resided. However, this author believed the biggest contribution to the repeat pregnancy appeared to be the perceived lack of emotional support.

Objective 4. To determine if client identified factors, which precipitated the initial pregnancy, parallel those of the repeat pregnancy.

It appeared that the circumstances which preceded the index pregnancy were repeated. These young women made the same "mistake" again. The repetition of their actions, being

sexually active without birth control, escalated the likelihood of subsequent pregnancies.

Objective 5. To develop a framework, based on research findings, for a program to deter repeat pregnancies of adolescent mothers.

As discussed in program implications, information generated from this research may be used to develop programs to deter repeat pregnancies. Also, existing programs may be modified to more accurately address the needs expressed by these young women.

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APPENDICES

APPENDIX A
FOCUS GROUP MEETING RESULTS

FOCUS GROUP MEETING

Participants:

A 13 year old mother of a 3 month old daughter
A 14 year old mother of a 4 month old daughter
A 15 year old mother of a 4 month old son
A 15 year old mother of a 2 month old son
A 15 year old mother of a month old daughter
A 16 year old mother of a 9 month old daughter
A 16 year old mother of a 2 month old son
A 17 year old mother of a 3 daughters, ages 3,
2, and 3 months

Questions and Responses:

Question:

Did everyone understand biologically how you got pregnant?

Response:

Laughter. Everyone said they knew how they became pregnant. The investigator should have asked them to explain the conception process to determine their level of understanding and cognitive functioning.

Question:

Was anyone using any type of birth control method?

Response:

There were two participants who said that they used birth control sometimes. One used condoms and the other had birth control pills that she took when she remembered. Another young woman mentioned that she wanted to get some birth control pills, but her mother was against the idea.

Question:

What was your age at first intercourse:

Response:

11, 12, 14, 13, 14, 12, 12, & 12

Question:

Do you feel that you were given any sex education information prior to your becoming sexually active?

Response:

No

Question:

Has becoming a mother changed your life? If so, how?

Response:

The most frequent answers were that you can't use your time as you wish and you can't go anywhere. A couple of participants said that their mothers took complete charge of the baby and they couldn't tell any difference. For those two girls, they still did everything they desired.

Question:

Have your friendship groups changed since parenthood?

Response:

Somewhat. Most of them had the same friends and some of their friends came over to "play" with the baby.

Question:

What were your feelings when you found out you were pregnant?

Response:

Fear and anger were the most common responses. One participant said that her anger was not directed to her boyfriend, but that she was angry at herself for being so stupid. One young woman stated that she was happy. She was the only one to admit to planning the pregnancy. She wanted to have a baby because she had baby-sat for relatives and had always liked babies.

Question:

Who was the first person you told when you discovered you were pregnant?

Response:

Friends and relatives, other than parents, were the most common responses. One told a cousin and another mentioned telling a sister. Most were afraid to tell their mothers. In fact, one young woman hid the fact of her pregnancy from her mother for seven months. She pretended to use sanitary napkins so that her mother would not ask questions. With one exception, they were all scolded by their parents. The participant who wasn't scolded lived with her grandmother, who appeared happy about the pregnancy. None of the participants told the boyfriend first.

Question:

Is anyone planning to marry in the near future?

Response:

Two stated yes, but continued by saying that they planned to marry when they were about 28 and 45 respectively. This illustrated that they had no concept of "near future". The seventeen year old was planning to marry within a year or two.

Question:

Prior to pregnancy, how were your grades and school attendance?

Response:

Only one had good grades. The others reported poor grades as well as low attendance. One stated that she hated school and had never liked it.

Question:

I noticed that no one mentioned their father. Do you live with both parents?

Response:

No. None of the young women were living in an intact family. The seventeen year old and her three daughters lived with her boyfriend, the father of her last two children.

Question:

Had any of you already started drinking alcohol prior to your pregnancy and do you feel that this was related in any way to your becoming pregnant?

Response:

Five of the participants had already started alcohol consumption. However, they did not feel that this behavior was related to their pregnancies. In other words, they were not intoxicated when they engaged in intercourse. All of them, except one, stopped drinking during pregnancy because of consideration for the baby. One young lady continued to drink during the pregnancy because she wanted to kill the baby.

Question:

Were all of your babies healthy?

Response:

All babies were healthy except one, the child of the young woman who continued to drink. Her baby was in and out of the hospital all the time. She was unsure of the exact nature of her baby's illness.

Question:

Did all of you have vaginal delivery?

Response:

Six had vaginal deliveries and two had C-sections.

Question:

Has anyone had an abortion or miscarriage?

Response:

The young lady with three children had an abortion between her second and third child. Two of the girls wanted abortions, but waited too long to seek one. One of the girls, who wanted an abortion, was the one who tried to kill her baby through alcohol. The others felt that abortion was wrong, with one citing religious beliefs.

Question:

What is your relationship with the baby's father?

Response:

Seven of the girls were still dating the father. One young lady had absolutely nothing to do with the father. Two of the young men were in the delivery room at the time of birth.

Question:

Do you know if your mother was a teenager when you were born?

Response:

Six had mothers who were teenagers at the time of their birth. In fact, two of their mothers were 14 years old.

Question:

Do you know if the father of your baby has children by other girls?

Response:

Except for the 17 year old, the others felt that their child was his only one. The father of the 17 year old's three year old daughter had other children. This didn't bother her since she had a relationship with someone else.

Question:

Are you presently sexually active?

Response:

Six were sexually active and two were not.

Question:

What is your current contraceptive practice?

Response:

Three were sexually active with birth control. Two were using birth control, but were not sexually active. Three participants were sexually active without birth control. Of those three, one had a doctor's appointment because she thought she was pregnant again. Her baby was four months old. Another had a one month old baby and was sexually active prior to her 6 weeks check-up. She said that her boyfriend had promised to raise the month old baby if she got pregnant again.

Question:

Where does most of the sexual intercourse take place?

Response:

Always at my house or his house.

Question:

Do all of you plan to continue in school until graduation?

Response:

Yes. The investigator suggested to the 17 year old to consider taking the GED test when she got 18, because she was only in the seventh grade. Also, she was the working mother of three children. She wanted to graduate by walking across the stage and getting her diploma. Therefore, she planned to stay in secondary school until she was in her twenties.

APPENDIX B
INFORMED CONSENT FORM

Informed Consent

The University of Tennessee, the Chattanooga Public School System, and the Hamilton County Health Department are cooperating on a research project to study repeat pregnancy among Black adolescents. The results may improve program planning for parenting adolescents. You are being asked to be a part of this study by answering questions. You may say yes or no. If you are in school, being in the study will have no effect on your grades or performance in school. If you are a client in the Black Infant Mortality Project, being in the study will not change the treatment or services you or your children are getting at the health center. Except for Mrs. Prater, no one will know what you said in answering questions. After completion of the project, all materials with your name will be thrown away. Until that time, all materials will be stored in a private file cabinet and seen only by Mrs. Prater.

We believe that you are in no danger or harm by being in the study. In fact, many teens enjoy being a part of a research study. Every effort has been made to make sure that other people will not know what you said. If you want to stop being in the study, you are free to do that. Nothing will happen to you if you decide to drop out of the study. You do not have to answer any question you don't want to answer. You don't have to discuss anything that you feel might upset you. There will be no questions asked which could get you in trouble with the police.

Mrs. Prater would like to ask you some questions about yourself and your life. You are free to say yes or no about doing this. If you agree, she will meet with you at least twice, each time for about an hour. While you are talking to her, she will make a tape recording of what is said. Mrs. Prater will use the information you give for research and publication purposes. Any publication resulting from this research will not include your name or any information that could trace responses to specific individuals.

If you have any further questions about the research or about your rights if you decide to be a part of this, you may contact Mrs. Prater or her advisor, Dr. Fox. The information is as follows:

Loretta Pinkard Prater
1161 W. 40th St.
Chattanooga, Tn. 37409
825-7287

Dr. Greer L. Fox
UTK College of Human Ecology
Child and Family Studies
Knoxville, Tn. 37996-1900
(615) 974-5316

If you have read everything above, had your questions answered, and agree to be a part of this study, please sign below. A copy of this form will be given to you to keep.

Adolescent _____ Date _____

Witness _____ Date _____

APPENDIX C
INTERVIEW INSTRUMENT

INTERVIEW INSTRUMENT

The questions were derived under four major categories. The first one was to request general background information. The other three series of questions were designed to gain information related to three social science models for studying adolescent pregnancy. Those are the deficit, decision-making and subjective utilities models.

A. Background

1. How old are you?
2. How many children do you have? What are their ages?
3. How old were you when you became pregnant with your first child? Your second child?
4. With whom do you live?
5. What is your major source of income?
6. Are you enrolled in school? If yes, what grade are you in school?
7. What grades are you making in school?
8. On an average week, how many days do you attend school?
9. What are your career goals?
10. At what age did you begin dating?
11. At what age did you become sexually active?

B. The Deficit Model

12. How did becoming a mother for the first time change your life?
13. Was becoming a parent what you expected? If no, how was it different from what you thought it would be?

14. How did you feel when you discovered that you were pregnant again?
15. How has becoming the mother of more than one child been different from parenting one child? (only for subjects already parenting more than one child)
16. What would be different about your life if you had not become pregnant?
17. Did you have any complications during pregnancy which caused health problems for you or your baby?
18. Has pregnancy interfered with your getting an education? Explain.
19. Would you recommend parenthood to other adolescents? Why or why not?
20. Would you describe yourself as a happy person? Explain.
21. There are some who feel that Black youth are already disadvantaged and pregnancy only makes the situation worse. How do you respond to that?
22. Do you feel that the income you have for you and your child/children is enough money? Explain.

C. The Decision-Making Model

23. Some girls drop out of school when they become pregnant, what factors have kept you in school?
24. In your opinion, why do girls engage in premarital sex? Of the reasons you mentioned, which was most influential in your decision to have sex?
25. What are your feelings about birth control? If you practiced birth control, what methods did you use and why do you think it failed?
26. Where did you get your information about birth control?
27. If you have not been using birth control at all, what could be said or done to make you consider its use?
28. Have you ever been a part of any community program designed to help young mothers to not become pregnant again? If yes, describe what that program did for you.

29. Some girls decide they want to get pregnant. Did you make that decision the first time? If yes, what were the reasons for that decision?
30. Given the fact that you know what it is like to be a teenage parent, did you want to get pregnant again as a teenager? Explain.
31. What factors influenced your decision to keep your baby rather than to abort or put it up for adoption?
32. Did you have an opportunity to marry the father/fathers of your baby/babies? If yes, what influenced your decision to remain single? If no, would you have married him if given the opportunity? Explain.
33. How soon after you became sexually active did you first become pregnant?
34. How often do you engage in sexual intercourse?

D. Subjective Utilities Model

35. What was the age and marital status of your mother at her first pregnancy. Older sisters (if applicable)? Friends who are parents (if applicable)?
36. Who are the people in your life who love you?
37. Who are the people in your life who are important to you?
38. If you were making a TV commercial to tell all the wonderful things about _____ (name of girl), what would you say?
39. Tell me about the relationship between you and the man/men in your life?
40. How has religion influenced your life and behavior?
41. How are the people in your life whom you feel that you could talk about anything, including sex?
42. If I were a person who wanted to get to know your mother, what could you tell me about her?
43. If I were a person who wanted to get to know your father, what could you tell me about him?

44. Some believe that poor adolescents experience more premarital pregnancy because they don't have the money to do other things with their time. How do you feel about this?
45. There is a theory which suggests that Blacks are more sexually active than other groups because this is one area in their lives in which they can control, whereas, in many other ways, they are not in control of their lives. How do you feel about that theory?
46. If you had the power to change anything in your life or in your past, what would that be? Explain.

APPENDIX D
CASE REPORTS

CASE REPORT OF CLIENT 1

I. DEMOGRAPHICS

Client 1 was an unmarried 18 year old who was the mother of two daughters, a 2 year old and a 7 month old baby. At the time of the initial interview, she was 3 months pregnant with her third child. Since that time, she has had another daughter. Client 1 was 15 years old when she first became pregnant. She resided with her boyfriend.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 1 received regular medical care during her second and third pregnancies. Her first deliveries were by caesarean section. With her first pregnancy, the hospital staff tried everything to facilitate a natural birth process. When that was unsuccessful, they performed a caesarean. She requested a caesarean with the second pregnancy. The third child was born naturally. All of the babies appeared to be healthy. This was especially rewarding, considering that Client 1, with her first pregnancy, kept her condition a secret and delayed seeing the doctor until she was 5 months pregnant. Her mother made the appointment because she noticed that Client 1 was sleeping a lot and had become very irritable. Prior to that doctor's visit, even her mother was not sure of her condition.

Education

At the initial interview, Client 1 was a high school senior enrolled in an alternative school for pregnant teenagers, where she remained until her recent graduation. Prior to this pregnancy, she was a print shop student in an area vocational high school. At the vocational school, climbing the steps made her tired. Also, teachers did not take into consideration the fact that she was a pregnant mother, when they assigned homework and expected her to be in school almost everyday. She was usually in school, unless she had baby-sitting problems or a doctor's appointment. Getting to school on time was a chore. Because of the various things she had to do for her daughters and herself in the mornings, she estimated that she had to get up about two hours earlier than if she did not have children.

She has always liked school and made pretty good grades, although she wished her grades had been even higher. However, she dropped out after her first baby because she did not have a baby-sitter. Someone informed her about a day care center that she could afford. After having her child placed there, she was able to return to school. Her family has supported her continuing school by helping with the children in the afternoons, in order for her to complete her homework.

For her career goal, she would like to be a social worker. However, when asked what does one have to do to become a social worker, she replied, "I don't know, but I heard you have to go to school four years or something." In a later interview, she said that she was going to enroll in a 2 year technical college and major in printing. It appeared that she has yet to clearly define her career direction.

In 10 years, she envisioned herself as a working wife, the mother of "smart" children, and a homeowner.

Income

Client 1 was financially dependent on AFDC (Aid to Families with Dependent Children) and her boyfriends' employment. The first child received AFDC benefits. She has gotten no financial assistance from the father of her first daughter or from his family members. Her boyfriend was taking care of the other two children, who were his daughters. With his two jobs, he was able to take care of all of the household expenses. Client 1 has worked in the past, but decided that child care for three children was consuming most of her salary.

Family Structure

Client 1 was from a family of divorced parents. Her parents ended their marriage when she was about 6 or 7 years old. She had a twin brother, a sister who was one year older, a younger brother, and two half-sisters. The only siblings she has resided with are her older sister and her brothers.

Teen Parenting Impact

It appeared that family support helped to cushion the negative impact of parenting responsibilities. Said Client 1, "I had a lot of help and I didn't experience any hard times." Her mother and sister helped greatly with the first child, including attending to the baby when she woke

up in the middle of the night. Said Client 1, "I know they are going to take care of her, so I just turn on back over and go back to sleep." Presently, her boyfriend assisted in the caregiver responsibilities. In response to the question, "How did becoming a mother change your life", she replied, "I had somebody to go places with me". She always hated going places by herself, and, after motherhood, she could take her daughter with her. "However, if you wanted to go somewhere with just your friends, you had to make sure you had a baby sitter," commented Client One. This was especially apparent after she moved from her mother's house.

She loved dressing her baby and combing her hair. In fact, she equated the caring for her first born to playing with dolls. In identifying differences between playing with dolls and caring for babies, she said, "If you drop a baby, it will cry and you might hurt it and when you get tired of a doll, you can put it in bed and it will sleep for two days." That association was understandable, considering that she had just recently stopped playing with dolls. "My mother used to tell me to put them up and that I was too old to be playing with dolls", said Client One. She continued, "And when I got pregnant, I told her she should have let me play with dolls a little longer."

If she had never gotten pregnant as a teenager, she believed that she would have been a very active high school student at the vocational school. She had planned to be a cheerleader. Client 1 didn't recommend parenting to other teens. Instead, she felt that they should just play with other people's kids and continue their plans for the future. She sometimes wished that she had continued to play with her little cousins and delayed parenthood until later. The only difference she cited in having more than one child in comparison to parenting one was that you had more things to buy. If she had the power to change anything in her life, it would be that she would not have any children right now. However, she quickly added, "I love my children."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 1 started dating at age fifteen, the same age she initiated coitus and became pregnant. On the first date with the father of her first child, she became sexually active. They dated, off and on, for about 2 months before she became pregnant.

Client 1 felt that pressure from boys was the main reason teenage girls had sex. Also, she admitted that pressure from boys was the main reason that she began coitus. Another reason mentioned was that it would provide an opportunity to prove womanhood. In her situation, there were no thoughts or discussions of possible consequences of such behavior. Client 1 expressed that the lack of money nor race had any bearing on the sexual behavior of teenagers.

Contraceptive Behavior

Client 1 was introduced to knowledge about birth control at school and by watching television programs. Her mother tried to talk to her about birth control. "What she was saying went in one ear and out the other", she said. At that time, Client 1 was still playing with dolls and was uninterested in the topic. Her mother said, "If you ever need some birth control, just come to me." Client 1 had already seen birth control pills and been informed of their purpose through interacting with her sister.

At the "right" time, Client 1 plans to tell her daughter that if they want to have sex, make sure it is with someone you care about and that she will go and get the pill for them.

Client 1's first experience with any form of birth control was after the birth of her first child. She tried to take the pills, but discontinued their use because she became ill. She did not return to the doctor to ask for a change in prescription. She went through the same process after the birth of her second child. "I was taking those birth control pills, even though they were making me sick", she said. She continued taking the pill until she needed a refill. She was negligent and didn't go back and get any more. "I just stopped taking them and I got pregnant," she said. She admitted that each time she stopped taking them, she wasn't even thinking about she would get pregnant again. Prior to the second pregnancy, her boyfriend was using the condom, which made her feel more secure after she discontinued use of the pill. Before becoming pregnant for a third time, her only birth control method was reliance on him to use the condom.

Client 1 expressed a desire to have her tubes tied after the birth of the third child, although her mother was against the idea. However, this did not occur. Medicaid would not pay for this procedure until the patient is twenty-one. Therefore, she could not afford to have the operation. Also, her boyfriend desperately wanted a son. Since the third child was another girl, he wanted her to get pregnant again, in an effort to have a boy. When asked what would happen if she had another girl with her next pregnancy, she reported that she is willing to have at least three more pregnancies in order to have a son. However, if she had a son with a fourth pregnancy, then she would not want more babies. She would also like to have a boy because she liked shopping. Since, she continued to have girls, she used a lot of the clothes already accumulated. Currently, her only birth control measure was her boyfriend's use of the condom.

Client 1 did not consciously plan her pregnancies. She stated that some girls want to have a baby to have something to call their own or to keep their boyfriends. She made no such plans. After she had her first baby, she wanted to wait until she finished school before becoming pregnant again. Unfortunately, her behavior, regarding the use of contraceptives and continued sexual activity, was contrary to her goal of pregnancy avoidance.

Pregnancy Resolution

In discussing her decision not to give her children up for adoption, she said, "I wasn't gone carry it no nine months and then give it away. Going through all that pain and stuff, and then give it to somebody who ain't even went through the pain." She never considered abortion as an option.

Marriage was not considered or discussed with the first pregnancy. She had no feelings for this young man which would suggest that she wanted to become his wife. She was planning to marry the father of her other two daughters. They have been waiting for the "right" time, preferably on her birthday. Since they were in a common-law marriage arrangement, they already had established a household. She didn't anticipate any differences in her life after she was legally married than she was experiencing at the time of the interview. "It seems like we are already married," she said.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 1 had always felt loved by family members and friends. She had no problem responding quickly when asked about people who loved her. She described herself as "spoiled" and a "big baby". She felt that people got along with her easily. She admitted to being a shy person. "I just don't come out and talk to nobody. I just keep things to myself," she said. Contrary, her friends liked to talk to her about their problems, because she was a good listener and would keep their secrets.

She felt that she was a happy person. She made that clear more than once during the interview. She was very lively and laughed and smiled a lot during the whole process. She seemed to have a strong positive self-concept. Based on her discussions about her daughters, it appeared that she was proud of motherhood. She said, "I'm not like these other girls, like to leave their babies with their parents. I like to take mine with me, because I like to show them off."

Influence of Significant Others

A. Family

The mother of Client 1 was an unmarried teenager when her first child was born. However, she got married three weeks after having given birth. She was a divorcee with a live-in boyfriend. Client 1's oldest daughter considered her grandmother's boyfriend to be a grandfather. After all, he was living there when Client 1 and was still at her mother's house. He was very good to her children and had spoiled them, according to Client One. Client 1 described herself as looking like her mother and being like her in other ways. Her mother was quiet, nice, had a hard time saying "no" to people, and was easily hurt. In fact, the reason Client 1 kept knowledge of her first pregnancy from her mother for so long, was that she dreaded hurting her.

Client 1 described her unmarried 42 year old father as wild and loud. "He wants to be young, loves to go out every weekend, and is always out looking for a girlfriend," she stated. When she was growing up, Client 1 remembered his coming over on weekends and giving her things that she wanted. She has no memory of when he lived in the house with them as an intact family. Now, her father was very involved in her life. On his way home from work, he visited everyday during the week. He loved her children and her boyfriend. She described her father and boyfriend as being very much alike.

Client 1 appeared to be very close to her older sister. In fact, she was the first person she told about her first pregnancy. Her sister was sworn to secrecy. Also, in response to the question who can you talk to about anything, she said, "My sister and my best friend." Her sister was a nineteen year old single parent with two daughters and a son. In fact, each time Client 1 got pregnant, her sister was also expecting a child. Their first two children were only five months apart in age and their babies were only one month apart. Her sister had no marital prospects.

B. Friends

The best friend of Client 1 was someone with whom she was friends in childhood. This young woman was not a parent. She was a recent high school graduate and had a basketball scholarship to an area university. Despite a difference in their lifestyles, they remained "best" friends through the years. Her other good friends were parents. These were young women with whom she became acquainted after entering the alternative school program. According to Client 1, she had lots of friends.

C. Male partners

When Client 1 first started experimenting with dating at 15, she was not emotionally attached to anyone. She would merely go out with them, drop them, and began to see someone else. She got tired of being with the same boy. She was having fun. They were going places, talking, and exchanging presents. At that time, there were no sexual relationships. Except for one person she dated during that time, she didn't care for any of them.

Later during her fifteenth year, Client 1 began to date the father of her first daughter. In fact, she had intercourse with him on their first date, although she described him as one of the people for whom she cared little. After that encounter, they engaged in coitus infrequently. However, two months after their first date, she became pregnant. She didn't have any feelings for the father of her first daughter. Her attraction to him ended by the time she found out she was pregnant. She currently had no interaction with him.

Client 1 had been living with her 20 year old boyfriend for nineteen months. She met him at the fast food place where she was employed. He was the manager. She knew him for a year before they started dating. The father of her second and third daughters and her husband-to-be, she felt that they loved each other.

D. Religion

Client 1 attended church regularly as a child. She stopped going when she was around 15 and had recently returned to church. As a child, she always liked going to church, but she didn't enjoy staying for two services. "That's your weekend right there. It's just all gone", she said. In response to the question what was it you liked about church, she replied, I liked learning about God, reading the Bible and singing in the choir.

While attending church, she learned that you shouldn't have sex until after you are married. Also, she was taught that you shouldn't have children until after you get married. When she got pregnant with her first child, she was afraid to tell her mother. "I know I did something I shouldna did," she said. However, she believed that you can have sex if you love somebody.

V. DISCUSSION

Deficit Model

The model is focused on problems of health, education, income, and overall well-being of the mother and child. Repeat pregnancy does not appear to have had devastating consequences for Client One. She had healthy children and appeared to be in good health herself. She had graduated from high school and expressed plans to enter a two year technical school next fall. Although she has had three children during the course of high school, she managed to graduate with her class. Attending the alternative school allowed her to keep up with her studies. In anticipating college for the fall, she had already made arrangements for her children to be placed in an affordable day care center.

She had established a home with her boyfriend and three children. Primarily, he was responsible for the expenses of the family and worked two jobs in order to meet his obligations. However, she was still dependent on AFDC for the care of her first born. Since she was not married, she was continuing her eligibility for that assistance. However, she was planning to be married soon. Considering their age, level of education, and number of dependents, they appeared to be doing well.

The Decision-Making Model

Client 1 seemed oblivious to the decision making process regarding sexual behavior. She didn't discuss or consider consequences of actions, but merely allowed fate to rule. This same attitude carried over to the pregnancy resolution. She didn't consider any options, so the natural outcome was that she had the babies and kept them. The only apparent decision she made was to go back and remain in school.

The Subjective Utilities Model

Based on Client 1's information about her mother, she seemed to be very much like her, including becoming pregnant before marriage and entering into a common-law marital arrangement. Her older sister, whom she adored, was sexually active in her teen years and, also, became an unmarried mother of three. The intergenerational cycle of premarital pregnancies was evident in this family.

Although her parents divorced and her father moved out, Client 1 seemed to have a good relationship with him. He spent a lot of time at her house. From all reports, she also seemed to like her mother's boyfriend and got along well with him. All indications were that she had a positive regard for men, including the father of her first born. She casually excused his behavior of non-support by labeling him as childish.

Client 1 felt good about herself, which probably resulted from the fact that she has always felt well loved. She was happy with her life, her children, and her future. She was looking forward to more pregnancies in order to try to have a son.

CASE REPORT OF CLIENT 2

I. DEMOGRAPHICS

At the time of the initial interview, Client 2 was a 17 year old unmarried pregnant mother of a 14 month old son. Since that time, she has given birth to a daughter. Client 2 experienced her first pregnancy at sixteen. She resided with her mother and grandmother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 2 appeared to be in good health. Her babies were born healthy. During her first pregnancy, she was sick a lot at first. This was probably the normal first trimester "morning sickness" experienced by many women. Otherwise, her pregnancies were uncomplicated. During the birth of her first baby, she remembered being given a shot. She recall having very much pain after that. It was a rather easy delivery.

Education

Client 2 was an 11th grade student enrolled in an alternative school for pregnant girls. This was her second time being a student there, since she attended this program during her first pregnancy. She didn't consider dropping out of school because she didn't want to sit around and do nothing. Client 2 wanted to get an education in order to take care of herself and her children.

She was making average grades and attended school regularly, almost everyday. She stated that school was very important to her. According to Client 2, the only disadvantage pregnancy had caused, in her educational pursuit, was that sometimes she is delayed in completing her homework.

Her career goal was to become a lawyer. She believed it will require about nine years of additional study beyond high school to become an attorney. When she finishes school, she plans to marry her boyfriend, join him at his army base, and attend college there. He has told her that day care facilities are available.

Income

Her source of income was from an AFDC (Aid to Families with Dependent Children) check and her boyfriend, the father of her second child. Client 2's grandmother also provided financial assistance and purchased most of the family's food. Housing for Client 2 was rent free. Client 2 was using a large portion of her AFDC check to pay the \$25.00 a week day care charge. She anticipated that her expenses would increase with the responsibilities of another child.

Family Structure

The parents of Client 2 married after her birth. They were teenagers at that time. Although they were not divorced, her parents had been separated for approximately 11 years. She had two half-brothers and a 7 year old half-sister, who were her father's other children. She has never lived with any siblings. Therefore, her mother and grandmother raised her as an only child.

Teen Parenting Impact

Client 2 had no idea that she would become a parent so soon, although she perceived little change in her life since becoming a parent. "I never liked to go anywhere anyway," she said. Therefore, she did not experience any anxiety over finding evening baby sitters, since she was usually there. Also, her mother and grandmother helped her tremendously. The only difference she perceived in having more than one child will be in the area of day care while she continued school. Her mother and grandmother worked during school hours.

Although she loved her children, Client 2 would not recommend parenthood to other adolescents. "They are just too young to have children now," she said. She admitted that she was too young. The strain of parenting sometimes caused her to feel anger toward her children. If she had remained childless, Client 2 felt that she probably would have more friends. She felt that the fact that she was Black had no bearing on her teen parenting situation.

Client 2 was a sensitive parent. If she had the power to change anything in her life, past, present, or future, she would like to teach her children to be good children, and have the money to educate them. According to her, the best thing about being a teenage mother was shopping for baby clothes. The worst thing was changing diapers.

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 2 believed that girls began sexual relationships because they just get certain feelings, everybody else is doing it, or to keep their boyfriends. "They are crazy and think they can keep their boyfriend or something," she said. She also believed that pressure from the boy was a factor. Client 2 didn't feel that having money, or the lack, of it had any significance on teenagers engaging in sex.

Client 2 had her first sexual experience at 15, one year before she actually started dating. Her main attraction to sex was curiosity. She commented, "Sometimes I would just be thinking about it, about what it would be like, so, I just did it." Her sex partner was coming over to her house after school when no one was at home. Her sexual encounter with this young man did not result in pregnancy.

Her second sex partner became the father of her first child. She was 16 when they started dating. They dated for several months before engaging in intercourse infrequently. "I had sex with him because I cared about him a lot," she said. Four months after they began having sex, she was pregnant. She was very scared when she found out about her condition.

Contraceptive Behavior

Client 2 has tried contraceptive measures, but not with consistent and long-term use. She used birth control pills before, but discontinued their use because they hurt her breathing. According to Client 2, when she got pregnant with her first baby, her grandmother said, "I told you...you should have taken those pills so this wouldn't happen." Sometimes her boyfriend would use a condom. On some occasions, he refused to use them sometimes because he didn't like them. She felt that her second pregnancy resulted from a condom bursting on more than one occasion. "I just knew I was pregnant, but it wasn't my fault," she said.

No one instructed her on how to use other methods. However, she tried the foam for awhile. She stopped using it because the foam was messy. Client 2 would not consider using a diaphragm because she didn't want anything put up in her. She even admitted a fear of using tampons. "I heard about a girl whose string came off her tampon, and she had a hard time getting that thing out of her," explained Client 2. She would rather just take a shot to prevent pregnancy, if such a method were available. Client 2 didn't plan either of her pregnancies and doesn't desire any more children in the near future. After having a third child one day, she would like to have her tubes tied.

Pregnancy Resolution

Client 2 never considered adoption as an option. She said, "I just can't do that, give my baby away." In response to the abortion option, she stated, "I can't do that either...I can't kill no person." With her first pregnancy, marriage was never discussed. Even if he had asked her, she would have declined. Client 2 explained, "He just wasn't the kind of person you would want to marry." She discussed marriage with the father of her second child. This event was scheduled to occur next year, after her high school graduation.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

In describing a happy person, Client 2 said, "Someone who likes themselves and who doesn't care what other people think about you". She said that she was a happy person. She didn't worry about anything. When she found out she was pregnant the second time, she felt sad. Then she started to feel better about herself. She stated, "Most of the time, I just keep things in me and don't even talk about it". She felt that telling other people only created problems. She expressed a desire to have someone with whom she could talk. Client 2 said, "I would feel better if I had someone to talk to...I would feel more secure."

Client 2 was a very pretty young woman. She felt that she was loved by her mother, baby, and best friend. She deliberately excluded her grandmother from that group. She stated, "Forget about my grandmother." In naming her positive qualities, she said that she was honest and trustworthy, was willing to share with others, and tried to help people.

Influence of Significant Others

A. Family

The 35 year old mother of Client 2 experienced her only pregnancy at age seventeen. Although she married Client 2's father later, she was unmarried at the time of conception. Client 2 expressed love

for her mother. However, she was not pleased with some of the things her mother did. She seemed especially annoyed that her mother was frequently unemployed and never had any money. "She won't hold no job," she said. This meant that Client 2 sometimes had to request money from her grandmother. She detested having to ask her grandmother for money.

Client 2 appeared to have a distinct dislike for her grandmother. She stressed that they did not get along at all. Even so, her grandmother was the first person she told about her first pregnancy. She felt bad because her grandmother seemed so hurt. Although she didn't feel that her grandmother loved her, she recognized that she was receiving some financial help from her.

She practically had no relationship with her father. She has hardly even talked to him since she was a little girl. In the past, Client 2 missed not seeing him. Now she had gotten adjusted to his absence, since he never came around. In describing her thirty-something year old father, she said, "He is no good." She shared that he cheated on her mother when they were living together as a married couple. They only lived together for a short time. When her parents married, her father was in the Armed Forces. He came to live with them when he was discharged. The marriage ended in an indefinite separation when Client 2 was five or six years old. Growing up, she had little memory of his being a father to her.

B. Friends

Client 2 still had some of her friends that she had before becoming a parent. While at the alternative school, she became friends with other parenting and/or pregnant teens. It appeared that she was very influenced by one good friend in particular. This friend had two children, got her tubes tied, married a military man, and was attending college out of town. Therefore, she didn't see much of her anymore. The future which Client 2 projected for herself, closely resembled the life of her friend.

Her best friend was not a parent and was the one person whom she felt she could talk to openly. Regarding her friend as being trustworthy, she said, "She don't never go back and tell anything and she don't never bring anything up." She mentioned that mother had a tendency to bring up things in the future.

C. Male partners

Client 2 experienced "puppy love" in the third or fourth grade. She recalled talking to a certain young man on the phone, playing with him, and writing love letters. That relationship went on for a long time.

Client 2 started dating her 17 year old boyfriend when she was sixteen. The person she first dated became the father of her son. They met while she was visiting her cousin's house. Although she had previously curtailed contact with him, she admitted to thinking about him sometimes. She said, "I can never forget about him. I had a baby by him." He and his family moved to California. Prior to dating him, she had a sexual relationship with another young man.

Client 2's present 19 year old boyfriend was the father of her second child. He was in the military, stationed in Europe. They got very serious before he left the states. They planned to get married when she finished high school next year. They wrote to each other frequently and he sent her money. He came closer to being the man of her dreams than anyone else she knows. In listing characteristics of her ideal man, she said, "Young, educated, good job, understanding, and don't argue."

D. Religion

Client 2 attended church regularly as a child, although she seldom attended anymore. At her church, the congregation expected unwed mothers to come before the people and acknowledged having sinned. "I know I wasn't going before the church because I wasn't married," she said. Some members of her church had asked her to make such an acknowledgement. She mentioned that the church people don't seem to bother the boys who got girls pregnant, but they talked about the girls. She believed that church people think you are bad if you don't ask the church for forgiveness, but she didn't think that she was bad.

Her religious teachings were that sex before marriage was wrong. However, Client 2 did not agree with that. She believed that a person was not going to go through life without thinking about sex.

V. DISCUSSION

The Deficit Model

Client 2 didn't perceive any negative consequences from being an unmarried teenage parent, other than having fewer friends. She was continuing her education, her basic physical needs were being met, and she appeared to be in good health. She was planning to get married and continue her education

through college. The pattern she was following closely resembled that of her mother. They both got pregnant by military men and marriage was planned after the birth of the baby.

The Decision-Making Model

Client 2 made a conscious decision to remain in school and carry her babies to term and keep them. Otherwise, she had allowed other events in her life to just happen. Regarding sexual and contraceptive behavior, it didn't appear that there was any thought to considering consequences. She was a very shy young lady who avoided communicating about matters which may have been embarrassing for her to discuss.

The Subjective Utilities Model

Client 2's behavior reinforced the intergenerational cycle of being an unmarried teenage parent. However, her mother only had one child. If her mother served as a role model, then Client 2's actions were anticipated. Because of her parents failed marriage and the irresponsibility of her father, Client 2 did not have very much attention from a male until she began her heterosexual relationships.

It was interesting that, although she continued to mention planning to marry the father of her second child, she failed to name him as a person who loved her or as one she loved.

With the exception of her good friend, Client 2 was surrounded by other adolescent girls who were unmarried parents. Therefore, this made her situation appear to be the norm. Friends and acquaintances at her present and former school were parents.

Although Client 2 maintained that she was a happy person, she didn't demonstrate any body language which supported her contention. She was very solemn during the interview process and rarely even smiled. She gave the impression of someone who was depressed rather than happy.

CASE REPORT OF CLIENT 3

I. DEMOGRAPHICS

Client 3 was a 17 year old unmarried teenager with a 2 year old son and a 4 week old daughter. She experienced her first pregnancy at age fourteen. She resided with her mother and a 13 year old half-sister. She moved into her mother's house when she was in the fifth grade.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 3 experienced no health problems related to pregnancy. Her babies, both birthed by vaginal deliveries, were born healthy. In fact, her daughter weighed six pounds and eight ounces.

Education

Client 3 was an 11th grade student at an alternative school for pregnant adolescents. She will return to her regular high school at the end of the quarter. She had a history of behavior problems in school, saying, "My mama wouldn't let me have fun after school, so I decided to have fun in school. Her grades were not very good and she expected to make a D in most of her classes. She attributed some of her poor school performance to parenting, saying "It messes up my grades that I am making...It's because of my children, they be up all the time." She reported that she was rarely at school five days in a row because of baby-sitting problems. Usually, she was there at least three days out of each week. This baby-sitting problem was so great that, if she had the power to change anything in her life, it would be to have a baby sitter all the time. If all of these problems cause her to fail in her classes, she planned to drop out of school and take the GED test.

She reported that her career plans were to be a fashion merchandiser and own a business. However, she seemed unsure of steps needed to reach that goal, other than to finish school and work hard. She said that after she finished high school, she planned to go to college and major in fashion merchandising and business. "I plan to, but I don't know," she said. Her major reason for continuing in school was that she wanted to make something out of herself and not have to depend on a monthly welfare check.

Income

Instead of getting welfare, Client 3 received a social security check resulting from her father's death. This placed her in a unique situation in terms of medical care. She claimed that she and her children were taken off Medicaid every 5 months because of some fiscal matter related to her getting social security. During the interval when she was off Medicaid, she was responsible for any medical bills. According to Client 3, the money she received was not enough for the family's needs. Her check was \$385.00 a month. From that amount, she had to pay her mother 185.00 monthly. She said, "Sometimes with the little money you get, you can't even give them some of the things that they need. It's hard, it's true, but I try." She would like to work during the summer, but baby-sitting problems prohibit her working. Although places like Human Services provided baby sitters for adolescent mothers, Client 3 hadn't found the agency to be very helpful to her.

Family Structure

Client 3 was born to parents who were never married to each other. Although her father later married someone else, her mother never married. Her mother felt that the responsibility of parenting was too great for an 18 year old, so she gave Client 3 to her father to raise. He later married someone else, but her mother never married. Client 3 lived with her father and step-mother until his death. Her mother had another daughter, who was 13 years old at the time of the interview. Her father had no other children.

Teen Parenting Impact

One of the first impacts mentioned by Client 3 was that she couldn't go anywhere after she began parenting. "I needed my freedom, I wish I hadna done it," she said. Her mother kept her first baby while she attended school, but her child was her responsibility after school hours. Her mother's friend was the baby sitter of the second child. Client 3 had expected her mother to assume more of a parenting roll and give her more freedom, but her mother said, "You had the baby, not me...You are the one who laid down and got pregnant." Her mother continued to stress to Client 3 that, whatever the

needs of the baby, it was her obligation, as the mother, to attend to those needs. Client 3 had imagined parenting to be much easier than she actually experienced.

Worrying about dropping out of school was another consequence of adolescent parenting, according to Client Three. Sometimes she felt angry because of the pressures of parenting. "I get mad every now and then and I might holler at my children," she said. When she considered how her life might have been different if she were not parenting, Client 3 said, "It wouldn't be so hard trying to go to school and I would have the chance to go to college." Client 3 would not recommend parenting to other adolescents. When asked to explain her feelings, she said, "The way I see it, if you ain't got naun, keep your life together... Children just slow you down... I think you should live your life, set your goals, and don't think about one, cause its hard." She felt that parenting robbed her of all of her teenage years.

Client 3 felt disadvantaged as a Black adolescent mother. She believed that public service agencies were more likely to help White mothers than Black. In terms of baby-sitting provisions, her experience was that the agencies helped working adults more than school-age mothers. She said, "The way I see it, they find places for children of people that work. Well, if they work, they can pay someone to keep their children, but, for the students who want to go to school, they can't find nobody for them." In answering the question, what is the best thing about being a teenage parent, she said, "I don't know nothing."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 3 began having sexual intercourse at age fourteen. She was sexually active for a year before becoming pregnant. She felt that pressure from the boys and just having something to do were the major reasons many girls began sexual relationships. "When they tell you that they love you and you are the only one in the world, it sounds good," according to Client Three. That's the situation she experienced. Now, she wished that she had never listened. Whenever she felt unloved, sad, or angry, it seemed that her boyfriend could take away all the pain. She thought sex would fulfill her need for comfort, love, and support. However, she admitted that she didn't enjoy her sexual experiences. "I didn't like it naun time, that ain't no lie," she said.

Contraceptive Behavior

Client 3 was using birth control pills. She decided to use contraception after the birth of her first child. She had experimented with foam and, at times, her boyfriends used a condom. According to Client 3, she experienced no problems with birth control pills and was consistently taking them when she got pregnant with her second child. Her doctor claims that her prescription wasn't strong enough. Client 3 never planned pregnancy. She felt that girls who got pregnant, in an effort to hold on to their boyfriends, were fools because the boyfriends were going to leave anyway.

Pregnancy Resolution

When Client 3 found out she was pregnant with the first baby, she was scared and wanted to have an abortion. "I just didn't know what to do," she said. However, she delayed discussing her situation with anyone. She was unsure what she should do. She considered abortion with the second pregnancy, but waited too late to legally seek pregnancy termination. She admitted that for each of her pregnancies, she would have aborted if she had gotten treatment early enough.

Client 3 considered adoption as an alternative to parenting a second child. She decided against it because "God don't put no more on you than you can bear", she said. Although she admitted difficulty in having two children, she felt that everything would eventually work out for her. Based on warnings from her mother, Client 3 anticipated that she would have the responsibilities of parenting without the babies' fathers. Client 3 said, "Like my mama always told me, 'Mama's baby and daddy's maybe', you got to be stuck with that baby for the rest of your life, not him." No marriage proposals were ever offered Client Three. Even if either of the fathers had asked her to marry, she would have refused. She described them as bums and drug dealers.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

According to Client 3, she was a happy person, although happiness involved pain and joy. Somewhat contrary to her declaring happiness, was her definition of a happy person. In her listing characteristics of a happy person, she said, "Getting to have fun, go and do things you want to do, but...you know, having fun at the games and stuff." She quickly added that she was happy, because her children were her pride. Client 3 claims that she used to feel that having a baby would mean that she would have someone to love and someone to love her. After her father died, she felt that nobody else

really loved her. After becoming a mother, she said, "When you are hurting inside, you can look at your baby...you feel warm and you know you got that love." The cause of her hurting inside was the relationship she had with her mother, according to Client Three. When asked to name all of the wonderful things about herself, the first attribute mentioned was that she was a good mother.

Influence of Significant Others

A. Family

The mother of Client 3 was an unmarried teenager when she experienced her first pregnancy, which resulted in the birth of Client Three. Client Three's parents did not marry because her mother rejected the proposal. Her mother's pregnancy resolution was to give the baby to her father, saying that she was too young for children. This arrangement may seem unique. However, Client 3's grandfather was a young widower who raised Client 3's mother. Client Three's situation paralleled her mother's in some ways. Her mother had two children and had not been married. In naming people whom she perceived loved her, Client 3 mentioned her children, her grandmother, and her best friend. She failed to name her sister and mother. Concerning her mother, she stated, "I know she doesn't love me, I'm serious." She also excluded her mother and sister when she identified people who were important to her. Among that list of significant others, she included some of her teachers and her doctor, but not her mother. Not only did she admit to not loving her mother, but she also didn't trust her. When she further described her relationship with her mother, Client 3 said, "I feel that she don't care nothing about me....I feel that she just had me to be having me, cause she got pregnant by my daddy, that's all." Client 3 seemed convinced that her mother loved her younger sister, but not her.

Client Three's father died when she was in the fifth grade. He died, after being in a coma for 3 weeks, from injuries received in an automobile accident. He was the owner of a gas station. She lived with her father and step-mother until his death. She was very close to her father, missed him deeply, and felt that he loved her very much. She said of her father, "He was a good daddy." Right after his death, she moved in with her mother. Client 3 expressed that her life would have been different if her father had lived. For instance, she stated that she would still be making the good grades she was making when she lived with him.

B. Friends

Client 3 had a lot of friends who were unmarried parents. Client 3 gave credit to her friends for providing her knowledge about birth control. She had one very special girl friend, but the person with whom she could discuss anything was one of her male friends. According to Client 3, she could tell him anything and he wouldn't go back and tell it.

C. Male partners

When Client 3 was growing up, she described herself as a tomboy. She wasn't interested in boys, romantically, although she played with a lot of boys. That changed when she entered the ninth grade. Client 3 started dating when she was fourteen. Her mother had told her that she couldn't date until she was sixteen, but she dated without her mother's knowledge. Oddly enough, Client 3 wanted her daughter to be 15 or 16 before she started dating. She was meeting her boyfriend at her cousin's house. She now felt that the relationship was a mistake and that her mother was correct in not allowing her to date. At the time, she thought she was in love, but later decided that it wasn't love. She said, "It wasn't love, I don't know what it was." She described the man of her dreams as someone who was kind, loved her and her children, and was legally employed.

Regarding the fathers of her children, she had no ongoing relationship with either of them and received no assistance, financial or otherwise, from them. Neither of them resembled the description of her ideal man. The father of her first born, who denied paternity, was a 19 year old drug dealer. He had babies by other girls and was known to beat up on them. According to Client 3, he had never hit her. Also, he had been jailed before. His most serious offense was fatally shooting his mother's boyfriend. The father of her second child was a 23 year old drug dealer. Although both fathers had been incarcerated in the past, neither was currently in jail.

D. Religion

Although Client 3 was made to go to church as a child, religion didn't have much meaning in her life until recently. She had joined a Bible study group organized by her next door neighbor. After becoming involved in that group, religion had become important in her life and she felt that she was getting her life together. Her understanding was that the Bible said premarital sex was wrong. She believed that to be true. However, she said, "You can ask God for forgiveness...sometimes you just can't help it."

V. DISCUSSION

Deficit Model

Early pre-marital pregnancy had caused Client 3 to be disadvantaged. She had experienced problems in trying to complete her education. Baby-sitting arrangements hindered her from regular school attendance. Child care responsibilities caused her to limit the time she had for studying and completing homework assignments. Therefore, her grades suffered because of parenting.

Client 3 didn't have enough money to care for herself and two children. However, baby-sitting problems and limited education, restricted her opportunities for employment. Although she desired a better life than one which can be provided by a social security or welfare check, the reality was that circumstances make it less likely that she would become the fashion merchandiser that she dreamed to be.

The Decision-Making Model

The need for love and comfort motivated Client 3 to begin a sexual relationship. When she first became sexually involved, there was no thought of the consequences. Therefore, no contraception was used. After the birth of the first baby, she consistently used birth control pills. She made a conscious decision to avoid a subsequent pregnancy. Unknowingly to Client 3, these pills were not strong enough for her body chemistry. Since she continued sexual activity, she became pregnant.

Abortion, adoption, nor marriage was pursued as a resolution for either pregnancy. Although Client 3 claimed that she wanted to abort in both cases, it was felt that she did not take any measures to carry through that intention. Therefore, the motivation to abort appeared to be very weak. Client 3 considered adoption for her second child, but decided against that option. Her belief that God would help her entered into her decision to keep her baby. Since marriage was never proposed, it was not an option in either pregnancy.

The Subjective Utilities Model

The key to the subjective world of Client 3 appeared to be the death of her father. Prior to that time, she felt secure and loved. Two weeks before Christmas, during her fifth year in school, she found herself without a father and living with a mother who was a stranger. She had lived with her father since infancy. Those two simultaneous adjustments, the death of her father and moving in with her mother, were very traumatic for her. Since that time, she has been searching for that lost love. Client 3 was convinced that her mother had no love for her. Her children seemed to be her validation for personhood.

Client 3 was continuing an intergenerational cycle of pre-marital pregnancy and single parenting. Her situation was a repeat of that experienced by her mother. Also, Client 3 had friends who were single adolescent parents. It appeared that her physical, social, and psychological environment was one which supported the idea of pre-marital parenthood. She resided in a densely populated housing project where generations of single parents lived. Most of her friends were single teenage parents, a fact which supported the idea of peer influence. Also, having two children allowed Client 3 to receive love from some unconditional source.

CASE REPORT OF CLIENT 4

I. DEMOGRAPHICS

Client 4 was a 17 year old unmarried teenager who experienced her first pregnancy at the age of fourteen. She was the mother of a 3 year old son and was 9 months pregnant with her second child, a daughter. She and her son lived with her mother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 4 experienced no health related complications with the first pregnancy. With her second pregnancy, she was 3 weeks overdue.

Education

Client 4 was a senior in an alternative secondary school for pregnant adolescents. After the birth of her baby, she will return to her previous high school for her last semester of work. She reported that her grades are good and she was in school four days out of every week, only missing school for doctor appointments. Client 4 understood that she needs to continue in school, since she would like to become a nurse one day. She was determined to graduate. "I told everybody, I don't care how many children I have, as long as I finish school," she said.

Income

Client 4 was an AFDC recipient. She felt that wasn't enough money and would like to get a job in the future. One of the main reasons she did not consider dropping out of school was that she wants to get a good job one day.

Family Structure

Client 4 was from a family of divorced parents. She had one older sister. Client 4 had no contact with her father.

Teen Parenting Impact

Client 4 stated that becoming a parent changed her life a lot. She didn't like the fact that it slowed her down. Before parenting, she used to be able to go a lot of places. After her baby was born, she had to take him with her. Having a child taught her that you have to take care of your responsibilities.

Client 4 felt that her life would be different if she were without children. In reference to having just one child, she said, "Its hard, but it ain't that hard...not to me it ain't." However, in anticipation of the second child, she said, "It is going to be hard."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 4 was sexually active for about a year prior to pregnancy. She felt that peer pressure motivated her to experiment with coitus. She stated, "When you be round girls and stuff and they tell you how they be doing it, I be wanting to try it." During the year before she became pregnant, she reported having sex about every other day.

Contraceptive Behavior

Client 4 did not plan either pregnancy. With her first baby, she merely had not considered that she would get pregnant. In fact, she expressed surprise and hurt by her pregnancy. She started taking birth control pills after that initial pregnancy. She took them for 2 years before she became pregnant again. Client 4 admitted to taking them on an irregular basis, when she thought about it. In the future, she plans to take the pills as instructed. She didn't want another baby soon. In fact, if she had the power to change anything in her life, it would be for her to stop having babies. Client 4's doctor informed her about contraception. Prior to becoming sexually active, Client 4 recalled that her

mother tried to talk to her about birth control. She wasn't really listening to her mother. She said, "I wasn't even paying attention then."

Pregnancy Resolution

Client 4 did not consider abortion or adoption as an option for her. Referring to abortion she exclaimed, "I couldn't have no abortion...that's killing a human being!" Concerning adoption, she said, "You be hurt when you give it to them, and about a year later, you be probably wanting it back and stuff". "I couldn't do that," she said. Regarding marriage, Client 4 had the opportunity to marry the father of the first child. She declined because she felt it would not work. "He kept getting in trouble and stuff", she said. Currently, he was in jail.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 4 identified herself as a happy person, being loved by her mother and sister. According to her, a happy person was one who didn't have things on their minds. She appeared to be worry-free. She expressed that her babies and mother were the people in her life who were important to her. When asked to list things about her which made her wonderful, she had a difficult time thinking of any answers. "I can't think of anything, she said." Finally, she mentioned that she stayed in school and she didn't do drugs.

Influence of Significant Others

A. Family

The mother of Client 4 was 20 years old when she had her first child. She was married at the time. She had two children, Client 4 and another daughter. Client 4 was 4 years younger than her sister. Her sister was an unmarried mother who had her first child at sixteen. Client 4 described her mother as being real nice, a person who stayed to herself, and didn't get in other people's business. Client 4 seemed to appreciate her mother. She said, "She raised me and she try to help me with my baby."

Client 4 had no relationship with her father. She had not seen him in so long that she didn't want to see him now. She was 3 years old when she last saw him. "I can't even tell you how he look," she said.

B. Friends

When inquiring about her friends, Client 4 bluntly stated, "I don't have friends." She continued to explain that she just didn't call them friends anymore.

C. Male partners

Client 4 started dating at approximately 13 years of age. She was still dating the father of her second child, although they were not planning anything serious right now.

D. Religion

Client 4 attended church. She admitted that her views on abortion originated with church teachings.

V. DISCUSSION

Deficit Model

Client 4 was continuing in school and was expected to graduate. However, based on her responses and lack of understanding indicated during the interview process, this researcher felt that she was functioning on a low cognitive level. Therefore, it was questionable if she would be able to get the "good" job which she desired. Also, her goal of becoming a nurse would require a higher degree of academic preparation than was believed she could attain. Even with a high school diploma, this circumstance may force Client 4 to remain on Aid to Families of Dependent Children. A job, which she could successfully manage, may only pay minimum wage. That would not be enough money to support herself and two children, since she would like to live independently of her mother. Client 4 appeared

unaware of the long-term disadvantages of early parenting. The changes she mentioned were related to the more immediate circumstance of retarding her social life.

The Decision-Making Model

Client 4 succumbed to peer pressure to engage in premarital sex. She used no decision making logic and did not consider any consequences of her behavior. She merely reacted to the pressure of her friends and responded to her own curiosity. After her first child, she made a decision to contracept. This was not an educated decision in that she inconsistently used the pills. Because of her strong aversion to adoption and abortion, she decided to carry her babies to term. With her first pregnancy, she decided to remain single. Marriage has not been an option since that time.

The Subjective Utilities Model

The subjective world of Client 4 was very small, consisting mostly of her mother, sister, and children. They were the people who loved her and whom she felt were important. Her behavior and attitude regarding premarital pregnancy could have been influenced by her sister, who became a parent at sixteen. Client 4 had no meaningful friendships or romances. Based on her difficulty in listing personal attributes, it was sensed that she had little concept of self.

CASE REPORT OF CLIENT 5

I. DEMOGRAPHICS

Client 5 was an unmarried 18 year old mother of a two year old and a one year old son, and a five month old daughter. She experienced her first pregnancy at fifteen. She currently resided with her grandmother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 5 reported that she experienced no health problems related to any of her pregnancies. Also, her babies were born healthy. She and her babies got regular medical care from the neighborhood health clinic.

Education

Client 5 dropped out of school after completing her ninth grade year of junior high. Because of child care considerations, she had not been able to return. Her grandmother worked on the day shift and could not care for her children during school hours. There was no one else she desired as a baby sitter. "I don't trust people with my children," she said. Therefore, she felt it was her responsibility to care for them. Her ideal situation would be to attend a school where there was day care on the premises. In that way, she would still be near her children. Now that they were getting older, she was planning to work a different shift than her grandmother and allow her grandmother to watch the children.

When she was enrolled in school, her grades were average. She mostly made Cs and Ds in her classes. She had a goal of finishing high school. With only a ninth grade education at her age, the logical option is to take the G.E.D.(Graduate Equivalency Diploma) test. Otherwise, she would be at least 21 years old when she finished school. Her limited formal education will cause her difficulty in trying to pass the test. Her plan was to take the test after she got situated in her own house.

As a future goal, Client 5 would like to get a good job and a house of her own. She was seeking any type of employment except working in fast food. She realized that she was very limited without a high school education. She recently failed a test for a job which she desired.

Income

Welfare or AFDC (Aid to Families with Dependent Children) was the major source of income for Client Five. Her monthly stipend was \$184.00 and she felt that amount was adequate. However, she was getting some additional assistance, in the form of clothes, shoes, and food, from the paternal grandmother of her children and from her new boyfriend, who had not fathered any of her children. For a brief period, when her grandmother could keep her children, Client 5 worked at a fast food restaurant.

Family Structure

Client 5 was born to teenagers who never married each other. She had a younger half-brother. Her mother has since married and lived in another state. Client 5's father was deceased. The maternal grandmother of Client 5 assumed the primary caregiver responsibilities of her since childhood. Her grandparents divorced when she was young. Therefore, she had no memory of ever residing in a household with a married couple. She had never met her paternal grandparents or any of her father's relatives.

Teen Parenting Impact

Client 5 admitted that parenting changed her life a lot. The most dramatic difference was that she had to drop out of school. Another difference mentioned was that she was not able to get material things that she wanted. Her grandmother had tried to give her things that she wanted, but, after she started having babies, their needs had to come first. When asked to name all the good things about getting pregnant at fifteen, she said, "There ain't no good things about it, nothing at all." She admitted that sometimes, because of all the responsibilities, she felt anger toward her children.

Having more than one child was different because the children tended to get on your nerves, according to Client Five. "They cry and fight a lot," she said. If she had never had children, Client 5 believed that she would be graduating from high school this year, working, and getting ready to pursue her dream of going to modeling school. If she had the power to change anything in her life, it

would be for her to be childless at this point. She preferred to have waited until later to become a mother.

She described her life as boring. In describing her typical day, she said:

"I wake up and I lay in my bed. I get up and then I still go back and lay in bed. I fix them some breakfast and stuff, give them a bath, and put them on some clothes. Then, I get back in my bed. Then, I take me a bath and put on some clothes after my soap operas go off. Then, I lay back in the bed and watch TV, unless my grandma ask me to do something. If she does, then I'll do it. My kids play outside or they be in there with me laying down or playing. Most of the time, we just be in the bed playing with each other."

Client 5 did not feel especially disadvantaged because she was a Black unmarried teen mother. Ten years from now, she envisions herself as having a house, car, job, and kids who were in school.

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 5 became sexually active at the age of fifteen. She became pregnant prior to her sixteenth birthday, six months after the beginning of coitus. At that time, she was engaging in sex about once a month. The main reason she began coitus was that she thought everybody else was doing it, and because friends would talk about you if you didn't. When she was refusing to have sex, people started calling her names at school. According to Client 5, she was being referred to as "virgin of the school". In order to feel more accepted by the group, she started having sex. "You wouldn't want the whole school to know, and be laughing and talking about you still a virgin," she said. When asked if it had ever occurred to her to lie about her virginity rather than have sex, her reply was "No".

Also, Client 5 felt direct pressure from her boyfriend. "I really didn't want to, but he wanted to," she said. He was five years older and already experienced. She didn't really know what to expect and reported that it was not an enjoyable experience. Like many other young women, her first sexual encounter occurred in his home. When it was mentioned that many parents are suspicious of car dates, Client 5 exclaimed, "I refuse to do it in a car!"

Contraceptive Behavior

When Client 5 was fourteen, her grandmother talked to her about wanting to put her on birth control pills. Client 5 was not concerned about birth control, because she was a virgin. After her first baby, she tried birth control pills but discontinued because they were making her sick. When her grandmother found out that she had stopped taking them, she started administering them to her, in the same way that parents give medication to young children. However, sometimes her grandmother would forget. When this happened, Client 5 would not take the pill. She was never introduced to other methods of birth control. Client 5's boyfriend never used the condom. As soon as she stopped taking the pill, she got pregnant again.

As Client 5's friends were encouraging her to have sex, they neglected to mention birth control. There was no discussion about that. The only information she received was from her grandmother and in the health class at school. It was unfortunate that she didn't put the knowledge of birth control to practice, considering that Client 5 did not consciously want to get pregnant.

Client 5 had finally learned the value of consistent use of birth control pills. She was using them now, although they made her sick for awhile. She returned to the doctor to have the prescription changed. The new pills were agreeing with her body chemistry. Her new boyfriend was reinforcing her use. He asked her daily if she had taken the pill or actually gave it to her and waited for her to swallow.

Pregnancy Resolution

The only solution Client 5 considered as an option to resolving a premarital pregnancy was to have her babies and keep them. Client 5 had yet to consider marriage. She felt that she was too young for that type of commitment. The father of her children had never proposed marriage. All of her children were fathered by the same young man. In explaining why she did not give her babies up for adoption, Client 5 said, "If you lay down and get it, you might as well keep it. Client 5's grandmother wanted her to have an abortion with her first pregnancy, but she refused. She felt that if you laid down and got it, then you should take care of it. Since Client 5 was so strongly against abortion, her grandmother never bothered to mention that option again.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 5 described a happy person as someone who had a job, could get what they wanted, and was living their life the way they desired. Her life didn't seem to fit that description, but she claimed to be a happy person. She said, "You know, I got kids, so I'm happy." She also felt proud that she was a mother.

She felt that she was loved by her family members and her new boyfriend. In sharing her perception of her good qualities, she reported that she was nice, had a nice personality, and liked to cook. She had been cooking since she was 7 years old.

Influence of Significant Others

A. Family

Client 5's mother was 16 years old when she got pregnant with Client Five. She and Client 5's father never married. She appeared to have little respect for her mother. Her mother was described as someone who acted "crazy" and was an alcoholic. "I don't want people to even know she's my mama", stated Client Five. She continued, "When people ask about my mama, I always say that my mama is at home in the bed or at work, but I be talking about my grandmama then." The emotion expressed regarding her mother was fear. "When my mama found out I was pregnant, she said, [I'm gone kill her]", reported Client 5. She was afraid to tell her mother.

Client 5 considered her grandmother as her mother. She moved in with her grandmother when she was in the fourth grade. At that time, her mother had a live-in boyfriend. He would often beat her mother. On one occasion during an argument, her mother stabbed him. Her grandmother was the one whom she felt she could talk to about anything. She described her grandmother as a nice and wonderful person, who didn't drink.

Client 5 never had an opportunity to know her father. He died when she was two years old. He was in the armed forces and was killed in a plane crash returning from a leave home. Client 5 felt that not having a father was a part of her life that she had missed. After his death, his family members moved to California, according to her mother. As far as she knew, she was her father's only child.

B. Friends

When Client 5 dropped out of school, she saw an immediate decrease in her number of friends. After curtailing school enrollment, she said, "I just only really had about three friends, cause the rest of them, they just get behind your back and talk about you." Of the friends that she did have, all became adolescent mothers.

C. Male partners

Client 5 started dating when she was fifteen. Her boyfriend, who is the father of her three children, was twenty at the time. They met during her eighth grade year. She was attracted to him because she thought he was cute. Now, she think he's ugly. Initially, her grandmother thought he was about the age of Client 5, because he looked younger than his years. Therefore, she did not protest their dating. Five years and three children later, they have ended their relationship. She stated that some days he would be okay and some days he wouldn't. She was careful to stress that he never hit her. For a short time, after the birth of the first baby, she lived with him. Currently, she didn't want to have anything else to do with him and reported that she was through with him. She was getting no financial assistance from him, nor was he participating in the care of the children in any way. Legally, he was unemployed. He made his money by selling drugs, according to Client Five.

Her present 23 year old boyfriend had proposed marriage. Client 5 declined his offer. Her response to him was that she needed a couple of years to think about marrying him. Her major complaint with him is that he was too jealous. He wouldn't allow her to have any male friends. However, she described him as being real nice and as one who would do anything for her.

D. Religion

Client 5 used to go to church as a young girl, but stopped when she had her first baby. When she was attending, she loved going. She would go to Sunday School, morning service, and afternoon service. After she got pregnant, she felt that the church people were talking about her. She had no opinion concerning religious beliefs regarding premarital sex. She never thought about whether she felt it was right or wrong, but merely participated.

V. DISCUSSION

Deficit Model

Client 5 had seriously limited her educational and income potentials by parenting three children at her age. Given her current circumstances, it seemed unlikely that she would ever get her high school diploma. She dropped out of school before being exposed to a lot of the material which will be on the G.E.D. test. Child care problems would make it difficult for her to attend the G.E.D. preparation classes. Although there were some programs surfacing which could help her in this situation, it didn't appear that she had very much motivation. She spent most of her time in bed watching television.

Her dependence on AFDC may be long term. She seemed to be in an unfortunate "Catch 22" cycle. She was not qualified for most jobs, because of her lack of education. Child care concerns were keeping her from returning to school. With a ninth grade education, any job she could find would not pay enough to cover child care and, otherwise, support herself and three children. With Medicaid benefits, food stamps, and the AFDC allotment, she was almost destined to continue on welfare. She desired to get a house of her own. Considering her financial situation, public housing would probably be her only option.

The Decision-Making Model

Client 5 appeared to be led by the desires and suggestions of others, rather than making decisions of her own. Even now, deciding that she wanted no more children, she was relying on her boyfriend to remind her to take the pill. There was no evidence of her actually planning for the future or considering the consequences of her actions.

The Subjective Utilities Model

Client 5 appeared to have accepted the fact of her situation and was proud to be a mother. She claimed to be happy, but described her daily existence as boring. She was continuing in an intergenerational cycle of having premarital pregnancies, beginning with her mother. She had no sisters, but her unmarried teenage cousins also had children.

Her grandmother had provided stability in her life. She had little regard for her mother. Client 5 had not experienced an "intact" family, therefore, she may not have realized that her situation was socially unacceptable.

She was very much influenced by her friends, who were also teenage parents. She gave up her virginity to please them and her boyfriend. Although one boyfriend fathered her three children, she didn't feel that he had any further responsibility to her. She just wanted him to stay away. She didn't seem to have knowledge of the concept that parenthood should be a responsibility shared by a mother and father.

CASE REPORT OF CLIENT 6

I. DEMOGRAPHICS

Client 6 was 15 years old, unmarried, 7 months pregnant, and the mother of a 1 year old daughter. Temporarily, she and her child lived with her boyfriend and his parents. Her mother recently moved. After her mother gets the house situated, Client 6 plans to return to living with her. Previously, she and one sister resided with her father. Her other sister lived with her grandmother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 6 had experienced no health complications related to pregnancy. She maintained good health during her pregnancy and exercised by walking and jogging. In fact, her first delivery was a very quick and easy process, according to Client Six.

Education

Client 6 was a 10th grade student enrolled in the alternative school for pregnant adolescents. She had been there for about a month, where her grades were passing. Unless she had a doctor's appointment, she was in school daily. In reference to her feelings about school, she said, "I always loved school." She realized that some adolescent mothers dropped out of school. She considered this alternative when she found out she was pregnant with her second child. According to Client 6, she said, "I think I'm just going to keep on going to school." She decided that she really wanted to finish school, especially since her career goal was to become a lawyer or a cosmetologist.

Income

Client 6 was not getting AFDC. She was told by that agency that, if the father claimed the baby, the mother was ineligible for welfare. Her financial assistance was from her boyfriend and the baby's paternal grandmother. Regarding all the help she had received from the paternal grandmother, she said, "If I didn't have her, I don't know what I would do." Client 6 received little help from her own parents. She felt that her income was inadequate for the needs of her and her daughter. Client 6 had tried to help herself by working. She was employed at a fast food establishment quite a distance from her home. She had quit because the manager wanted her to work from 5:00 p.m. until 1:00 a.m. She had to get up in the mornings, get her child ready and off to a baby-sitter and report to school. Working until 1:00 a.m. was too much of a hardship.

Family Structure

The parents of Client 6 were married for approximately 15 years before they separated. Client 6 was 12 years old at the time of the marital break-up. When that occurred, her mother took the children to Memphis where she resided with a boyfriend. She had two sisters, a 17 year old, a 20 year old, and a half-sister. After a year in Memphis, Client 6 returned to her hometown to live with her father. Shortly after her return, her mother and sisters moved back to Chattanooga.

Teen Parenting Impact

Client 6 reported that parenting changed her life a lot. She sensed the responsibility of parenthood by feeling needed. She admitted that parenting was hard, especially trying to make baby-sitting arrangements in order to stay in school. For a mother of her age, it was also difficult getting the money for all of the needs of a baby. According to Client 6, the best thing about being a teenage mother was shopping with your child. She described that as being fun. Otherwise, she wished that she had waited and became a parent later. "I wanted to wait and finish school and get a good job, and something like that before I had any kids," she said.

Client 6 expected her life would be different when she has a second child, because she will have two people to depend on her. She was thankful for the assistance of her boyfriend and her daughter's paternal grandmother. She said, "My baby's grandmother said, 'I'll help you out with her because I know that you are going to have another child'." If Client 6 could change anything in her life, it would be for her not to be pregnant a second time.

Client 6 felt that her life would be a lot different if she had never gotten pregnant. She felt that if she were not a parent, she would be in a good school making good grades. She admitted that parenting responsibilities interfered with completing homework assignments. Mainly, she wouldn't have

to worry so much. She said, "I have to worry about my little daughter and, if I didn't have her, I would probably just worry about what am I going to wear the next day, or something like that." Client 6 was very much unprepared for parenthood and reported that it seemed like one day she was a little girl and the next day she was a mom. She would not recommend parenthood to other adolescents. She felt that one should wait until high school is completed, the necessary money was available, and the age of 20 had been reached, before considering having a child. Client 6 suggested, "That's the time you can decide on a family, but, right now, it is too early."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 6 felt that when she got in junior high school, peer pressure really began to influence her life. "I was listening to what other people were saying and, not really, doing what I really wanted to do," she said. She continued, "I didn't want to go all the way because I knew what could happen." However, she admitted having a problem saying "no" to people. "I always give things to people because, for some strange reason, I don't like to see people have to beg for something," she said. Another type of pressure which entered into Client 6's decision to become sexually active was indirect pressure from the boy. According to Client 6, if a sexually active boy approached his virgin girlfriend and she refused, he might tell her that he would wait for her. However, the girl fears that he will be with someone else to have sex. In order to keep her boyfriend from seeing other girls, the girlfriend feels pressured to have sex with him. Also, some girls believed that having sex was a way to show the boy that you really loved him, according to Client Six.

Contraceptive Behavior

Client 6 didn't plan or anticipate pregnancy. When she found out she was pregnant with her daughter, she was very confused and hurt. She added, "When I found out I was pregnant, I was shocked...I would cry all the time." She had just turned 14 at that time, engaged in sexual intercourse infrequently, and had never used any methods for pregnancy precaution. She felt that the best birth control methods were the condom and the pill. Her boyfriends had occasionally used the condom. She was supposed to go on the pill after her second baby, but neglected to return to the doctor for that appointment. "Like a fool, I forgot about it," said Client Six. She planned to take birth control pills after her second baby. She expressed some concern, saying, "I'm gonna tell them to try to give me the kind thats not so high, because sometimes it can make you bloated and can mess up your periods and stuff." When Client 6 is old enough to have her tubes tied, that would be her preference for a birth control method.

Pregnancy Resolution

Client 6 was not opposed to the idea of abortion, but respected each person's right to make that decision. "I think its a choice, its what that person wants to do", she said. With both her pregnancies, she chose to carry the babies to term. "That's not right to try to push your child into doing something that they don't want to do, especially abortion," she said. With her two pregnancies, her parents tried to get her to have an abortion, but she was against it for herself. In the first instance, they disregarded her wishes and took her to a local clinic to have an abortion. The doctor would not perform the procedure because she was past the first trimester. He recommended another place, in a different state, where she could have one. Because Client 6 objected so strongly, her parents decided to allow her to have the baby. Although Client 6 previously rejected the proposal of abortion, if she were to become pregnant soon after the birth of her second child, she indicated that she would seek pregnancy termination. "I don't want no more kids", she said. As far as adoption was concerned, she described a feeling of attachment to the child which prohibited her from giving up her baby.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 6 described herself as a shy person. She felt "down" about being pregnant with her daughter. After she had her and got on Medicaid and WIC, she started to feel a little better about herself. When asked what is a happy person, she said, "A person who smiles a lot, who can take a joke, how enjoys having friends...a person who can be able to laugh a little all the time." She admitted that she was not a happy person all the time. Her last memory of being unhappy was when she found she was pregnant again.

Client 6 felt that she was loved by all her relatives, her boyfriend, and his mother. Regarding her mother, she says, "I don't know about her...She acts like she does sometimes, but I really don't know." However, her mother was the person whom Client 6 can talk to about anything, although her mother didn't keep secrets well. "Don't tell her too much because she might tell everybody," said Client Six. The persons most important to Client 6 were her daughter and boyfriend. In listing all the wonderful things about herself, Client 6 shared that she was fun to be with, and she loved to go to school and spend money.

Client 6 was proud of her little girl and loved her a lot. She wanted to be the type of mother to her daughter that she never had. Also, Client 6 wanted to provide a middle-income lifestyle for her children. In ten years, she envisions herself as middle class and working toward college completion.

Influence of Significant Others

A. Family

Client 6's mother was an unmarried 19 year old when she experienced her first pregnancy. She and her 20 year old boyfriend, Client 6's father, married before the baby was born. Client 6 had a strained relationship with her mother. She felt that her mother was more interested in her boyfriend than in her daughters. She said, "My mama, she never has really been there for us or anything like that...with me anyway, she never has really been there." Her perception was that her mother liked her 17 year old sister the best, because she was so much like her mother. Regarding her mother's response to her, she said,

"My mama, she never really paid any attention to me." Continuing, she said, "That's why I don't really talk to people that much, because I never did understand why my mother did me the way that she did." During her baby's birth, her sister and mama went in the delivery room. According to Client 6, her sister was holding her hand, while her mama sat in the corner in the back of the room. In summing up feelings about her mother, she said, "Don't trust her...never trust her because she doesn't go by her word."

Client 6 felt closer to her father than mother. She could talk to her father about anything except sex. She described him as being funny, crazy, sweet, and a nice person with a temper. When she was growing up, she recalled that he was the only parent who showed any interest in her. When she worked hard in school, her daddy was the one who would ask to see her report card and reward her for making good grades. "My mama, she never...she never asked to see my report card", she said. When she made the honor roll, he would take her out and buy her something. At her 9th grade graduation, both parents were present. However, her mother left before the program was over. Her father stayed and took her out to eat to celebrate her having graduated. Client 6 was living with her father during the time of her first pregnancy. Her mother never even called to see how she was doing. The only thing about her father which puzzled her was that he does more for her sister's little boy than for any of the other grandchildren, according to Client 6's perception.

Client 6's two older sisters were unmarried parents. They got pregnant as teenagers. In fact, Client 6 and her two sisters were all pregnant at the same time. Her mother's reaction to that situation was that they all must have been drinking the same punch. One sister, the real quiet one, remained a virgin until she was eighteen. "I was real proud of her," said Client Six. Her parents wanted her sister to get an abortion, but she was too far along when they discovered the pregnancy. Client 6 described her other sister, who experienced a second pregnancy as a 16 year old, as a "firecracker". The first pregnancy was aborted. "It was very sad," said Client Six. She reported that her sister was far enough along that she had to go through the labor process for the abortion. Client 6 explained, "You know it kinda hurt her bad, because she seen her little baby...It lived for 2 hours and then it died." This sister's second baby and the baby of Client 6 were born only two weeks apart. Her other sister's baby was born 5 months later.

B. Friends

Client 6 felt that some girls have babies because they have friends who are mothers. Most of Client 6's friends were unmarried teenage parents. She had one friend who married at 15 because of pregnancy.

C. Male partners

Client 6 started dating when she was thirteen. Prior to that, she described herself as a tomboy with little concern for boys. "I just didn't care too much for boys," she said. She became attracted to boys as she began junior high school. Client 6 was influenced by the actions of others at the school. "I was entering junior high school, and I guess I was trying to be like all the other people," she said.

Client 6's first boyfriend, the father of her first baby, was 15 when his daughter was born. They started dating when she was in the 8th grade, the same year she became pregnant. They dated off and on for about 3 years. She described their relationship as not serious. After their romance ended,

they became very good friends, from then until the present. She felt that their young ages impacted their curtailment of a more serious relationship.

Her present 19 year old boyfriend, with whom she resided, was the father of the child she was carrying. The relationship with this boyfriend was the first serious one she has experienced. They had discussed marriage for sometime in the future, but not right now. "I don't want to rush into anything like that," she said. However, he and his parents had "been there" for her during this pregnancy.

D. Religion

Client 6 appeared to have a religious orientation. In reference to her struggle to complete junior high school, she said, "I guess God was helping me through it and stuff, because it really did work out." She felt that religion had influenced her life a lot. She reportedly listened attentively to the preacher's message. When I go to church and I hear the preacher, he seems like he be talking to only you and he be knowing whats wrong with you today," she said. Before she got pregnant, she used to go to church all the time. She didn't attend during her pregnancy, because she didn't want to embarrass her grandmother. She started going back to church after her daughter's birth. "After you stay out of the church so long, it seems like your life just sort of goes down," she said. Client 6 continued, "When I stopped going to church, I still prayed and listened to church music." She was glad that church attendance was a regular part of her life. She said, "Since I being going to church, it seems like I really brought my life back together." Concerning premarital sex, her church taught to "say no" and try to wait.

V. DISCUSSION

Deficit Model

Client 6 felt disadvantaged in continuing school and in providing adequate financial support for her children. She was not working on her ability level because the responsibilities of parenting detracted from completing school assignments. She didn't have the money to support herself and one child, not to mention the child anticipated. Baby-sitting problems and school demands hindered her from working. For a person of her age, Client 6 felt that her life would be different and better if she had never gotten pregnant. Client 6 was a very intelligent and insightful young lady who seemed to realize the far-reaching implications of her situation.

The Decision-Making Model

Client 6 evidenced decision making regarding pregnancy resolution. It was her decision to carry her babies to term and keep them. She knew that she did not want an abortion, nor did she desire to give up her babies for adoption. Regarding sexual involvement, she allowed peers to make decisions for her. She admitted being influenced by them. She did not consider or discuss contraception as a part of becoming sexually active. Prior to getting pregnant in both instances, Client 6 was oblivious to pregnancy precautions.

The Subjective Utilities Model

Client 6 was a shy and very sensitive young lady. She felt loved by most everyone except her mother. There were some unresolved issues regarding the relationship between Client 6 and her mother. Although Client 6's parents were separated, she had continued a very close and loving relationship with her father. Her mother, two sister, and friends all got pregnant as unmarried teenagers. Client 6 admitted that she was unassertive and swayed by suggestions from others. Her getting pregnant as an unmarried teenager was not unique, considering the actions of persons around her. Client 6's sensitivity extended into her religious beliefs. She had faith that God had helped her through some bad times, and believed that her life was better since resuming church attendance.

CASE REPORT OF CLIENT 7

I. DEMOGRAPHICS

Client 7, a pregnant unmarried 17 year old, was the mother of a year old son. She was 16 years old when she experienced her first pregnancy. According to the results of the ultrasound test, she was 9 months pregnant with a baby girl. Client 7 resided with her mother and father.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 7 experienced no health problems related to pregnancy. Her son weighed 8 pounds and 9 ounces at birth.

Education

Client 7 was attending the alternative school for pregnant students. A senior honor roll student, she enrolled there 2 months ago, at the suggestion of her former high school principal. He informed her that he could not excuse all the days necessary for her to be absent because of childbirth. At the alternative school, the days were excused. Client 7 was at school everyday, unless she had a doctor's appointment or if her baby was sick. She never considered dropping out of school and had always liked school. "School ain't never bothered me too much," she said. She never participated in any extra-curricular school activities. She was interested, but reportedly scared to try out for anything.

As a career goal, Client 7 would like to be a cosmetologist or work with computers. "I like doing hair," she said. When she graduates from high school, she plans to work. After a prior experience as a cashier in a fast food restaurant, she didn't want that type of work again. When she reaches the age of eighteen, her brother had promised to get her a job working with him. If she gets the job, her mother will baby-sit for her.

Income

Client 7 had no income and was primarily dependent on her parents. She appeared to be comfortable with that arrangement. She said, "I don't be worried about no clothes or nothing like that." She received food stamps. When Client 7 requested things from the baby's father or his mother, they would comply. Otherwise, he was not providing consistent monetary support for his son. However, she indicated that the assistance she was getting from him was adequate. "I don't need too much of nothing," she said.

Family Structure

The parents of Client 7 had five children. Client 7 had a 32 year old half-sister, who was not the biological child of Client 7's father. Additionally, she had a 30 year old brother, a 19 year old sister, a 16 year old sister, and a 14 year old brother. Living in the house with Client 7 and her parents were a child fathered by her 30 year old brother, Client 7's 19 year old sister and her twin boys, and two younger siblings.

Teen Parenting Impact

In responding to the inquiry of how parenting has changed her life, she said, "It ain't changed nothing, really." However, she would not recommend parenthood to other teenagers because they might question her telling them what to do. She continued to explain that she never liked to go anywhere, except just around her family. The only problem she experienced with parenting was that her son rambled and got into stuff. Client 7 had not considered how parenting two children might be different. She claimed to be happy with her life and wouldn't want to change anything.

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

At age 15, Client 7 dated her first boyfriend for 3 months before she became sexually active. She felt that peer pressure influenced young girls to become sexually active. She explained, "They see their friends older than them and I guess they want to be like them."

Contraceptive Behavior

Client 7 did not plan either pregnancy. "It just happened," she said. She explained, "I was going to wait until I finished high school and then, it just happened." Although people came to her school to talk about birth control, she never really thought about it until after having her first child. Her mother never talked to her about birth control. After that pregnancy, she seriously considered using contraception. She took the pills for about a month. They were making her sick. She tried to get the doctor to change the prescription. "The doctor wouldn't change them, so I just stopped taking them," she said. She was going to the health center physician. With this pregnancy, Client 7 was seeing a private physician. "The health center people, they hate to write prescriptions," she said. After the birth of her second child, she plans to resume using the pill, since she desired no future pregnancies. Client 7 never discussed birth control methods with her boyfriend.

Pregnancy Resolution

When Client 7 discovered she was pregnant with her first child, she was pleased. She said, "I was happy when I found out I was pregnant...I don't know, I was just happy...with the first one." Her mother wasn't upset either about the pregnancy, because she liked her boyfriend. Her father showed no reaction. "He don't never say nothing...He's the quiet type," she said. Client 7 wasn't as happy when she got pregnant the second time. "I was kinda upset until I found out I was going to have a little girl," she said. She continued, "I had always wanted a little girl." Her positive responses to her pregnancies may have explained the reason she had never thought about adoption or abortion as a pregnancy resolution.

Client 7 and her boyfriend had never discussed marriage. "He never talk about it and I hope he never talk about it, cause I be seeing what married people go through," she said. Client 7 did not want to get married. Her view of marriage was very dismal. She described it as pain and playing on each other. She might consider marriage when she is about 40 years old.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 7 stated that she did not know how to describe a happy person, but considered herself to be happy. "I'm happy until somebody makes me mad," she said. She reportedly was easy to get mad, which led the investigator to speculate that she was often unhappy. Client 7 felt that she was loved by her parents and baby. The people in her life who were important to her were her parents and her baby. When questioned as to why she did not include her boyfriend, she said, "Well, I'll just say him too."

Influence of Significant Others

A. Family

Client 7 didn't know her mother's age when she became pregnant with her oldest sister. However, Client 7's oldest sister had a father different from the other siblings. Her sister's father was deceased. Client 7 shared little information about her mother, other than she was a friendly person. Client 7 said that she never knew what her father was feeling.

Her oldest 32 year old sister, who was divorced, had four children. Her brother had a 3 year old child who was adopted by Client 7's parents. He had this child by a former girlfriend. Currently, he had been married to someone else for two years. Client 7's unmarried 19 year old sister had one year old twin boys. The twins were born prematurely, weighed two pounds each at birth, and were having problems learning to walk. "They go to school and stuff to try to teach them how to walk and stuff," she reported. Client 7 and this sister were pregnant at the same time.

B. Friends

Client 7 had one best friend, who was pregnant with her first child. This person was the one first she confided in about her first pregnancy. "She was happy for me and stuff," said Client Seven. Her friend's teenage sister was also a mother. Her best friend was the one person in her life whom she could talk to about anything. Client 7 had one other good friend who was not a mother. Since Client 7 began parenting, other friends came around less frequently. "I got a lot of friends over here and where I stay at, but, they not my best friends," she said.

C. Male partners

Client 7 started dating at fifteen. Her first boyfriend, who was 18 at the time, was the same person she currently dated. She met him through overnight visits at her cousin's house. He lived near

them. Through those meetings, she started "going with" him before her parents knew they were dating. In reference to coming to her house, she said, "He was afraid to come over there at first." He was the father of her son and the child she was carrying.

D. Religion

Client 7 was a church member, but she hadn't been to church in about 2 years. "I just haven't been going since I been pregnant," she said. She explained that she needed to buy some dresses, since she mostly wore pants. In regards to premarital sex, she recalled that the preacher talked about God and sin. She believed that it was a sin to engage in premarital sex.

V. DISCUSSION

Deficit Model

From Client 7's perception, she could see no disadvantages from being an unmarried adolescent parent. In fact, it appeared that she was satisfied with her situation. She had always wanted to parent a son and a daughter. Her first child was a boy and she was pregnant with a girl. She expressed a distaste for marriage. Therefore, being a single parent was more appealing to her than being a part of a couple with children. Her parents' support was protecting her from any financial blows she might, otherwise have experienced. Client 7 had no health complications and was about to graduate from high school. Whereas research might suggest socially undesirable consequences of her behavior, Client 7 expressed contentment with the "here and now".

The Decision-Making Model

Cognitively, Client 7 made few decisions regarding her pregnancies. She had allowed things to "just happen". By default, Client 7 carried her baby to term and became a single parent. She never considered abortion, adoption, or marriage as options. Her participation in a sexual relationship was in response of urging from peers. She made no decision based on her wanting to have sex. The clearest evidence of Client 7 attempting to make a rational decision was in her insistence that she would faithfully use birth control pills in the future. It appeared that she had considered the consequences of avoiding contraception.

The Subjective Utilities Model

With the exception of her parents, Client 7 was surrounded by friends and family members who were single parents. She would have been unique if she had married prior to pregnancy. Client 7 was not ostracized or criticized because of her behavior. Her mother was accepting of her parenthood status and her father showed no reaction. Client 7's primary source of love was from her parents and child. Although she was still dating her first boyfriend, the father of her son and unborn child, their emotional bond was secondary.

CASE REPORT OF CLIENT 8

I. DEMOGRAPHICS

Client 8, an unmarried 17 year old, was the mother of a 7 month old daughter. She experienced her first pregnancy at age 15 and, 3 months after delivery, became pregnant again. She was 4 months into a second pregnancy. She and her baby resided with her mother and step-father. She lived with her father for a little over a month in a neighboring county in Georgia. She returned to her mother's home when she found out she was pregnant.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 8 was under the care of the doctor. During her first pregnancy, she experienced no complications. Early in her pregnancy, she started going to the health center and became a part of the WIC program. Her baby was born healthy.

Education

Client 8 was a 10th grade student enrolled in a magnet school for pregnant teenagers. She had attended this school for about three months. Prior to this, she attended an inner city high school. She stated that it was better for her to change schools because the magnet school would allow her to miss as many days as needed for doctor's appointments. Also, there were no steps to climb. Client 8 was familiar with her current school because she attended it before when she was pregnant.

Pregnancy had caused Client 8 to miss some time in school, since being 17 and in the 10th grade was not the norm. She appeared to be making an effort to do well in school. She made the honor roll on her last report card. Her mother helped with the baby for about 2 hours in the evening so that she could do her homework. Client 8 tried to attend school on a regular basis, unless she had an appointment or problems with baby sitters. Her mother was unable to keep the baby because she worked during the day. Her step-father tried to keep the baby for her. He worked on a midnight to 7:00 a.m. shift. However, that arrangement was interfering with his rest and she had to stay home until she could find another sitter.

She plans to continue school until graduation, two years from now, and then join the Air Force. While in the Air Force, she would like to attend college. As a career goal, she desired to be involved with computer technology.

Income

Client 8 was primarily dependent on her mother for financial support. Her father contributed very little. After she is 6 months pregnant, she will start getting AFDC (Aid to Families with Dependent Children). She felt that AFDC and financial assistance from her mother would be enough to support her and two children. She realized that this situation was a financial strain. She stated that her mother never had money to buy clothes for herself. Also, if she had the power to change the situation, she would make the household financially comfortable and change residences. She desired to live in another community in a white neighborhood. She said, "Where we stay at, there are a lot of drugs going on." She felt that this was not a problem in white neighborhoods.

She was receiving no money from the fathers of either baby or their families. The father of her daughter had helped out in the past and his mother offered to baby-sit occasionally. She had no contact with the father, or his family, of the child she was carrying. She had no intention of trying to force him to take care of the baby. Her mother's advice was to just take care of her own children and leave the fathers alone.

Family Structure

Client 8 considered herself as an only child, although she had a half- brother and half-sister. She was born to teenagers who never married each other. When Client 8 was 5 years old, her mother married. The step-father assumed the active role of fatherhood. Her father, now divorced, was married for about two years. He had a 5 year old son by his ex-wife and a 3 month old daughter by another woman.

Teen Parenting Impact

Parenting limited Client 8's mobility. "I couldn't go nowhere like I used to," she said, "I became responsible, real responsible." Parenting was different from what she thought it would be. "I

thought it would be fun, but it ain't fun being no parent," she said. She planned to cut out all of her extra-curricular activities and stay home with her child, because she was the one who got pregnant. Therefore, she expressed that taking care of the baby was just something she had to do. However, her dream was still to go in the Air Force in two years and leave her children with her mother. When asked how her mother would manage that and work too, she replied, "She will just put them in day care or do whatever I would do if I were here".

In response to the question, "What do you think would be different about your life if you had never become pregnant?", her response was, "I could date more, have things that I want, like a car and have more goals for myself, but my child is in the way." In fact, she sometimes felt anger toward her daughter. "I love her, but it seems that she is just holding me back," she stated. The best thing about teen parenting, in her view, was that you had someone to talk to and the worst thing was staying up at night. She would not recommend parenthood to other adolescents and suggested that they wait until after finishing school.

Pregnancy impacted her social life. In her opinion, since she had a child and was pregnant with another, everybody turned against her. She felt alone because people didn't seem to want to be bothered with her. She couldn't even get a boyfriend. Her mother tried to comfort her by saying, "You'll find you somebody one day and it will be the right person for you, but remember, your child always comes first." Client 8 rationalized by saying, "Hey, if nobody don't like me, then they don't have to put up with me and my children."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 8 became sexually active when she was approximately 14 years old. Her mother had talked to her about sex, telling her that it was alright to have sex if you really loved somebody, and as long as you didn't have sex with too many different guys. She had been dating one person for about a year prior to their initiation of coitus. During the following year, she had approximately four sexual relationships. However, she did not become pregnant because of birth control.

She believed that girls were having sex to please the boy. She shared that she had a few "one night stands" in which the boy never did come back. "I hated that," she said, "but that's in the past." According to Client 8, the most influential reasons for engaging in premarital sex were to please the boy and peer pressure. Also, many girls were just curious about what the experience was like. She didn't feel that external factors, such as having money to do other things, had any significant bearing on adolescent sexual behavior.

Contraceptive Behavior

At the time when Client 8 became sexually active, she was using birth control pills. She went, without parental knowledge, to the health center to get information about birth control and to receive the pills. An older, sexually active, girl had referred her to the center. She took birth control pills for about a year. She stopped using them because they began to make her sick. Soon after she curtailed use of the pill, she became pregnant. Client 8 had tried different kinds of pills, but they all made her sick. She had been given the foam to use, but sometimes forgot to use it. Some of the young men, with whom she had intercourse, used withdrawal and the condom as contraceptive methods. After she has the second baby, she planned to be fitted with a diaphragm.

Pregnancy Resolution

In neither situation did Client 8 consciously decide that she wanted to get pregnant or planned the pregnancy. In fact, each time she found out she was pregnant, she was scared. She didn't consider adoption or abortion and believed that she would have regretted it if she had selected either of those options. Concerning adoption, she stated, "If I gave my child for adoption, I could see my child on the street, but I wouldn't know who she is." She further concluded, "I would hate myself if I gave my child up for adoption, cause its just brutal." Her attitude toward abortion is that it was an act of destroying life and she believed that you should give a beautiful baby a chance to live.

At the time of her first pregnancy, marriage was proposed. Her boyfriend stated, "I love you and I want to marry you and my mama thinks its only right." Client 8 didn't feel that she was ready to settle down, after all she was only 15 and he was 14 years old. If she had the opportunity to marry him now, she would consider it. However, although he was working, she did not perceive that he had enough income to take care of them. She believed that he might be still willing to marry her even though she was carrying someone else's child. Her thinking probably was unrealistic, considering that she virtually had no relationship with him at the present time. When asked, "Who are the people in your life whom you love?", she mentioned her baby, parents, and other family members. No boyfriend was included.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 8 had a difficult time listing her wonderful attributes. She finally said, "I would just say that I'm a good going person." She added that she liked to have fun by going to the movies, shopping or just going places with friends. She quickly added, "Some people have friends that they go places with, but I don't have no good friends." She described herself as lonely because of the lack of close friends.

Client 8 wasn't very happy with her appearance when she was pregnant with her daughter. She stayed in the house and was afraid to go places. "I thought people were going to be laughing at me," she said. She was also embarrassed because whenever people told her that she was going to get pregnant, she always denied it. When she was out walking, she felt that people in her neighborhood were talking about her. Although the other girls at school were also pregnant, she felt that they talked about her too.

She defined a happy person as someone without children. Yet when asked about her own state of happiness, she replied, "I think I'm happy", and "With a second child, I think I can still be happy." However, she shared that she felt sorry for herself because of the intimate relationships she had in the past. Although she regretted getting pregnant, she wouldn't change that if she could. What she would change was the way people acted toward her. "They act like I done something to them or something," she said.

She expressed some self-conscious feelings about being a pregnant Black teenager. She mentioned that it seemed that people were looking at her when she went to the doctor. It was as though they were thinking, "She is fixin to have another baby." She perceived whites in a more positive image in comparison to Blacks. If possible, she desired to live in a white neighborhood, as stated previously. Also, the short time she lived with her father, she attended a predominately white high school. Her impression was that white friends treated her much better than Black friends. She was the only black girl in her classes. "I would rather have a white friend than a Black friend," she said.

One of the earliest childhood memories of Client 8 was that the girls at school didn't like her. She felt that they were jealous of her because she was an only child which caused her to have more material things than some of the others from larger families. She always had problems saying no to friends and boys, because she wanted them to like her. When schoolmates tried to get her to smoke, it was difficult saying no. "Its hard to say no to your friends," she stated. She had said no to boys when she was a virgin. Then she thought that having sex would make them like her, but she found out it made no difference.

Influence of Significant Others

A. Family

Client 8 described her 34 year old mother as a nice, understanding person with whom she could talk about anything. Her mother was happy when she found out she was pregnant with the first baby. She just stressed that she wanted her to stay in school. When her mother was told that Client 8 was pregnant a second time, her response was, "Well, maybe God put you on this earth to have children." Again, her mother was happy and stressed that she finish school. Client 8's mother got pregnant with her when she was sixteen. She dropped out of school and never did finish. She didn't want that to happen to her daughter. Unlike Client 8's grandmother, her mother was committed to giving her the support she needed to help her get through school. She reported that her mother said, "I'm there for you, but my mama wasn't there for me." Client 8 was 5 years old when her mother married.

Client 8 described her 37 year old father as the "party type" and the type of guy who would bring you down. She said, "All he cares about is finding him a woman." He didn't assume his responsibilities for her during her childhood years and spent very little time with her. In fact, he used to deny being her father. Because of that, she didn't feel close to him or address him as daddy. Only in recent years had he tried to do anything. He wanted to come around now and take her places. She replied, "I'm too old for that now, I'm a mother." It appeared that Client 8 was repeating the experience of her mother. In fact, she said, "I'm going through what my mama went through with my daddy."

Client 8 called her stepfather daddy. He had been very good to her and her baby. Everything was fine with him as long as you didn't get him mad. He was a Vietnam veteran and his experience of having killed caused him to have nightmares. Also, he seemed obsessed with Army artifacts and war movies. According to Client 8's perception, he treated her like he was her real daddy. She said, "If I ever get married, he would be the one to walk me down the aisle."

Her maternal grandparents were not married. When her grandmother got pregnant, her grandfather went off to the service until after the baby, her mother, was born. At first, he denied paternal rights, although his daughter looked just like him, according to Client Eight. She said, "I hate when somebody, they look just like they daddy, and the father denies them." Her mother was the only child her grandfather had with her grandmother. However, he and her grandmother had other children. Her grandfather, the owner of a car repair business, lived in another state. After always lecturing, he

gave her mother money upon request. He was unaware of Client 8's second pregnancy. When he heard about the first one, he was angry and said to her mother, "Why didn't you stop it?" Her paternal grandmother was a widow.

B. Friends

Client 8 reported having no close friends. In fact, that was what she yearned for, to have had very close friend. Even when she was a child, there were people in her neighborhood with whom she played, but she mostly stayed by herself. She described friends as trouble. There was only one person she considered a good, but not close, friend. That person was also pregnant. Based on the number of times she brought up the issue of friendship, she seemed plagued by this desire for a close friend. The following was her description of a good friend:

"Somebody who won't go behind your back and talk about you. Somebody I can tell secrets to. You know, somebody to just go out and have fun, go shopping and stuff. Some friends, if you have a boyfriend, they will try to take your boyfriend. I want a friend who is not like that. I want somebody I can really trust, but in the past, I don't trust no girl".

C. Male partners

Client 8 started dating when she was 13 years old in junior high school. It seemed that this was not any meaningful relationship since she referred to him as "just a guy". She was still in junior high when she met the father of her first child. He was one year younger than she. When he found out she was pregnant, he was shocked. He didn't even tell his parents for a long time. He used to come over sometimes when he desired. She wanted him to be a full-time father to his daughter. When she approached him with this, he said, "I ain't gone be there for her." He used to call, but doesn't do that anymore. When he got to high school, he denied that the baby was even his. She described him as very immature. That didn't seem unusual, since he became a father at fifteen.

She became acquainted with the father of the second child when she got to high school. This 19 year old was not enrolled in school, but he used to come over to the school all the time. Now, he had nothing to do with her. She hadn't even had the opportunity to tell him directly that she was pregnant, but had sent messages to him by his friends. She has seen him driving by sometimes when she was sitting on the porch. He didn't even speak to her and, otherwise, totally ignored her existence. His actions made her feel bad. He was in and out of town conducting his business of selling illegal drugs. Also, he was the father of two other children. All of his children were by different women, none of whom were receiving financial support from him.

She briefly dated another young man while pregnant with her first child. However, she didn't actually consider that as dating. She thought a real date was when a young man took you out to dinner and to the park, or something of that nature. When she dated that young man, he picked her up around 11 or 12 at night. They mainly rode around listening to music. They had to go places in the dark, because he had another girlfriend, who was the mother of his two children. He took her to the doctor and came to the hospital when she had her baby. After that, she stopped seeing him. She felt uncomfortable being the second woman.

Generally, her experiences with males have not been that positive. In the past, she had some to tell her things that sounded good for the moment to benefit their purpose. She said, "I done had some that tell me things and then get my head all filled up, but I done got hip to their game now." They mostly wanted to just come over her house when they pleased, pick her up, and take her over to their houses. She further stated, "I ain't never had nobody to really care about me, at least male wise." She continued, "My heart has been broken a lot." Her opinion of "the perfect guy" was one who would treat her like a lady, give her money, and spend time with her child. To Client 8, being treated like a lady meant being with someone who was polite, would pull the chair out for you, opened doors for you, and who would not go back and tell their friends what they did on the date. She didn't know anyone who fitted that description.

D. Religion

Client 8 attended church on a regular basis. She realized that there were church teachings about girls getting pregnant, but she had no beliefs about whether it was morally right or wrong. During her earlier years in church, she had no memory of any instruction dealing with sexual behavior and what the church advocated. Her uncle was a preacher and he said to her, "It's not wrong getting pregnant, but don't make a habit of it." He further stated, "Don't make sex every weekend." She reported following his advice by not having sex every weekend.

V. DISCUSSION

Deficit Model

The model is focused on problems of health, education, income, and overall well-being of the mother and child. Client 8 appeared to be a healthy young lady and she reported that her baby was likewise. She had consistent medical care during her two pregnancies. Therefore, it did not appear that pregnancy, at the adolescent stage of her life, had negatively impaired her health or that of her baby. Client 8 was scheduled to become a recipient of AFDC. At that time, she will join the group of young single mothers labeled as the fastest growing poverty group in America. Client 8 had not dropped out of high school. She was continuing her education toward a high school diploma, which she expected to receive two years from now. She had a family support system in place which was encouraging that effort.

Ten years from now, she predicted that she would be a working wife and mother. Her husband would have a good job and they would be the owners of a nice house and car. Currently, she had no viable prospects for a marital partner. Her relationships in the past had not included men who shared this dream. Her expectations appeared unrealistic. For instance, when asked how much money she thought it would take for a woman with two children to live comfortably for a year, her reply was, "Over three hundred thousand dollars." Her cognitive functioning did not appear to be at a level to rationally access the long-term outcome of her situation.

The deficit model is a function of predictions derived from research. Reports from previous studies would indicate that Client 8 will have some problems aligning with the mainstream. In all likelihood, given her pattern of behavior, her chances of having more children before age 20 were probably greater than her chances of getting married. Her actions had restricted her income and educational opportunities. However, her perception, based on short-term realities, was that she was only disadvantaged socially and prohibited from getting personal goods for herself.

The Decision-Making Model

Client 8 made a rational decision to get on birth control prior to becoming sexually active. However, there was a break-down in that process when she decided to stop birth control measures because of discomfort. She did not decide to discontinue coitus. This, in essence, was a decision to risk getting pregnant. In continuing this pattern after the birth of her daughter, she was deciding to have a subsequent pregnancy.

Her pregnancy resolution decision was by default. She did not perceive abortion, adoption, or marriage as an option which she could select. Therefore, the only available solution was for her to have the children and parent without a partner. The fact that she was living with her supportive mother lessened the social consequences of that decision.

The Subjective Utilities Model

Client 8 was continuing in an intergenerational cycle which dated back to her maternal grandmother. There was a family pattern of having babies out of wedlock by men who, initially, denied paternity. This pattern of behavior appeared to be acceptable within the family context. Her mother indicated to her that this may be of God's plan, for Client 8 to have children at this time. More emphasis had been placed on Client 8's completing high school than completing family size.

Client 8 had a very weak self-concept. She seemed convinced that she was disliked. She was consumed with trying to please others. Like most individuals, she wanted to be liked and accepted by persons significant to her. She seemed overwhelmed by the need of a close friend and was trying to use her daughter in that role. This was evident when she said, "The best thing about teen parenting is having someone to talk to." Males in her life benefitted from her wanting to please. They told her things to make her feel wanted and loved for the moment, only to desert her afterwards. She had unsuccessfully used sex as a means of gaining love and approval. Whenever this occurred, her low self-concept became even more embedded. This yearning for acceptance, immaturity of rational thought processes, selection of irresponsible partners, and inconsistency of birth control use, made her very vulnerable for future premarital pregnancies.

CASE REPORT OF CLIENT 9

I. DEMOGRAPHICS

Client 9 was an unmarried 17 year old who was the pregnant mother of a 12 month old son. She was four months pregnant. She experienced her first pregnancy at sixteen. She and her child resided with her grandmother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 9 had an uncomplicated first pregnancy and delivery. She had natural childbirth and her baby weighed 7 pounds and 5 ounces at birth. Client 9 was under the doctor's care. She appeared to be healthy, with the exception of scars which covered her arms. Her school administrator believed Client 9 was subjected to child abuse. She felt that the scars were aged marks from cigarette burns.

Education

This was the second time Client 9 had been a student at the alternative school for pregnant girls. She enrolled in order to continue her education rather than dropping out of school. Considering that Client 9 was a 17 year old ninth grader, one might conclude that she had previously dropped out of school. When asked if this had ever happened, Client 9 responded by reporting that she was not in school last summer. According to the school administrator, Client 9 was cognitively a very low functioning student. She had spent most of her school years in special education classrooms. After talking with her, the research investigator concurred with the school official's assessment. The question was asked, "What was it that made you decide to stay in school?" Client 9 replied, "I ain't want to drop out". She continued "My grandmama nem kept telling me, don't drop out." Although she expressed that she wanted to get an education, she had no career or occupational goals. Concerning her occupational future, she replied, "I ain't decided yet."

Income

Client 9 received a monthly social security check of \$525.00 from her deceased father. She felt that her income was sufficient.

Family Structure

The family of Client 9 consisted of her mother and 10 siblings. Her youngest sister was three months old. Client 9 and her son lived with them until her recent move to her grandmother's house. The main reason she moved was because her grandmother felt that Client 9 had too many responsibilities for the care of her younger sisters and brothers.

Teen Parenting Impact

Client 9 didn't perceive that there had been any change in her life resulting from parenthood. Since she was the oldest of 11 children, she helped her mother take care of the younger ones. Becoming a mother was what she had anticipated, based on the caregiving role she had assumed as the oldest child in the family. Client 9 enjoyed caring for babies. In fact, she wanted to get pregnant with her first child because she loved taking care of babies. The anticipation of having two babies didn't seem to bother Client 9, since she believed her grandmother would help her. Considering all this, she still would not recommend parenthood to other adolescents. In fact, she stated that she was going to try to wait until she got older. Although Client 9 couldn't think of any response to the question, "What is the worst thing about being a teenage mother", she was able to reply to the question, "What is the best thing about being a teenage mother?" She said, "It helps you stay out of trouble, for one thing. Client 9 continued, "It helps you stay out of the streets."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 9 began sexual intercourse at age sixteen. She only had one sexual partner, the father of her son and the child she was carrying. She didn't know why young girls engaged in premarital sex.

When asked about her personal reasons, she replied, "I don't know, I guess we had wanted to." She reportedly engaged in intercourse once a week. She admitted that it was not a pleasurable experience, but rather just something that happened.

Contraceptive Behavior

Client 9 was taking birth control pills after she had her first child. According to her, she took them until she was advised by the doctor that it was time for her to stop. "There was something else he was saying," she said. It was highly likely that Client 9 misinterpreted the doctor's directions. She had never used any other type of contraceptive, but her boyfriend had used the condom. He just stopped using condoms. Client 9 had no idea why, because she never asked him. After the second child is born, she plans to return to using birth control pills. She didn't want anymore children, "But that's what I said after the first one," she stated.

Pregnancy Resolution

Client 9 desired to become pregnant the first time. Therefore, she wanted to carry her baby to term and take care of him. With the second baby, she considered abortion. She didn't want the baby because she wasn't getting along with its father. Client 9's mother encouraged her to have the second baby. According to Client 9, her mother said, "Just go ahead and keep it, and don't do away with it. Concerning adoption, she said, "I was seeing it on the news where all of those folks were giving their babies away, and I said, nawl, I will go ahead and keep it." Although her boyfriend asked her once to marry him and his parents wanted them to marry, Client 9 did not desire marriage. She didn't want to marry him because she believed that he was "messing around" with other girls.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 9 felt loved by her mother and grandmother. In addition to them, her baby was the only other person who was important to her. Client 9 was happy sometimes, when she was not angry. She was happiest when she was getting along with her relatives and her boyfriend. She was sad when her boyfriend argues. When asked to share great things about her, she said, "Not nothing, cause I'm mean." After deeper probing by the investigator, Client 9 still could not think of one positive thing to share about herself.

Influence of Significant Others

A. Family

The mother of Client 9 got pregnant with her at age sixteen. Her mother did not marry Client 9's father nor any of the men who fathered her other 10 children. Client 9's 33 year old mother had never been married. She described her mother as a nice person, although the school administrator suspected that her mother abused her.

Client 9 remembered little about her father, who died when she was six years old. She recalled that he used to come and see her, before he died on one Christmas day. She remembered that it was on Christmas day, because her hospitalized mother had just had her sister on Christmas Eve. She had nothing to do with any of her father's relatives. She said, "After my daddy died, they started "tripping a lot. I don't go around them." Client 9 was the only child her mother had by him.

B. Friends

Client 9 had friends who were also attending the alternative school for pregnant girls. Her friends who were not at the school were parents, but not currently pregnant.

C. Male partners

Dating for Client 9 began when she was 15 years old. She had only one boyfriend, the 17 year old father of her son and unborn child. They were still dating, although she had no desire to marry him and did not view him as the man of her dreams. Her ideal man was one who was nice and did not like to argue. She had limited her dating to one guy because she felt that other young men were either on drugs or selling them.

D. Religion

Client 9 used to attend church with her grandmother. They stopped going earlier in the year when her grandmother had surgery. She planned to start attending again. Client 9 had no idea of the church's position on premarital sex.

V. DISCUSSION

Deficit Model

The investigator perceived that Client 9's intellectual functioning was very low. The world view of Client 9 appeared to be extremely limited. Therefore, it seemed difficult for Client 9 to conceptualize any references to the future. She reported no disadvantages to early parenting. Client 9 was continuing in school, she experienced no health problems with pregnancy, and she was happy with her income. Since she was accustomed to caring for her siblings, taking care of children was not a problem. She viewed early pregnancy in a positive light in that the responsibilities of parenting prevented one from getting in trouble in the streets.

The Decision-Making Model

There were no indications that Client 9 rationally made any decisions of her own. Sexual intercourse "just happened". She stopped taking birth control pills, because that was what she thought the doctor wanted her to do. When she considered aborting the second pregnancy, her mother told her to carry the child to term. A television news report influenced her to keep her baby rather than give it up for adoption. Client 9 allowed her boyfriend to use or not use condoms at his discretion, without even talking to him about his decision. It was the investigator's opinion that Client 9 was cognitively unable to make decisions based on the evaluation of alternatives.

The Subjective Utilities Model

The most influential person in Client 9's life appeared to be her mother. Since Client 9's mother was a 33 year old, never married mother of 11, it appeared that the intergenerational cycle for teenage parenting was a factor. Assuming that Client 9 used her mother as a role model, she will have more children and remain unmarried. Since Client 9 will parent two children within a 17 month period, it appeared that she was repeating her mother's behavior.

CASE REPORT OF CLIENT 10

I. DEMOGRAPHICS

Client 10 was an unmarried 19 year old who was the mother of three daughters, aged three, two, and seven months. Client 10 was 15 years old when she first became pregnant. She resided with her mother.

II. RELATIONSHIP TO THE DEFICIT MODEL

Health

Client 10 had all three children by natural childbirth. She experienced no personal health problems and reportedly had rather fast deliveries. The fact that she was a former track runner could have facilitated an easier process. With her first child, she took some Lamaze classes, although she didn't finish the course. One of her daughters required hospitalization as an infant. Another daughter entered the hospital at two months of age because of dehydration. Otherwise, she had normal deliveries and her daughters were healthy at birth.

Education

Client 10 was completing her senior year at an alternative school for pregnant adolescents. She was making average grades in her classes. Prior to attending the alternative program, she was enrolled in vocational cosmetology classes at an area technical high school. She was usually at school about four days a week. Client 10 was scheduled to get her diploma during the summer school session. However, since cosmetology was not offered at the alternative school, she will have to make other arrangements to complete those courses to meet state licensure requirements. She had a career goal of owning her own beauty shop one day.

Before Client 10 ever became pregnant, she was a member of the girls' track team. After her first baby, she went back to the team. When she returned from having her second child, she couldn't run as fast as she had prior to pregnancy. "When I was pregnant and took off those nine months, I got slow," she said. Client 10 continued, "My running wasn't as good as it used to be."

Finishing school was very important to Client Ten. "I always had a goal of finishing school", she said. She continued, "Really, I'll be the first one in my family, between my mother, my sister, and my brother, to finish school." Her mother and sister dropped out of school because of pregnancy. Her younger half-brother was still enrolled in school.

Income

Client 10 was receiving AFDC (Aid to Families with Dependent Children) benefits of \$220.00 monthly. After her first child, Client 10 tried to support her family by working at fast food establishments. "I wasn't on welfare or nothing," she said. After her third child, she got on welfare because of the Medicaid benefits. Realizing the financial responsibilities of parenting, she said, "If I could do it all over again, I'd wait until I'm financially able or until I'm married to someone who would help me." She continued, "Cause they're here, I'm gonna try to take care of them the best way I can." Client 10 was thankful that her mother taught her money management skills and how to economize in the grocery store. Explained Client 10, "When I go shopping, I try to get the lowest thing." She didn't spend all of the money as soon as she got it. "I try to do what I need to do for them, then I take care of me," she said. She was trying to get a place of her own. In trying to manage this, she said, "I'll just pay the rent and get the house, right now the furniture is not important."

Family Structure

Client 10 had a sister one year older. Client 10's maternal half-brother was one year younger than she. She and her siblings and their children all lived with her divorced mother, including her brother's five month old daughter. Client 10 also reported that she had 3 or 4 paternal half-sisters and brothers. She was unsure of the claim by one little girl. They all lived with their different mothers. Client 10's father, disabled from a work accident, lived alone in a nearby apartment in the same federally subsidized housing complex as Client Ten.

Teen Parenting Impact

In describing how becoming a parent changed her life, she said, "Its like when I went to school or something, I didn't have a child...When I came home, I had one." Parenthood was not what she thought it would be. She had not considered the parental responsibilities of feeding, providing clothing, and constantly watching her daughters. Client 10 realized that being the mother of three

children entailed additional responsibility in comparison to the parenting of one. "If I'm going out, I have to get three other people ready, too," she said. She described her situation by saying, "I'm a single parent and I have to take care of myself and my kids. I have to make sure that they got a roof over their head, feed them and clothe them." In advising other adolescents about parenthood, she would say, "Girl, you just don't want to have no children."

III. RELATIONSHIP TO THE DECISION-MAKING MODEL

Sexual Behavior

Client 10 started dating at fifteen, the same year she became sexually active. Oddly enough, she was more interested in running track than in dating. "I spent most of my time running...I loved it," she said. Client 10 was motivated to engage in sex because she was trying to keep her boyfriend. She felt that many girls were engaging in premarital sex because they had older boyfriends who were more experienced. Also, peer pressure was a factor. "Some girls have older friends who are experienced too, and they try to fit in with them," she said. Some of the girls in her neighborhood seemed attracted to older guys who were dope dealers. According to Client 10, some young girls are attracted to the material things that these drug dealers could purchase.

Contraceptive Behavior

When Client 10 first discovered that she was pregnant, it didn't really bother her. "I didn't really have no feelings because...I guess cause my sister, she had a baby," she said. In responding to a question about her feelings regarding birth control, she said, "I think it is something that should be used and more than just the pills...I think a guy should use something too." Her preferred method of birth control was sterilization. Client 10 had used the pills in the past. She didn't use pills consistently because her dating patterns and sexual encounters were irregular. In fact, she got pregnant with her last child by having unprotected sex when her boyfriend received a weekend pass from prison. Since he was incarcerated and she wasn't dating anyone else, she saw no reason to be on birth control. She described her sexual involvements as off and on. "It wasn't like I enjoyed it", she said. Based on a statement she made, it became apparent that Client 10 was misinformed about birth control. She said, "I'm not sure they will give you birth control if you are not sexually active." She continued, "They wouldn't give my friends some. They told her parents that she wasn't having any sex, so she couldn't get any." "So, I don't know if they do or not," said Client Ten.

Pregnancy Resolution

Client 10 perceived abortion as killing a baby. She could not do that, although she believed some of her friends have had them. Although she stated that she didn't desire pregnancy in either instance, she said, "But I didn't want to kill them either." Adoption was not considered an option for Client Ten.

Although marriage was mentioned by both young men for whom she had children, Client 10 didn't want to be tied down and felt that she wasn't ready for marriage. She would like to marry one day, but not to either of the men with whom she was previously involved. She described the man of her dreams as someone who was willing and desired to work, without being forced, and someone with a good attitude. She also desired a husband who didn't drink or smoke, who was well-groomed, and had an outgoing personality.

IV. RELATIONSHIP TO THE SUBJECTIVE UTILITIES MODEL

Perception of self

Client 10 felt that happiness began in childhood with feeling loved and having someone to understand you and talk to you. She expressed that she was a happy person, although she admitted that she had no one with whom she could openly discuss intimate and deeply personal matters. Client 10 mostly kept things to herself. After expressing reluctance to participate in this project, she was extremely open. This suggested a desire to have someone with whom she could share feelings. She does feel loved by her parents, siblings, and children. She felt that she was a cheerful and understanding person, who didn't like to hurt other people's feelings. Also, she treated others the way she liked to be treated.

Influence of Significant Others

A. Family

Client 10 was appreciable of the help she received from her mother. Her mother, who was 100% supportive of Client 10, baby-sat for her so she could continue school. Her mother became pregnant, dropped out of school, and married as a 17 year old high school junior. It was Client 10's maternal grandmother's idea for her mother to get married. Her mother told Client 10 and her sister not to allow parents to influence marital decisions. Although Client 10 described her mother as real smart, she never finished high school, as well Client 10's older sister. There seemed to be a strong family commitment for Client 10 to finish. Her mother, divorced from Client 10's father, had two daughters by him and a third child, a son, by another man. She had only been married to Client 10's father. From the account of the events reported by Client 10, it appeared that her mother got pregnant with her son when her husband was away in military service. Client 10's father signed the papers to give the child legally his name, but the marriage soon ended in divorce.

Client 10's older sister was the unmarried mother of a child. Her teenage brother was the father of a five month old daughter. His baby lived with them, although he didn't have legal custody of the child. His mother took care of her while he was continuing school.

Client 10 didn't have a lot of interaction with her father. She saw him occasionally when she went over to his house. Actually, the divorce occurred when she was so young, that she didn't remember living with him. "I don't stay around him long enough to know how he acts," she said. Her father did not assist them financially. Prior to their eighteenth birthday, she and her sister received social security, since he was disabled. He lost one eye through an industrial accident and was going blind in the other one.

B. Friends

Client 10 reported that she had three good friends who were also parents. She had become friends with other teenage parents since she enrolled in the alternative school.

C. Male partners

Client 10 dated young men who did not fit the description of her "ideal" boyfriend. First of all, neither liked to work, which was in contrast to the work ethic which seemed important to her. She was good friends with the 21 year old father of her first baby, but had curtailed social relations with the 22 year old father of her last two daughters. The second boyfriend had an attitude, drank alcohol, liked to start trouble, and had tried to hit her, according to Client Ten. Also, he had been in jail, although she was unsure of the crime he committed. Right now, she was not serious with anyone and was just casually seeing people, but not her previous boyfriends. She wasn't "going with" anyone at the time of the interview. Client 10 said, "I'm just dating them, but I'm not having sex with them or doing things that I'm not suppose to do." She described most of the guys she met as being pretty nice.

D. Religion

Client 10 used to go to church all the time. She planned to resume church attendance after she got her daughters some church clothes. The mostly had play clothes. She had always enjoyed going to church. "I want them to grow up going to church and willing to stay in school like I did," she said. Regarding premarital sex, she didn't recall any church teachings about that. However, she remembered that it was wrong to live with a guy before marriage. She, believed it was wrong, although she admitted to having cohabitated.

V. DISCUSSION

Deficit Model

The model is focused on problems which an early pregnancy may cause for the adolescent and her children. Deficits, for Client 10, were not perceived in the areas of health and education. Client 10 had medically uneventful pregnancies and deliveries. She would soon be a high school graduate, which seemed to be her ultimate educational goal, even if she had not become pregnant. Client 10 expressed disadvantages in terms of money and personal time for herself. She realized that the \$220.00 monthly government stipend was insufficient for caring for herself and three children. Client 10 believed that it would have been better if she had waited until being more financially stable before parenting. She was trying to do her best, but it was difficult. She desired to work, but the Medicaid benefits motivated her to seek welfare. Even after receiving her high school diploma, it was doubtful if she could find a job making the money comparable to the welfare stipend, Medicaid benefits, food stamp allocations, and housing subsidies. Therefore, she might find herself "trapped" on the welfare rolls.

The Decision-Making Model

The decision-making model examined if there were any rational thought processes involved in sexual and contraceptive behavior, and pregnancy resolution. Client 10 began her sexual relationship because of her desire to please her boyfriend. She was more interested in running track than having sex. She was the type of person who didn't like to hurt anyone's feelings. Possibly, she felt that she may have hurt the boyfriend if she had denied him sex.

Her understanding of contraceptive use was that it was necessary after one was involved in a regular, consistent sexual relationship. Client 10 was using birth control pills at one time. Since coitus was irregular for her, she decided that she could discontinue the use of birth control pills. This was a decision which resulted in the birth of three children. Her behavior was continuing along the same path. Currently, she didn't have a "steady" boyfriend and was not having sex, therefore, she was not using birth control pills. She would like to have her tubes tied, but she was too young to qualify for Medicaid to pay for the procedure. There was a good chance that she will get "caught" again unprotected.

Regarding pregnancy resolution, Client 10 viewed carrying the baby to term as her only alternative. Therefore, the decision was by default. Abortion was killing, according to Client 10. Adoption nor marriage was considered. She followed the advice of her mother who suggested that pregnancy was not a good reason to marry. Client 10 didn't want anymore children, but she would like to marry one day. She had no desire to marry either of the fathers of her daughters.

The Subjective Utilities Model

This model is concerned with the influences of significant others or factors in one's environment. It appeared that sex outside of marriage was the "norm" of Client 10's family members. From her mother to her younger brother, all experienced early premarital parenthood as a teenager. Client 10 admitted that she wasn't too concerned when she discovered she was pregnant, because her sister already had a baby. Her mother, divorcing early in her marriage, raised three children without the benefit of a husband. If Client 10 modeled that behavior, she would do the same. It appeared that she might duplicate the familial pattern of single parenting. Client 10 didn't want to marry either of the fathers of her babies. Although she would like to marry one day and described the "dream" choice of a mate, it will be difficult for her to find a "good" husband to be the father of her three children. Since Client 10's father had three or four other children, all by different women, it was apparent what his attitude was concerning sex outside of marriage.

Client 10 was a member of a church and expressed a fondness for church attendance. However, her belief that certain actions were morally wrong hadn't deterred her from participating in those activities. Her desire to please her boyfriends seemed to overpower any moral or practical considerations.

VITA

Loretta Pinkard Prater was born in Chattanooga, Tennessee on February 16, 1946. She attended public schools in that city and graduated from Howard High School in June, 1964. She began her undergraduate studies at Spelman College, Atlanta. After marrying Dwight Prater and becoming the mother of sons Leslie and Stefan, she later transferred to the University of Tennessee, Chattanooga. In 1974, she received her Bachelor of Science degree in Home Economics Education.

Her professional career in public schools spanned 15 years in the Chattanooga Public School System. She taught science, home economics, and was a system-wide administrator as Coordinator of the Drug Free Schools Program. During that time, she returned to graduate school at the University of Tennessee, Chattanooga, to complete a Master of Education degree in Secondary School Counseling in August of 1983. In 1987, she had the distinction of being selected as the system-wide High School Teacher of the Year.

The author is a member of the National Council of Family Relations, the American Home Economics Association, and the National Education Association. She recently accepted a position as Assistant Professor in the Department of Human Ecology at the University of Tennessee, Chattanooga.