ADOLESCENT PREGNANCY AND CHANGES IN FAMILY FUNCTIONING: THE VIEWS OF PREGNANT ADOLESCENTS LIVING AT HOME AND THEIR MOTHERS

DIANNE GRIFFIN, R.N., B.A., B.S.W.

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BY

© Dianne Griffin, R.N., B.A., B.S.W.

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Abstract

Adolescent pregnancy was examined as to whether or not its impact on the family was distinguishable from that associated with adolescence in general. The perceptions of a group of thirty-two (32) pregnant adolescents and their thirteen (13) mothers was analyzed. The Family Assessment Device (FAD) was applied to indicate the teenagers' and their mothers' recollection of family functioning before and after the pregnancy. Mean scores were collected within and across the scales which made it possible to compare the subject's perception prior to and after the pregnancy occurred. Results indicated there were no significant differences found on the scales before and after the pregnancy, nor between mothers' and daughters' perceptions of family functioning.

Introduction

In Canada and the United States much care and attention are given to the increasing numbers of pregnancies occurring among unmarried adolescents. In both countries the highest rates of unmarried adolescent pregnancies occur between the ages of 15 to 19 years.

Canadian statistics report a decrease in the total number of births between 1980 and 1985. However, during this period the numbers of babies born to single mothers has increased by almost 30% (Statistics Canada, 1980-1985).

More than 95% of teenage mothers are choosing to keep their babies (Black & DeBlaissie, 1985; Wallis, 1985; Weinman, Robinson, Simmons, Schreiber & Stafford, 1989). Families are expected to provide assistance, particularly when the teenage mother chooses to remain at home and in school. Consequently the nature of family involvement has to be negotiated. Families are expected to improvise a realignment of family roles. (Furstenburg, 1980).

Families are affected by patterns and shifts in cultural values particularly those relating to sexuality and parent-child relationships (Fox, 1981). In the area of sexuality, for example, societal values have shifted from a strict moralistic code to a more permissive attitude. This presupposes that parents of adolescents, particularly those who are middle-aged, need to review their values and attitudes about sexuality and possibly make changes that fit the more liberalized sexual mores (McGoldrick, 1988).

Based on this survey of the literature and the investigator's professional experience, it is evident that families handling the adolescent developmental tasks experience changes in structure and organization. Adolescence is a time of change in parent-child relationships, a time of struggle for power and independence on the part of the adolescent.

The purpose of this research project is to examine whether or not the impact of adolescent pregnancy on the family is distinguishable from that associated with the impact of adolescence in general as perceived by a group of pregnant adolescents and their mothers.

At the present time most services which are designed to help the pregnant adolescent are focused on her as an individual, not on her family. This study focuses on the effects of adolescent pregnancy on the family. Does a pregnant adolescent in the family cause it to function differently from the family which does not have this problem? The results of this study are likely to have important implications for professionals providing direct service to pregnant, unmarried adolescents as well as those involved in program planning.

Literature Review

The available literature on the family relationships of pregnant adolescents is limited. Most of the attention has been focused on causative factors and on consequences of the pregnancy on the adolescent. (Furstenburg, 1980; Landy et al., 1983; Stafford, 1987). "Researchers are trained to study individuals not families; policies and programs are designed to serve individuals, not families" (Furstenburg, 1980, p.65).

Based on a review of the literature this investigator has concluded that societal attitudes towards adolescent sexuality, and particularly adolescent pregnancy, have changed over the past several decades.

Leontine Young (1954), a social worker, described society in the early fifties as being punitive toward the unmarried mother; she was seen as "bad". When the pregnancy was discovered many such unmarried mothers escaped into marriage or fled their communities for shelter in a maternity home, where they remained until

the baby was born and usually placed for adoption. Agencies providing services for the unwed mother were often judgemental and punitive. Teenage pregnancy was not viewed as an appropriate area for public policy in the 1950s, because it was believed to concern individual morals (Stafford, 1987). Services other than adoption were non-existent.

Prudence Rains (1971) described a similar attitude during the sixties. Unwed mothers were viewed as being "deviant". Social agencies were described as punitive and moralistic. Pregnancy was a major crisis. Families and schools expelled the unwed mother. She usually left to seek an abortion or to deliver her baby and release the child for adoption. If she kept the baby, her chances of finishing school, getting a job or finding a respectable husband were considered to be ruined. In the 1960s with the expansion of social programs designed to help the poor, teenage pregnancy was redefined as an economic issue (Stafford, 1987). With the dissemination of oral birth control, (the pill was introduced in 1962) and the emergence of the women's movement, the needs of pregnant adolescents

came into focus. Fertility control was considered to be a matter of individual right (Stafford, 1987). Obstetricians and pediatricians drew attention to the health risks of early pregnancy and child bearing.

Chilman (1980) reports that the number of adolescents, particularly those between 15 and 19 years of age, participating in nonmarital intercourse rose sharply during the mid and late sixties. At the beginning of the decade the stigma associated with unmarried pregnancy was diminishing. Schools were no longer allowed to exclude students on the basis of their marital or parenthood status. The majority of unmarried mothers were choosing to keep their babies rather than releasing them for adoption in order to escape societal criticism and ostracism.

In her review of the literature, Susan Phipps-Yonas (1980) agrees that the pregnant teenager faces a different reality now than in the past. She attributes this to a change in societal norms and values concerning premarital sex, out of wedlock childbearing, and adoption.

In the past ten years there has been a dramatic

increase in the probability that the unmarried teenager will keep her child (Phipps-Yonas, 1980).

The direction of public policy concerning teenage pregnancy began to shift during the 1970s. There was more emphasis on developing community services for pregnant adolescents and school aged parents (Stafford, 1987). In the 1970s, as well, welfare benefits to single mothers and their children became more accessible (Weinman et al., 1989). During this time many homes for pregnant girls closed and adoption was seldom considered as an option (Phipps-Yonas, 1980).

Today, ... "In Western countries, a sexual relationship between two unmarried people has moved in the direction of becoming a private activity, not subject as it once was to the punishment of neighbors, kin, and legal authorities" (Goode, 1982, p.49). Goode identifies several possible factors contributing to this trend: (a) parents cannot control their children as much as in the past; (b) family lines are viewed as less important than in the past; (c) the greater freedom of courtship experienced by young people has not led to as many catastrophic unions as parents

believed (Goode, 1982).

This investigator's experience as a social worker, working with single expectant mothers, supports those views. A change has been observed in attitudes among the adolescents themselves, as well as their parents and families. In 1980 when this investigator began working with this group of clients, the major clinical issue for most girls was guilt. They felt guilty because of their sexual activities and of their pregnancy. In 1989, however, sexual activity has become an acceptable fact of life and the general reaction to being pregnant is no longer one of guilt, but rather one of frustration and anger because of being caught.

During this time as well, there has been a decline in the number of families seeking social services for single expectant mothers. The residential facilities in this area available to single expectant mothers closed because of a decline in their use and there has been a significant decrease in the number of girls who place their babies for adoption. Today, the majority of pregnant adolescents remain with their families

during their pregnancy. Most continue school and when the baby is born many of the young mothers begin to parent and remain with their families who offer support.

Families play an active role during an unmarried daughter's pregnancy, a fact that seems to be overlooked in the literature. Most studies ignore the fact that teenagers are remaining at home and continue to function as adolescents within their families. Researchers have a tendency to isolate the adolescent from the family and to focus exclusively on the pregnancy as a problem. In fact, adolescent pregnancy does not produce the observable chaos and crisis that it did in the past. While adolescent mothers receive family support and are able to remain at home, and are therefore, at least on the surface, better off than in the past, these new demands placed on the family system require adjustment and accommodation. For this reason it is our contention that families need to be supported in their new roles.

Family Dynamics

The family is an open system in a state of constant transformation. It experiences pressures towards change both internally through its individual members, and externally through societal demands (Andolfi et al., 1983; Minuchin, 1974). The internal and external pulls on the family along with the need for change require that family members continually assess their relationships and reevaluate the balance between family and individual growth (Andolfi et al., 1983). Family, as a system, implies that change in one member requires change in all of the other members and that an attempt to influence one part of the system is seen as an attempt to change the whole (Warkentin, 1969).

Every family develops its own range of expected behaviour (Leveton, 1984). Mutual expectations arise from constant implicit and explicit negotiations and interactions among family members. Within the family there is a power hierarchy whereby the parents and the child have different levels of authority (Minuchin, 1974).

Rules are transmitted through the process of communication. Each message conveys a content aspect (information about facts, opinions, feelings and experiences) and a relationship aspect (a definition of the relationship between the individuals) (Jackson, 1970). Therefore, in each communication, individuals seek to determine the nature of interaction by offering each other definitions of the relationship. In families this process becomes stabilized by mutual agreement, through rules which organize their interactions (Jackson, 1970).

"Family rules are those rules that determine repetitive interaction among family members" (Leveton, 1984, p.42).

Communication affects everything that goes on between human beings (Satir, 1972). "Communication is the largest single factor determining what kinds of relationships ... (the individual) ... makes with others and what happens to him in the world about him" (Satir, 1972, p.30).

Minuchin (1981) refers to communication as transactional patterns. These patterns evolve over

time within the family. They make up the family structure governing the functioning of family members, describing their range of behaviour and facilitating their interaction.

Members of the family constantly move through different life stages while being and interacting with other members at different stages. We must remember that parents as well as children are dealing with the developmental tasks of particular life stages. "The family ... provides an experimental laboratory for transcending the temporal dimensions of human life through involvement in the continual changes in the lives of loved ones" (Fox, 1981, p.11).

The family is the most effective agent in the process of socialization "by which people selectively acquire their values and attitudes, the interests, skills and knowledge - in short, the culture - current in the groups of which they are, or seek to become, a member" (Rose Croser, 1964, p.xxiii).

Dolores Curran (1983) has identified a number of traits common to healthy families. From her research she contends that the healthy family ...

> communicates and listens; affirms and supports one another; teaches respect for others; develops a sense of trust; has a sense of play and humor; exhibits a sense of shared responsibility; teaches a sense of right and wrong; has a strong sense of family in which rituals and traditions abound; has a balance of interaction among members; has a shared religious core; respects the privacy of one another; values service to others; fosters family time and consultation; shares leisure time and admits to and seeks help with problems (Curran, 1983, p.23-24).

Adolescence

The society in which today's child matures is very different from that in which his/her parents grew up. Parents can no longer rely on their childhood experiences, to guide them, the old standards no longer apply. The parents and the child are at different points in their life cycle. Even when the parents were at the same point in their life cycles as the child now is, their experiences were very different (Goode,

1982). In our technological society the family has become more dependent on external systems for teaching its children, setting limits on them and finding them jobs.

> Whereas in the past the family was able to offer practical training to children in the form of jobs, it must now provide them with the psychological skills that will help them differentiate and survive in an ever more rapidly changing world. Thus, the family's major function has been transformed from that of an economic unit to that of an emotional support system (Preto, 1988, p.255).

Ackerman (1980) refers to the adolescent as a "tweenager" - overfunctioning at one time and underfunctioning at another time. Adolescence is a time when the intensity of relationships change within the family. He or she becomes more involved with the peer group outside the family (Ackerman, 1980). Parents can no longer maintain complete authority or control of their teenagers. Adolescents can and often do open the family to new values as they bring friends

and new ideals into the family arena (Carter & McGoldrick, 1988).

Adolescent life tasks include the development of autonomy and separation where he or she gains distance from and resolves feelings about the family. This is a time of simultaneous pushing away from and pulling towards the family; there seems to be a constant struggle between trying to gain independence while trying to remain dependent. The adolescent must also consolidate his or her identity; another of the developmental tasks is the achievement of appropriate attachments to people outside the family. The final task of adolescents is that of self mastery, that is gaining control of one's impulses, predicting the future from the events of the present (Fox, 1981). This phase of life can be a time of uncertainty for both parents and adolescents. It is a time in the family life cycle when both parents and adolescents are undergoing major transitions. The adolescent is involved with a peer group and the parents may be experiencing mid-life crisis (Ackerman, 1980).

This metamorphosis involves profound shifts in

> relationship patterns across the generations, and while it may be signaled by the adolescent's physical maturity, it often parallels and coincides with changes in parents as they enter mid-life and with major transformations faced by grandparents in old age (Preto, 1988; p.255).

Within this interdependent family system these changes require accommodations and adaptations by members (Fox, 1981). Adolescence brings with it a new definition of the children within the family and also of the parents' roles in relation to their children thus beginning a new era within the family (Carter & McGoldrick, 1988). The adolescent's life is complex. He/she is involved simultaneously with the family and peers (Haley, 1973). The adolescent needs to separate from his/her family while remaining involved with them. This balance is important and is the focus of family struggles.

Parental demands often conflict with the teenager's demand for autonomy. Parenting becomes a difficult process of mutual accommodation (Minuchin, 1974). The parent may not only be dealing with

questions of autonomy but may also be involved in re-entry of their own parents' lives due to declining health or death (Minuchin, 1981). Changing and conflicting social expectations about sexual roles and standards of behaviour are imposed on the teenager by family, school, peers and the media. To establish autonomy the adolescent needs to gradually become more responsible for his or her own decision making (Preto, 1988). Defiance is the adolescent's first serious testing of the limits of adult authority (Stewart & Zaenglein-Senger, 1982). A power struggle develops between parents and their adolescent offspring. Behaviour becomes unmanageable when the balance of power within families shifts from parents to adolescents. Parents often fail to realize that as the child becomes an adult there needs to be an alteration in parental roles (Stewart & Zaenglein-Senger, 1982). Flexibility is necessary within families at this time. Increasing the flexibility of family boundaries and adjusting parental authority allow for greater independence and developmental growth for the adolescent (Preto, 1988).

Grotevant & Cooper (1985) studied eighty-four two parent families with adolescents, examining the differences among adolescents in their identity exploration and the interaction patterns of their families. The process of individuation consists of two complementary processes: individuality and self-assertion. Individuality is separateness seen in expressions of the differences of self from others; self-assertion is seen in the expressions of one's own point of view and in taking responsibility for communicating it clearly. Individuality and self-assertion of members are key factors in healthy family relationships. Connectedness is described as mutuality seen in one's sensitivity to and respect for the views of others. The findings of this study indicate that adolescent maturity is gained through the continued process of mutual redefinitions of parent-child relationships (Grotevant & Cooper, 1985).

The adolescent becomes less guided by parental values and concerns and begins to test them. The adolescent becomes more dependent on the values and approval of friends and other influences such as the

media. Adolescence is a time for experimenting and risk taking (Ooms, 1981). The teenager begins to experience sexuality and experiment with sexual behaviour (Mitchell, 1971; Stafford, 1987).

A great deal of attention is given to adolescent sexual behaviour. It is often a time of struggle and misunderstanding for both parents and teenagers. Whereas the adolescent views sexual behaviour as novel, exciting and stimulating, parents on the other hand view this with fear ... "perceiving it as a giant roulette wheel where losers get ... disease or unwanted children and winners get nothing" (Mitchell, 1971, p.30).

Adolescent Pregnancy

Each week about one thousand Canadian teenagers become pregnant (Alliance for Life, 1988). A review of the literature concerning adolescent pregnancy states that pregnancy is a product of social or interactional factors i.e. (poverty, broken homes, poor parent-child relationships, lack of information) or of disturbed intrapsychic processes (Gottschalk et al., 1964;

Babikian & Goldman, 1971; Hertz, 1977; Zongker, 1977; Chilman, 1980; Landy et al., 1983; Kirsh, 1984; Stafford, 1987).

Families are recognized as playing a central role in the occurrence of pregnancy by virtue of their role as sexual socializer. They also help in determining the course of action to take once the pregnancy is established (Young, Berkman & Rehr, 1975; Fox, 1981; Furstenburg, 1980). The family often provides counsel as well as material supports and may determine the daughter's decision as to whether she will keep her child or place him with adoptive parents (Furstenburg, 1980; Kirsh, 1984). Furstenburg's Baltimore study of four hundred adolescents focused on family members' support of the adolescent mother and her child during the first five years after delivery (Furstenburg, 1980). In a summary of the analysis of data collected for the Baltimore study between 1967 and 1972, it was found that parents who were willing to assist their daughters had an impact on the adolescent's residential choices, as well as on her decisions concerning abortion and keeping the child (Furstenburg, 1980).

In most families included in this study, pregnancy elevated the status of the adolescent. Although pregnancy brought on more responsibilities, the adolescent was often given greater recognition by parents and siblings because of the baby (Furstenburg, 1980). Although adolescents in this study initially expressed concern about parental reaction, the actual reaction usually was more understanding and supportive than anticipated. Often, pre-existing tension in the parent-child relationship dissolved and parents became more solicitous and protective (Furstenburg, 1980). Pregnancy was also viewed as benefiting the family: it was identified as a morale builder, a catalyst leading to intensified family exchanges, and a means of filling the empty nest (Furstenburg, 1980).

Stewart (1981) in her review of the literature states that most researchers view adolescent pregnancy as a psychological or social problem in need of explanation and that pregnant adolescents had problems by the fact that they were pregnant. This author points out that most researchers have isolated their subjects (pregnant adolescents) from the wider

structural and social environments from which they emerged to focus on only the problematic or deviant nature of the act or status, ignoring its normality.

By isolating the pregnant adolescent one cannot but fail to see the behaviours that are normal, non-deviant and non-problematic. If the adolescent is viewed contextually within her sociocultural environment, then much of what appears deviant should be reframed as a normal response to developmental expectations. Therefore, avoidance of labelling as deviant those behaviours which are at the same time accepted as quite ordinary conduct is most important. From this perspective then, an important developmental process during adolescence is that of autonomy and separation from parents. Thus, the evidence of hostility between mother and daughter may not be indicative of psychological problems; rather, it can be understood as an anticipated consequence of the normal process of breaking away from parental rules and established autonomy. Since adolescence is often referred to as a difficult transition period, the pregnant adolescent is "normal" (Stewart, 1981).

Research Method

This research project was conducted in a small urban, Maritime community with a population of approximately 23,000. The annual average rate of teenage pregnancy between 15 and 19 years of age is approximately 75. The project is an exploratory - descriptive study focusing on pregnant adolescents and their mothers.

Sample

The sample for this study consists of 32 pregnant adolescents who met the three basic criteria for inclusion in the study: pregnant; 16 - 19 years; who were living with their families during their pregnancy. In addition, 13 of these adolescents' mothers were also recruited for inclusion in the sample. Referral sources include: 15 pregnant adolescents and seven of their mothers from a private family services agency; nine pregnant adolescents and three of their mothers from public health nurses; six pregnant adolescents and two of their mothers from high school guidance

counsellors; one pregnant adolescent and one mother from the nutritionist with the Department of Health and Social Services.

Demographic Characteristics: (Table I, p. 25)

Age

The teenagers interviewed ranged in age from 16 to 19 years. The majority of adolescent pregnancies occur between 15 and 19 years of age. In this study however, 16 years was chosen as a minimum age for inclusion in order to avoid the problem of legal consent. The rights of 16 year olds to give independent consent is recognized, which allowed the investigator to approach them directly. Seven of the respondents were 16 years of age; six were 17 years of age; nine were 18 years of age and ten were 19 years of age.

Ethnicity

This was a homogeneous group, 31 adolescents were caucasian and one was North American Indian.

TABLE I

Demographic Characteristics (N = 32)

Age	16	17	18	19
	7 21.9%	6 18.8%	9 28.1%	10 31.2%

Ethnicity	White	Native (N.A. Indian)
	31 96.9%	1 3.1%

No. of Children	0	2	3	4+
	3 9.4%	10 31.3%	11 34.3%	8 25%

Place in the Family	Oldest	Youngest	Only	Middle
	8 25%	12 37.5%	3 9.4%	9 28.1%

Religion	Protestant	Catholic
	8 25%	24 75%

Education	Less Than Gr 8	Gr 8	Some High School	Grad	Univ
	1 3.1%	7 21.9%	14 43.8%	5 15.6%	5 15.6%

Type of Family	Intact	Single Parent(M)	Single Parent(F)
	26 81.2%	3 9.4%	3 9.4%

Length of Parental "Marriage" N = 31	0-5 yrs	6-10 yrs	11-15 yrs	16-20 yrs
	1 3.2%	1 3.2%	4 12.9%	25 80.6%

Family Income N = 31	<19,000.	20-30,000	30-39,000	>40,000
	3 9.7%	8 25.8%	13 41.9%	7 22.6%

Number of Children

From the sample of pregnant adolescents three (9.4%) were only children; 10 (31.3%) were one of two children; 11 (34.3%) were one of three children and eight (25%) were one of four children.

Place in the Family

Eight (25%) of these teenagers were the oldest child; 12 (37.5%) the youngest child; nine (28.1%) a middle child, and three (9.4%) an only child.

Religion

The sample consisted of 24 (75%) girls from Roman Catholic belief and 8 (25%) of Protestant faith. Since the majority of referrals came from a Catholic Agency it is not surprising that the majority of respondents are of this faith.

Education

Only one respondent had less than grade eight education. Seven (21.9%) had completed grade eight, 14 (43.8%) had some high school, five (15.6%) had graduated from high school and five (15.6%) had some university.

Type of Family

Generally, the respondents came from intact families, 26 adolescents (81.2%). Three (9.4%) came from single parent households headed by women and three (9.4%) from single parent households headed by men.

Length of Parental Marriage

The term "married" in this study is applied to both legally married couples and to couples who had a stable common law relationship of at least five years duration. Of the 31 "married" parental couples 25 (80.6%) were together more than 16 years, one (3.2%) had been "married" for one year (daughter was wife's child from a previous "marriage"), one (3.2%) from six to ten years and four (12.9%) 11 to 15 years.

Family Income

None of the adolescent sample were regular wage earners and all were dependent on the total family income for their needs. The families included in the sample had incomes ranging $15,000.00 to $60,000.00.

The incomes of families included in this study were listed as follows: three (9.7%) of these families had an income less than $19,000.00; 21 (67.7%) had

incomes ranging from $20 - 39,000.00. The remaining seven (22.6%) had incomes of $40.000.00 or more. One respondent failed to answer that question.

Procedure

This investigator personally carried out the data collecting interviews for this study. A letter was sent to the Deputy Minister of Health and Social Services informing him of the project and requesting his support (Appendix A). This was followed up with a meeting to discuss the project and his endorsement was obtained. He contacted the appropriate department heads introducing them to the project. Letters were then sent by the investigator to the Regional Director of the Department of Health and Social Services, as well as the Supervisor from the Department of Health. These were followed up with personal contacts to discuss the study in greater detail (Appendix B & C). Following these meetings appointments were arranged with the Nutritionist (Department of Health and Social Services) and the Coordinator of Programs for Single Mothers (Public Health) to discuss the research project

and to provide information sheets for distribution to clients (Appendix F) who would be interested in participating. In this way a list of perspective subjects was obtained. The investigator personally contacted each individual identified on the list in order to provide them with further information and clarification, and to schedule the interviews.

Each respondent who agreed to participate in the study signed an Informed Consent form (Appendix G). One hour face to face information gathering interviews were conducted with each subject. This scheduled interview for the pregnant adolescents consisted of a three part questionnaire that included: (a) demographic descriptions; (b) adaptations form H. Toumishey's Instrument devised for her Masters' Thesis in the context of her M.Sc. (1978); and (c) an adaptation of the Family Assessment Device (1983).

The investigator asked permission of the adolescents to contact their mothers for the purposes of the study. Thirteen of the teenage respondents were agreeable and as a result 13 of the mothers were recruited. For these participating mothers the

demographic description and adaptations from H. Toumishey's Masters' Thesis were dropped and the Family Assessment Device (FAD) was supplemented with five open ended questions that were felt to be especially pertinent to them.

Instrument

Family Assessment Device (FAD)

Permission was obtained to use the McMaster Model of Family Functioning developed by Nathan B. Epstein, M.D., Duane S. Bishop, M.D. and colleagues, and the Family Assessment Device which they refined (1983) (Appendix H).

The McMaster Model studies the individual's perception of the functioning of his or her family along the following dimensions: problem solving, communication; affective responses; affective involvement; roles and behavior control.

Problem Solving is defined as "a family's ability to resolve problems to a level that maintains effective family functioning" (Epstein, Bishop, Levin, 1978,

p.21). A family problem is seen as "an issue that threatens the integrity and functional capacity of the family, the solution of which presents difficulty for them" (Epstein, Bishop, Levin, 1978, p.22).

Communication is defined as "how the family exchanges information" (Epstein, Bishop, Levin, 1978, p.22). The focus here is solely on verbal exchanges.

Roles - "Family roles are repetitive patterns of behaviour by which individuals fulfill family functions" (Epstein, Bishop, Levin, 1978, p.23).

Affective Responses are defined as "the ability to respond to a wide range of stimuli with appropriate quality and quantity of feelings" (Epstein, Bishop, Levin, 1978, p.25).

Affective Involvement is "the degree to which the family shows interest in and values the activities and interests of family members" (Epstein, Bishop, Levin, 1978, p.25).

Behaviour Control is "the pattern the family adopts for handling behaviour in three specific situations: physically dangerous situations; situations involving the meeting of socializing

behaviour both inside and outside the family" (Epstein, Bishop, Levin, 1978, p.26).

General Family Functioning: The Family Assessment Device (FAD) is made up of seven scales. One scale, General Family Functioning assesses the overall health/pathology of the family. The other six assess the six dimensions of the McMaster Model of Family Functioning.

Toumishey's M.Sc. thesis

Since this study focuses on pregnant adolescents it was appropriate to add to the Family Assessment Device (FAD) a number of questions that pertain specifically to pregnancy. These questions were adapted with permission from the Masters' Thesis presented in 1978 at this university by Laura Hope Toumishey (Punishing the Pregnant Innocents: Single Pregnancy in St. John's Newfoundland 1978) (Appendix I & J).

Review of the instrument

Demography and History of the Pregnancy

The questionnaire used in this study was designed in the following manner (Appendix J). Questions one to five deal with demographic descriptions of the subject's family and situates the pregnant adolescent.

Questions six through 20 deal specifically with the pregnancy. These questions have been adapted from Laura Hope Toumishey's M.Sc. Thesis (1978). Questions eight through 11 specifically address issues associated with high risk pregnancy: this information is important; therefore questions focus on the presence of toxemia or other medical abnormalities which might put the health of the adolescent mother or her child at risk. Twenty-two of the respondents reported symptoms of nausea, headaches and swelling. This is not unusual particularly when 24 of the respondents were in their first trimester of pregnancy. Thirty of the respondents reported regular prenatal visits and one respondent did not answer the question.

Questions 11 to 16 focus on the social support networks available to the pregnant adolescent. Those

identified in the questionnaire as supports include: baby's father, parents, professionals and friends. "Use of supportive networks contributes appreciably to the health of the child and the mother's educational and occupational future" (Barth & Schinki, p. 524).

Questions 16 to 21 focus on the process of decision making around the pregnancy. These elements identify several important considerations for the pregnant adolescent, any of which may be the cause of much anxiety and worry during this period. During the pregnancy, the adolescent must begin to cope with adult tasks of motherhood while coping with the developmental tasks of adolescence.

Family Assessment Device

The Family Assessment Device (FAD) was the instrument used in the questionnaire in questions 21 through 80 (Appendix J, p. 83). The FAD is an empirical instrument that was developed from the McMaster Model of Family Functioning. Its purpose is to determine the degree of health or pathology in families. Its reliability and discriminative validity were established through a series of extensive

empirical studies involving clinician-rated healthy and unhealthy families. The FAD health/pathology cut-offs were found to have acceptable rates of sensitivity and specificity as well as high rates of diagnostic confidence (Miller et al., 1985).

In this study, application of the FAD somewhat differs from the original study. In the Epstein, Bishop, et al., (1983) study one set of scores drawn from scores on the six subscales was tabulated. In this study two sets of scores on each subscale were collected from each respondent. The first score indicates the teenager's recollection of family functioning prior to her pregnancy; the second score indicates her view of family functioning since the pregnancy has occurred. The intention in using the FAD in this fashion was to obtain a subjective impression of the pre and post pregnancy functioning of the teenager's family. However, one must recognize the limitations of this instrument when used retrospectively, that is, the subjects were asked to recall their feelings. These scores would then lend themselves to comparative statistical analysis.

The FAD was used with participating mothers in this study in the same way as with the pregnant teenagers with a view to the same kind of analysis. In addition these mothers were asked a brief series of open-ended questions designed to elicit qualitative information regarding their perception of the pregnancy in general (Appendix K, p. 103).

Other Pregnancy Related Variables (Table II, P.37)

Trimester

At the time of the research interviews 19 teenagers (59.4%) were in their first trimester of pregnancy; 5 (15.6%) in the second trimester; and 8 (25%) were in the third trimester. All had had their pregnancy confirmed and all had been seen by a doctor. For 31 of the subjects this was a first pregnancy and for one this was a second pregnancy. Thirty (96.7%) of the respondents reported prenatal medical care and one (3.2%) respondent did not answer the question.

Social Supports

Nineteen (59.4%) of the respondents reported that their baby's father was the first to know about the

TABLE II

Pregnancy Related Variables

Trimester	First	Second	Third
	19 59.4%	5 15.6%	8 25%

Time of Confirmation	1-2 mos	3-4 mos	7-9 mos
	24 75%	6 18.7%	2 6.3%

Reg. Prenatal Care Medical (N = 31)	Yes	No
	30 96.7%	1 3.2%

Problematic Pregnancy	Yes	No
	---	100%

First to know of pregnancy	Baby's Father	Doctor	Girlfriend	Mother	Sib
	19 59.4%	2 6.3%	8 25%	2 6.3%	1 3.1%

Who knows about pregnancy now	B's Father	Girlfriend	Everyone
	1	1	30

Guilt/Shame about Preg.	Yes	No
	13 40.6%	19 59.4%

TABLE II (CON'T)

Who has been most helpful	B's Father	Parents	Other
	10 31.3%	13 40.6%	9 28.1%

Parental Expectations re Baby	Keep Mother/Father		Adoption Mother/Father		Make Own Decision Mother/Father	
	11 34.3%	14 43%	9 28.1%	8 25%	7 21.8%	6 18.8%

	Other Mother/Father		Unknown Mother/Father	
	1 3.1%	2 6.25%	4 12/5%	2 6.25%

B's Father N = 26	Keep	Abortion	Adoption	Make Own Decision
	12 46.2%	1 3.8%	8 30.8%	5 19.2%

Adolescent's Decision	Get Married	Keep Baby	Adoption
	1 3.1%	18 56.3%	8 25%

	Make Own Decision	Undecided
	2 6.3%	3 9.3%

Plans after Baby is Born	Return to School	Univ	Job	Home	Other & No Plan
	17 53.1%	3 9.4%	1 3.1%	9 28.1%	2 6.2%

pregnancy; two girls (6.3%) reported their doctor was the first to know; eight (25%) identified a girlfriend; two (6.3%) told their mother; and one (3.1%) told a sibling. At the time of the interview 30 of the respondents reported that everyone referred to in the questionnaire now knew about the pregnancy; one reported that the baby's father, and another that a girlfriend were the only ones to know. Both of these teenagers were still in their first trimester at the time.

Guilt/Shame

The majority (19 respondents 59.4%) reported that no one had made them feel guilty about their pregnancy, 13 (40.6%) reported that someone (baby's father, parents, family) made them feel guilty.

Most Helpful

For 13 of the respondents (40.6%) parents were identified as being most helpful during the pregnancy, 10 (31.3%) reported the baby's father and 9 (28.1%) reported friends and other relatives. They reported that these people were most helpful by being available for them, making appointments and allowing them to make

their own decisions. Generally, the sample all had some type of support network.

Parental Expectations

Fourteen of the respondents' fathers (43.7%) and 11 of their mothers (34.3%) wanted the teenagers to keep their baby; eight fathers (25%) and nine mothers (28.1%) wanted the baby to be adopted. Six of the fathers (18.8%) and seven mothers (21.8%) wanted the adolescent to make her own decision. One father wanted his daughter to have an abortion, one mother recommended marriage, and one father did not want the adolescent to see the baby's father. Two respondents did not know what their father expected and four did not know what their mother wanted (of these six respondents, one father and one mother were divorced).

Baby's Father

Twelve respondents (46.2%) reported their baby's father wanted them to keep the child, one recommended abortion (3.8%). Eight of the baby's fathers (30.8%) recommended adoption and five (19.2%) wanted the teenager to make her own decision.

Adolescent's Decision

Of the respondents themselves, one wanted to get married (3.1%), 18 (56.3%) wanted to keep the baby, eight (25%) planned adoption and two (6.3%) wanted to make their own decision. Three respondents (9.3%) were undecided.

Plans After Birth of Baby

Seventeen of the subjects (53.1%) planned to return to school, three (9.4%) planned to enter university, one (3.1%) planned to get a job, nine (28.1%) planned to stay home with the baby and two (6.3%) were undecided.

Mothers of Adolescents N = 13

With regard to the questions asked specifically to the mothers of the pregnant adolescents six of them (46.2%) stated that they thought this was something that would never happen in their family, five (38.4%) thought that pregnancy was a possibility, one (7.7%) stated that another teenage daughter had a previous pregnancy and one mother (7.7%) stated that she had been pregnant as a teenager.

Ten of the teenager's mothers (76.9%) expected

that their daughters would parent their children on a full time basis, one (7.7%) stated that her daughter would parent the child while not in school and two (15.4%) believed that their daughter would probably not follow through on parenting the child. (It is interesting to note that the daughters of these two mothers planned to parent while the mothers wanted them to place the child for adoption).

Seven of the adolescents' mothers (53.8%) stated that they were satisfied with their parenting role with regard to the child, one (7.7%) said that she would resent parenting the child, three (23%) felt helpless stating that they felt they had no choice and two (15.4%) were glad to be helpful.

Four mothers (30.8%) stated that they would be the grandmother only, one (7.7%) would be part time grandmother and part time parent, eight (61.5%) felt they would be the grandmother helping out the mother.

Eleven of the mothers (84.6%) believed this baby would not affect their future plans, two (15.4%) were fearful that they would become the parents. Nine (69.2%) were determined not to allow the birth of the

child to affect their future plans, two (15.4%) were resentful about assuming parenting responsibilities if their lives had to change, one (7.7%) had no particular feeling regarding her future plans, and one mother did not respond to the question.

Summary of Findings

In summary, this group of 32 pregnant adolescents was generally a homogeneous group; the majority early in their pregnancy (59.4% in their first trimester), either Protestant (25%) or Catholic (75%) faith, caucasian (96.9%), of middle income range given the regional context. These girls generally report family support as well as support from their baby's father. The majority of respondents (75%) have some high school education. None report medically problematic pregnancies.

The majority of mothers questioned felt that their daughters would assume parenting responsibilities with some parental help and generally the mothers seemed willing to be helpful with regards to parenting their grandchildren.

Results

Purpose

The purpose of the analysis of the data was to discover whether certain independent variables characterizing this population were significantly associated with changes in family functioning prior to and following the occurrence of a teenage daughter's pregnancy.

Selection of Variables for Analysis

Independent Variables selected for analysis were: age, education; family income, number of years in the present marital status of the adolescents' parents. There was little point in looking at correlations on the issues of religious affiliation or ethnic origin given the fact that they are almost unanimously of one or other (homogeneous group). On other variables, however, such as age, education, income and number of years of parental marital status, there was some diversity in terms of subject responses. These then were the variables selected for inclusion in the

analysis with the scores on the family functioning scales. With these variables the investigator wanted to determine if there was any significance before and after the occurrence of the pregnancy. The independent variables were tested with the dependent variables utilizing the F test wich is "the test for determining the significance of the differences between the variances" ... (Guilford & Fruchter, p. 231). The investigator selected all of the referred pregnant adolescents from a particular area for inclusion in the study. The Family Assessment Device in the questionnaire uses interval scaling to determine the health/pathology in families. The FAD health/pathology cut offs were found to have acceptable rates of sensitivity and specificity as well as high rates of diagnostic confidence (Miller et al., 1985). The F test was deemed to be the best test of significance.

The means on the family functioning scales were tested before and after the pregnancy occurred utilizing analysis of variance (ANOVA). By doing an analysis of variance (ANOVA) on the family functioning scales, the investigator was trying to determine if

there was significance before and after the occurrence of the pregnancy. The family functioning scales were: Problem Solving; Communication; Affective Responses; Affective Involvement; Roles; Behavior Control and General Family Functioning (Refer to Table III).

Results (Table III & IV, pp. 47 & 48)

Since the question being asked in this project pertains to possible changes in family functioning as coinciding with the occurrence of a teenage daughter's pregnancy the mean scores were tested during the pregnancy and as recalled according to the participants prior to the pregnancy to determine if the independent variables affected the scores on the family functioning scales (Table IV, p. 48).

The analysis failed to yield any relationship between independent and dependent variables that was statistically significant. Several trends, however, were noted: Age as it was applied to General Functioning before the pregnancy (F [3,28] = 2.063, $p < .1$). Further analysis showed that General Family Functioning improved with increased age. Family Income

TABLE III

Analysis of Variance – Independent Variables: age, education, income, years married
Dependent Variables: Problem Solving, Communication, Roles, Affective Responses, Affective Involvement, Behavior Control, General Functioning

	AGE		EDUCATION		INCOME		YEARS MARRIED	
	Before	After	Before	After	Before	After	Before	After
PS	df(3,28) F=1.075 p >.05	(3,28) 1.298 p >.05	df(4,27) F= .325 p >.05	(4,27) .626 p >.05	df(4,26) F=1.124 p>.05	(4,26) 1.912 *p<.1	df(4,27) F= .800 p >.05	(4,27) 1.014 p >.05
CM	df(3,28) F=1.139 p >.05	(3,28) 1.351 p >.05	df(4,27) F=1.217 p >.05	(4,27) 1.334 p >.05	df(3,27) F= .584 p >.05	(3,27) .687 p >.05	df(4,27) F= .738 p >.05	(4,27) .866 p >.05
RL	df(3,28) F=1.139 p >.05	(3,28) 1.351 p >.05	df(4,27) F=1.217 p >.05	(4,27) 1.334 p >.05	df(3,27) F= .584 p >.05	(3,27) .687 p >.05	df(4,27) F= .125 p >.05	(4,27) .207 p >.05
AR	df(3,28) F=1.074 p >.05	(3,28) .647 p >.05	df(4,27) F=1.404 p >.05	(4,27) 1.099 p >.05	df(3,27) F= .345 p >.05	(3,27) .324 p >.05	df(4,27) F= .239 p >.05	(4,27) .449 p >.05
AI	df(3,28) F= .287 p >.05	(3,28) .039 p >.05	df(4,27) F= .169 p >.05	(4,27) .141 p >.05	df(3,27) F=1.138 p >.05	(3,27) 1.203 p >.05	df(4,27) F= .222 p >.05	(4,27) .293 p >.05
BC	df(3,28) F=1.652 p >.05	(3,28) 1.648 p >.05	df(4,27) F= .768 p >.05	(4,27) .689 p >.05	df(3,27) F=1.817 *p <.1	(3,27) 2.108 *p <.1	df(4,27) F= .536 p >.05	(4,27) .656 p >.05
GF	df(2,28) F=2.063 *p <.1	(3,28) 1.609 p >.05	df(4,27) F= .687 p >.05	(4,27) .929 p >.05	df(3,27) F=1.248 p >.05	(3,27) 2.293 *p <.1	df(4,27) F= .300 p >.05	(4,27) .773 p >.05

Note: There were no statistical significant correlations. The asterisks (*) indicate notable trends which will be addressed in the discussion.

TABLE IV

ANOVAs of the dependent variables before/after pregnancy for mothers and daughters.

	*PS	CM	RL	AR	AI	BC	GF
Before							
Daughters x	2.05	2.37	2.59	2.49	2.84	2.47	2.46
Mothers x	2.09	2.32	2.51	2.58	2.81	2.54	2.43
After							
Daughters x	2.03	2.37	2.58	2.50	2.83	2.48	2.43
Mothers x	2.03	2.34	2.49	2.60	2.79	2.54	2.43

PS	CM	RL	AR
df(1,48)	df(1,48)	df(1,48)	df(1,48)
F = .001	F = .012	F = .029	F = .038
p > .05	p > .05	p > .05	p > .05

AI	BC	GF
df(1,48)	df(1,48)	df(1,48)
F = .002	F = .022	F = .018
p > .05	p > .05	p > .05

Standard Scale Means N = 503

PS	CM	RL	AR	AI	BC	GF
2.3	2.3	2.4	2.4	2.2	2.0	2.2

*PS = problem solving
CM = communication
RL = roles
AR = affective responses
AI = affective involvement
BC = behaviour control
GF = general functioning

applied to Behavior Control before the pregnancy occurred (F [3,27] = 2.817, $p < .1$); after the pregnancy occurred (F [3,27] = 2.817, $p < .1$). Behavior Control improved as the family income increased. Family Income applied to General Family Functioning after the pregnancy occurred (F [3,27] = 2.293, $p < .1$). General Family Functioning improved as family income increased. Family Income applied to Problem Solving after the pregnancy occurred (F [3,27] = 1.912, $p < .1$). Problem Solving improved as family income increased (Table III, p. 47).

Mean scores of the research population (mothers and daughters) before and after the pregnancy occurred on each of the FAD scales were not significantly different (Table IV, p. 48).

Discussion

Initially, this investigator planned to recruit a sample for this study from those receiving services through the Department of Health and Social Services (Nutritionist and Public Health Nurses). However, it was not possible to recruit enough adolescents through this source and so several physicians and high school guidance counsellors were contacted by letter followed by a meeting to discuss the project further (Appendix D & E).

Several reasons were given for the difficulty recruiting the sample. Although there is a referral system in place within the Department of Health and Social Services where the physicians refer pregnant adolescents for nutrition counselling and childbirth education, not all teenagers avail themselves of these services. Some of these adolescents seek medical services only, some come late in their pregnancy and others do not see a doctor until they arrive at the hospital to deliver their baby. There is also a growing concern for the number of adolescents who are

leaving home to stay with friends, find their own place or request housing through the Department of Health and Social Services.

Recently, a study was conducted by a committee of guidance counsellors in this province identifying the number of students in crisis during the school year 1987 - 1988 (approximately the same time this study was being conducted). Out of a total of 12,000 junior and high school students about 1/3 of these youth (398) left home because of conflict for at least a few days. Approximately 52 stated that they had left home permanently and 161 students had left home, but had no place to go (Malone, Pilkington, MacDonald, Taylor, Ledgerwood, 1989).

Approximately 85% of the school counsellors responded to the survey which indicates that the actual numbers may be higher than those reported.

The sample in this project consisted of 32 pregnant adolescents. One additional adolescent declined participation at the time of the interview. The adolescents were asked for permission to contact their mothers for participation in the study. Thirteen

adolescents gave permission and all of their mothers agreed to participate.

As stated earlier in the text the population was homogeneous regarding the following: adolescence; healthy; pregnant; living at home with their families; junior high school education and beyond; receiving regular prenatal care; receiving assistance from parents and boyfriend. The majority came from intact families (26) whose income exceeds $20,000.00 (28). All reported religious affiliation: 24 of Roman Catholic belief and 8 of Protestant faith. This is not surprising since the majority of referrals came from a Catholic Agency.

The fact that all of the participants reported a healthy pregnancy and were receiving regular prenatal care controls for the stress to both the adolescent and her family that may be caused by a medically problematic pregnancy.

The Family Assessment Device (FAD) was applied retrospectively before and concurrently during the pregnancy. Both pregnant adolescents and their mothers showed no significance in differences in their scores

on the following scales: as applied to Problem Solving, Communication, Roles, Affective Responses, Affective Involvement, Behaviour Control and General Functioning. The scores also showed no interaction between the variables. However, several trends were noted. Before the pregnancy occurred their age was identified as a trend affecting General Functioning. Further analysis of data showed that as the age of the adolescent increased so did the level of General Functioning. Income was also identified as a trend affecting Problem Solving after the pregnancy occurred, to Behavior Control before and after the pregnancy occurred and also to General Functioning after the pregnancy. Further analysis of data also showed that higher family income resulted in higher levels of Behavior Control and General Functioning.

There seems to be a trend of some significance connecting age with General Family Functioning before the occurrence of pregnancy and connecting family income with General Family Functioning after the occurrence of the pregnancy (Table III, p. 47).

General Family Functioning

Families whose membership include adolescents are in the process of change. Adolescence is known for its behavior inconsistencies and unpredictability (Jorgensen & Sonstegard, 1984). The ...

> family metamorphosis involves profound shifts in relationship patterns across the generations, and while it may be signaled initially by the adolescent's physical maturity, it often parallels and coincides with changes in parents as they enter midlife and with major transformations faced by grandparents in old age (Preto, p. 255).

The data collected from the families in this population are consistent with the trends facing our present day nuclear families.

Increasing income often requires dual careers in families (Malone, Pilkington, Campbell, MacDonald, Taylor, Ledgerwood, 1989). As parents improve their financial status they are better able to provide their children with more opportunities. More time is spent chauffeuring, supporting and participating in these

activities as opposed to direct parent-child interaction. Parents, too can afford services and activities for their leisure such as health clubs, educational courses, travel and so on. So, children have their lives and parents, too, develop independent lives particularly as their children get older. These parents often become involved in such activities as service clubs, doing volunteer work or travelling. Family life may become hectic and hurried, resulting in distancing between parents and their adolescents. The family frequently becomes a battleground instead of a place to nurture, support, and grow (Malone et al, 1989).

There was also a trend of some significance connecting family income with Problem Solving after the occurrence of pregnancy and with Behavior Control both before and after the pregnancy occurred (Table III, p. 47).

Problem Solving

Problem Solving during adolescence has been specifically referred to in recent literature. Fox (1981) identifies one of the final developmental tasks of adolescence as that of self mastery, gaining control of one's impulses and predicting the future from the events of the past.

Piaget views the way adolescents solve problems as characteristic of their style of thinking. "The younger adolescent is likely to begin by making wild guesses about what might happen and then search for a solution by proceeding in a haphazard trial-and-error manner. The older adolescent is likely first to plot out a course of action, then test the hypothesis in a systematic manner by observing and perhaps recording the results of different actions, and finally draw logical conclusions" (Beihler, 1976, p. 579).

In a recent article, Wanda Franz (1988) expands on Piaget's developmental theory in the area of teenage sexuality. She contends that teenagers have limited ability to make decisions and a superficial understanding of their sexual relationships. She

continues by stating that these adolescents require support, assistance, and guidance to help them to mature into fully competent adults. The family is the adolescent's most important resource.

Franz (1988) believes that most adolescents have not reached Piaget's developmental stage of formal operations and contends that they are functioning at the concrete operations stage of cognitive development. Thus, adolescents think in concrete terms and cannot anticipate future outcomes, nor can they generate questions that must be solved. "They find it difficult to take responsibility for the outcomes that they have had a responsibility in forming, due to their decision making" (Franz, 1988, p.9). Teenagers feel invincible. They feel that nothing bad can happen to them. Unwanted pregnancies are things that happen to other people!

Developmentally, teenagers are not yet able to predict the future from events of the present. They need to be helped and supported in this area by their families. However, if the adolescents and their parents have developed their own independent lifestyles

within the family, it follows then that there would be very little communication. Therefore, the family may have difficulty problem solving in a new situation, such as a pregnancy.

Behavior Control

Often, a teenager attempts to accomplish his or her developmental tasks of identity-formation and autonomy through defiance. The teenager who has always complied with parental expectations now begins to challenge parental authority. A power struggle arises and often erupts frequently throughout adolescence.

The present study identifies behavior control as being affected both before and after the occurrence of the pregnancy which is consistent with the literature on adolescence.

Mothers of Pregnant Adolescents

Response to Pregnancy

The teenagers' mothers who participated in the study were asked several open ended questions. Generally, they stated that initially they were

surprised about their daughter's pregnancy, but felt they were adjusting. This is consistent with other studies that have been done, particularly Furstenburg's Baltimore study (1980).

Expectations Regarding Child Care

Most expected their daughters to parent their child and were planning to be supportive and helpful as the grandmother. They did not believe the birth of the child would affect plans they had made for their lives. These responses are consistent with the literature in regard to the change in societal attitudes toward adolescent sexuality and pregnancy. Today, having an illegitimate child as a teenager is not seen as deviant by the older generation. Furstenburg's Baltimore study (1980) found that pre-existing tensions between parents and adolescents often dissolved as parents became more solicitous and protective.

In the present study two of the adolescents' mothers expressed fear that their daughter would not follow through on parenting responsibilities. Their daughters both planned to parent their child.

The information obtained from the mothers in this study both to their response to the Family Assessment Device (FAD) and to their response to the open-ended questions support the fact that pregnancy did not affect family functioning.

General Comments

This study suggests that for this population, pregnancy does not add to the psychological and relationship demands that are already present in families whose membership include adolescents who are not pregnant, based on the demographic information drawn from middle class, urban, intact families who support their pregnant adolescent. This differs from the descriptions presented in the literature that seems to identify a population which is more deprived and high risk for psycho-pathology. Although this is a homogeneous sample we believe the sample may not be characteristic of the total population of pregnant adolescents. Therefore, this would affect the generalizability of the study. The study was carried out in a small rural region where families are closer

in proximity and more accessible than in larger areas, another factor that would limit the generalizability of the study. However, it should be noted that the families identified through this study are similar to those in the original study. There is very little difference between standardized scale means and those of the present study. We believe that the results of the study have definite implications for policy makers, program planners, and those directly involved in providing services to teenagers who are pregnant and to their families.

Summary and Conclusion

The results of this study support the notion that our society's attitude toward adolescent pregnancy has changed. This supports the literature on teenage pregnancy (pp. 4-9). We have become less judgmental and more accepting. Based on the fact that increasing numbers of adolescents are keeping their children and either assuming care of the child on their own or in their families, the need for ongoing services not only during pregnancy,but also in the early post natal years is crucial.

In this population the pregnancy of an adolescent daughter did not have an appreciable impact on family functioning in any of the dimensions studied. Furthermore, the mothers of these adolescents who were included, were in fact highly supportive of their adolescent daughter. The mothers were looking ahead to prepare to assume grandmother roles. Earlier in the text the inability of the majority of adolescents to plan for the future was discussed. Adolescents are preparing and planning for their own life. There is a

risk that planning for a child will become seconda y and it is especially important that they have family support. The fear of some of the mothers that they will be cast into the role of primary caregiver is not an unrealistic one. These families - the child, the teenage mother and her parents need ongoing support.

Ideally, the teenager has strong family support that will allow her to go on and plan for her life that will not affect the baby. However, it is not fair to expect grandparents to assume full parental responsibilities. They have their own developmental expectations. Therefore, community-based support networks and services need to be directed not only towards the pregnancy and delivery, but extended to meet the needs of the total family unit.

Within these families are three generations of people who are all at different developmental stages in the developmental cycle and who all have different needs. These needs ideally can be complementary - but only if from a societal perspective there is a supportive network to lend help, and provide

episodic interventions that will allow for this generational system to function properly.

Whereas in the past services to adolescent mothers were highly individualized, we believe present services should be delivered where possible in the context of the family.

This study, in spite of its limitations (p. 60), does provide a basis for further study. An interesting research project could be carried out on this population of adolescent mothers and their mothers a year after the pregnancy to determine changes in family functioning.

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APPENDICES

P.O. Box 698
Charlottetown, P.E.I.
C1A 7L3
September 22, 1987

Mr. Charles Campbell
Deputy Minister
Health and Social Services
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8

Dear Mr. Campbell:

During the past year I have been a student in the Master's Program in Social Work at Memorial University of Newfoundland. I have recently returned to work at Catholic Family Services Bureau and am preparing to collect data for my thesis.

As part of my thesis requirements for completion of my Masters of Social Work degree I am conducting a research project which will focus on the effects of adolescent pregnancy on the family.

I am writing to you as Deputy Minister because I am aware of the discussions in which you have been involved with representatives of the Board of Directors of Catholic Family Services Bureau regarding services to single expectant mothers.

I would like to meet with you to discuss my proposal and to seek your support. I plan to meet with department heads from the Department of Health and Social Services where I hope to obtain a sample group for my study.

I am enclosing a copy of my thesis proposal as well as a letter of authorization from the School of Social Work.

I will call your office within the next week to arrange an appointment with you.

Sincerely yours,

Dianne F. Griffin, R.N., B.S.W.

P.O. Box 698
Charlottetown, P.E.I.
C1A 7L3
October 7, 1987

Mr. Kenneth Barter
Regional Director
Department of Health & Social Services
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8

Dear Mr. Barter:

As part of the thesis requirements for completion of my Masters of Social Work degree at Memorial University of Newfoundland, I am conducting a research project which will focus on the effects of adolescent pregnancy on the family.

I am contacting you as Regional Director of the Department of Health and Social Services to ask for your assistance in the selection of my sample. I would like to obtain a sample of clients served through the Nutritional Services of your Department.

Gathering of data will involve one face-to-face interview with an unmarried pregnant teenager, aged 16 to 19 years inclusive, who is living at home with her family. The results of the study will be kept confidential and data will be summarized in statistical and numerical form.

I would like to arrange a meeting to discuss my proposal further and will contact you within two weeks to arrange such a meeting.

I look forward to discussing my thesis proposal with you.

Sincerely,

Dianne Griffin, R.N., B.S.W.

P.O. Box 698
Charlottetown, P.E.I.
C1A 7L3
October 7, 1987

Mrs. Margaret LeBlanc
Supervisor
Public Health Nursing
Department of Health & Social Services
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8

Dear Mrs. LeBlanc:

As part of the thesis requirements for completion of my Masters of Social Work degree at Memorial University of Newfoundland, I am conducting a research project which will focus on the effects of adolescent pregnancy on the family.

I am contacting you as Supervisor of Public Health Nursing to ask for your assistance in the selection of my sample. I would like to obtain a sample of clients served through the Childbirth Education Classes for single expectant mothers of your Department.

Gathering of data will involve one face-to-face interview with an unmarried pregnant teenager, aged 16 to 19 years inclusive, who is living at home with her family. The results of the study will be kept confidential and data will be summarized in statistical and numerical form.

I would like to arrange a meeting to discuss my proposal further and will contact you within two weeks to arrange such a meeting.

I look forward to discussing my thesis proposal with you.

Sincerely,

Dianne Griffin, R.N., B.S.W.

P.O. Box 698
Charlottetown, P.E.I.
C1A 7L3
February 11, 1988

Dr. Douglas W. Cudmore
Polyclinic
199 Grafton Street
Charlottetown, P.E.I.
C1A 1L2

Dear Doctor Cudmore:

As Part of the thesis requirements for completion of my Masters of Social Work degree at Memorial University of Newfoundland, I am conducting a research project which will focus on the effects of adolescent pregnancy on the family.

I am contacting you as an Obstetrician in the Province to ask for your assistance in the selection of my sample. I would like to obtain a sample of clients served through your office.

Gathering of data will involve one face-to-face interview with an unmarried pregnant teenager, aged 16 to 19 years inclusive, who is living at home with her family. The results of the study will be kept confidential and data will be summarized in statistical and numberical form.

I would like to arrange a meeting to discuss my proposal further and will contact you within a week to arrange such a meeting.

I look forward to discussing my thesis project with you.

Sincerely,

Dianne Griffin, R.N., B.S.W.

P.O. Box 698
Charlottetown, P.E.I.
C1A 7L3
February 11, 1988

Ms. Patricia Power
Charlottetown Rural High
100 Burns Crescent
Charlottetown, P.E.I.
C1E 1K6

Dear Ms. Power:

As Part of the thesis requirements for completion of my Masters of Social Work degree at Memorial University of Newfoundland, I am conducting a research project which will focus on the effects of adolescent pregnancy on the family.

I am contacting you as a Guidance Counsellor at Charlottetown Rural to ask for your assistance in the selection of my sample. I would like to obtain a sample of clients served through your office.

Gathering of data will involve one face-to-face interview with an unmarried pregnant teenager, aged 16 to 19 years inclusive, who is living at home with her family. The results of the study will be kept confidential and data will be summarized in statistical and numberical form.

I would like to arrange a meeting to discuss my proposal further and will contact you within a week to arrange such a meeting.

I look forward to discussing my thesis project with you.

Sincerely,

Dianne Griffin, R.N., B.S.W.

Information Sheet

As part of the thesis requirements for completion of my Masters of Social Work degree at Memorial University of Newfoundland, I am conducting a research project which will focus on how pregnancy during adolescence affects the family. Better understanding of teenagers' experiences and perceptions can hopefully lead to improved services for them as well as their families.

You are being asked to participate in a face-to-face interview lasting approximately one hour. I will personally conduct the interview.

The results of the study will be kept confidential and will be reported as an anonymous numerical and statistical summary.

Your consent to participate in this study is totally voluntary and you may withdraw at any time. Your decision to accept, refuse or withdraw will not affect your relationship with the group or agency through which you are contacted.

Dianne Griffin R.N., B.S.W.: Investigator

Date: _____

Name: _____

Address: _____

_____

Telephone: _____

Informed Consent Form

I _____ understand that the purpose of this project is to find out how pregnancy during adolescence affects the family.

I understand that the results of this study will be kept confidential and will be reported in anonymous numerical and statistical form.

I understand that my consent to participate in this study is totally voluntary and that I may withdraw at any time. My decision to accept, refuse or withdraw will not affect my relationship with the group or agency through which I was contacted.

I agree to participate in this project and to be available for an interview lasting approximately one hour.

I understand that Ms. Dianne Griffin, the principle investigator, is a professional Social Worker and that this project will serve as part of the requirements for her Masters of Social Work degree.

_____ _____

Date Signature

FAMILY ASSESSMENT DEVICE

March 5, 1987

Dianne Griffin
21 MacKenzie Street
St. John's, Newfoundland
Canada, A1A 2V4

Ms. Griffin,

Enclosed, please find the FAD packet that you ordered. You have permission to duplicate the copyrighted Family Assessment Device, the manual scoring sheet and instructions, and the Family Information Form. In the future, we may contact you to receive your feedback on the instrument.

Thank You for your interest and good luck in your future project.

Sincerely,

Ivan W. Miller, Ph.D.
Director
Brown/Butler Family Research Program

IWM/kld

Enclosure

PS: I will be sending the Computer Scoring Program you ordered next week. I apologize for the delay and any inconvenience this may cause you.

MEMORIAL UNIVERSITY OF NEWFOUNDLAND
St. John's, Newfoundland, Canada A1B 3V6

School of Nursing

Telex. 016 4101
Tel. (709) 737 8605

09 June 1987

TO WHOM IT MAY CONCERN:

This is to confirm that I have granted permission for Dianne Griffin to use the questionnaire in my thesis study entitled "Punishing the Pregnant Innocents: Single Pregnancy in St. John's, Newfoundland, 1977".

Signed _____

Date 10 June 1987

Appendix J

ADOLESCENT PREGNANCY

AND

CHANGES IN FAMILY FUNCTIONING:

QUESTIONNAIRE

Date of Administration: _____

Name: _____

Identification Number: _____

I.D. No. _____(1)(2)

Card No. _____(3)

Group _____(4)

Family Assessment Device

Identification Number: _____ Date: _____

Time Started: _____ Time Ended: _____

Demographic Information

First, to begin the interview I would like to ask you some questions about yourself and your family. The following information indicates the nature of each person's role in the house (i.e. husband, wife, son, daughter, friend, grandmother, etc.)

(Show the respondent a card with the same printed information).

1. a) b) c) d) e)

	First Name	Family Role	Religion	Age	Sex	Education (total no. of years)
(5)___ (6)___ (7)___ (8)___ (9)___	1)					
	2)					
	3)					
	4)					
	5)					
	6)					
	7)					
	8)					

For each family member not living at home, please complete the following.

(Show the respondent a card with the same written information).

2.

(not being coded)	First Name	Family Role	Religion	Age	Sex	Education (total no. of years)
	1)					
	2)					
	3)					
	4)					
	5)					
	6)					

3.a) Present marital status of heads of household. Check all that apply.

		Male	Female
(10)___	0) Married only once	____	____
(11)___	1) Remarried	____	____
	2) Single	____	____
	3) Never Married	____	____
	4) Separated	____	____
	5) Widowed	____	____

(12)___ b) Number of years in present

(13)___ marital status _____

(14)___ c) Number of previous marriages (male) _____

(15)___ (female) _____

4. Total family income.

(16)___ 0) $ 0 - 9,999 [ ]

1) $10,000 - 19,999 [ ]

2) $20,000 - 29,999 [ ]

3) $30,000 - 39,999 [ ]

4) $40,000 + [ ]

(17)___ 5. What is your racial origin. Check one.

0) Caucasian [ ]

1) Black [ ]

2) Oriental [ ]

3) North American Indian [ ]

4) East Indian [ ]

5) Other _____ Specify: _____

Pregnancy

Now, I would like to ask you some questions about your pregnancy.

(18)___ 6. How many months pregnant are you? _____

(19)___ 7. In what month did you first know you were pregnant?

_____

(20)___ 8. Have you seen a doctor since you became pregnant?

_____

(21)___ 9. Is this your first pregnancy? _____

10. Here is a list of complaints that some women have

(22)___ during pregnancy. Please state YES or NO when I read them. (Show the respondent a card with this list).

	YES	NO
0) Nausea	____	____
1) Vomiting	____	____
2) Headaches	____	____
3) Dizziness	____	____
4) Swelling of hands, feet or face	____	____
5) Blurred vision	____	____
6) Bleeding	____	____

(23)___ 11. Do you see your doctor regularly?

0) Yes ____

1) No ____

Using the following list, please answer questions 12, 13, 14 and 15. (Show the respondent a card with this list).

0) The father of your baby

1) Your doctor

2) Your girlfriend

3) A social worker

4) Your mother

5) Your father

6) A sister or brother

7) Other _____ Specify: _____

Choose the appropriate number from this list for each statement in questions 12, 13, 14 and 15. If there is more than one person, choose more than one number.

(24)___ 12. Who was the first person on the list that you told about your pregnancy? _____

(25)___ 13. Who on the list knows about your pregnancy? _____

(26)___ 14. Has anyone on this list made you feel unhappy, scared, guilty or ashamed about your pregnancy? If so, choose the appropriate number(s). _____

(27)___ 15. Who on the list has given you the most help during your pregnancy? _____

(28)___ 16. In what way do you feel that the person(s) named in the previous question helps you the most? Check off any of the following statements that you consider to be true. (Show the respondent a card with this list).

0) Shows concerns for your feelings. _____

1) Listens to you. _____

2) Is available when you need him/her. _____

3) Is willing to talk to the father of your baby. _____

4) Is willing to talk to you. _____

5) Makes plans for you and tells you what to do. _____

6) Allows you to make plans for yourself. _____

7) Makes all the arrangements for you to meet others who can help you. _____

Using the following list, please answer questions 17, 18 and 19. (Show the respondent a card with this list).

0) Get married

1) Keep the baby

2) Have an abortion

3) Place the baby for adoption

4) Stay in school as long as possible before the baby is born.

5) Leave school until the baby is born.

6) Want you to decide for yourself what to do.

7) Never to see the father of your baby again.

Choose the appropriate number(s) from the list above for each statement in questions 17, 18 and 19. If you choose more than one, please arrange in order of importance.

M (29)___ F (30)___ (31)___ 17. What do your parents want you to do? _____

18. What does the father of your baby want you to do? _____

(32)___ 19. What do you want to do? _____

20. If none of the above statements in the list apply to you, please specify.

_____

_____

_____

(33)___ 21. What do you plan to do after the baby is born?

0) Return to school [ ]

1) Enter University [ ]

2) Get a job [ ]

3) Get married [ ]

4) Stay at home with my baby [ ]

5) Haven't thought about it [ ]

6) Other _____ Specify: _____

Family Assessment Device

Instructions

This booklet contains a number of statements about families. For each statement that I read, please decide how well it describes your own family. You should answer according to how you see your family.

Please respond to the items in terms of how you feel your family has been functioning in the past two months (or since you became pregnant). If you were asked these questions last year, how would you respond?

I am interested in your personal view of your family.

For each statement there are four (4) possible responses. (Give the respondent a card with the responses).

1) Strongly Agree (SA)	Check SA if you feel that the statement describes your family very accurately.
2) Agree (A)	Check A if you feel that the statement describes your family for the most part.
3) Disagree (D)	Check D if you feel that the statement does not describe your family for the most part.

4) Strongly Disagree (SD) Check SD if you feel that the statement does not describe your family at all.

				Before	After
(31)___	22.	Planning family activities	SA	_____	_____
(35)___		is difficult because we	A	_____	_____
		misunderstand each other.	D	_____	_____
			DS	_____	_____
(36)___	23.	We resolve most everyday	SA	_____	_____
(37)___		problems around the house.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(38)___	24.	When someone is upset the	SA	_____	_____
(39)___		others know why.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(40)___	25.	When you ask someone to do	SA	_____	_____
(41)___		something, you have to check	A	_____	_____
		that they did it.	D	_____	_____
			SD	_____	_____

(42)___ (43)___	26.	If someone is in trouble the others become too involved.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(44)___ (45)___	27.	In times of crisis we can turn to each other for support.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(46)___ (47)___	28.	We don't know what to do when an emergency comes up.	SA A D DS	_____ _____ _____ _____	_____ _____ _____ _____
(48)___ (49)___	29.	We sometimes run out of things we need.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(50)___ (51)___	30.	We are reluctant to show our affection for each other.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(52)___ (53)___	31.	We make sure members meet their family responsibilities.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____

(54)___ (55)___	32.	We cannot talk to each other about the sadness we feel.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(56)___ (57)___	33.	We usually act on our decisions regarding problems.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(58)___ (59)___	34.	You only get the interest of others when something is important to them.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(60)___ (61)___	35.	You can't tell how a person is feeling from what they are saying.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(62)___ (63)___	36.	Family tasks don't get spread around enough.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(64)___ (65)___	37.	Individuals are accepted for what they are.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____

(66)___ (67)___	38.	You can easily get away with breaking the rules.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(68)___ (69)___	39.	People come right out and say things instead of hinting at them.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(70)___ (71)___	40.	Some of us just don't respond emotionally.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(72)___ (73)___	41.	We know what to do in an emergency.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(74)___ (75)___	42.	We avoid discussing our fears and concerns.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(76)___ (77)___	43.	It is difficult to talk to each other about tender feelings.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____

(78)___ (79)___	44.	We have trouble meeting our bills.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____

New Card
I.D. No. _____(1)(2)

Card No. _____(3)

Group _____(4)

(5)___ (6)___	45.	After our family tries to solve a problem, we usually discuss whether it worked or not.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(7)___ (8)___	46.	We are too self-centered.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(9)___ (10)___	47.	We can express feelings to each other.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(11)___ (12)___	48.	We have no clear expectations about toilet habits.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____

(13)___ (14)___	49.	We do not show our love for each other.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(15)___ (16)___	50.	We talk to people directly rathern than through go-betweens.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(17)___ (18)___	51.	Each of us has particular duties and responsibilities.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(19)___ (20)___	52.	There are lots of bad feelings in the family.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(21)___ (22)___	53.	We have rules about hitting people.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(23)___ (24)___	54.	We get involved with each other only when something interests us.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____

(25)___ (26)___	55.	There's little time to explore personal interests.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(27)___ (28)___	56.	We often don't say what we mean.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(29)___ (30)___	57.	We feel accepted for what we are.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(31)___ (32)___	58.	We show interest in each other when we can get something out of it personally.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(33)___ (34)___	59.	We resolve most emotional upsets that come up.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____
(35)___ (36)___	60.	Tenderness takes second place to other things in our family.	SA A D SD	_____ _____ _____ _____	_____ _____ _____ _____

(37)___ (38)___	61.	We discuss who is to do household jobs.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(39)___ (40)___	62.	Making decisions is a problem for our family.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(41)___ (42)___	63.	Our family shows interest in each other only when they can get something out of it.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(43)___ (44)___	64.	We are frank with each other.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(45)___ (46)___	65.	We don't hold to any rules or standards.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(47)___ (48)___	66.	If people are asked to do something, they need reminding.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____

(49)___	67.	We are able to make decisions	SA	_____	_____
(50)___		about how to solve problems.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(51)___	68.	If the rules are broken, we	SA	_____	_____
(52)___		don't know what to expect.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(53)___	69.	Anything goes in our family.	SA	_____	_____
(54)___			A	_____	_____
			D	_____	_____
			SD	_____	_____
(55)___	70.	We express tenderness.	SA	_____	_____
(56)___			A	_____	_____
			D	_____	_____
			SD	_____	_____
(57)___	71.	We confront problems	SA	_____	_____
(58)___		involving feelings.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(59)___	72.	We don't get along well	SA	_____	_____
(60)___		together.	A	_____	_____
			D	_____	_____
			SD	_____	_____

(61)___	73.	We don't talk to each other	SA	_____	_____
(62)___		when we are angry.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(63)___	74.	We are generally dissatisfied	SA	_____	_____
(64)___		with the family duties	A	_____	_____
		assigned to us.	D	_____	_____
			SD	_____	_____
(65)___	75.	Even though we mean well,	SA	_____	_____
(66)___		we intrude too much into	A	_____	_____
		each others lives.	D	_____	_____
			SD	_____	_____
(67)___	76.	There are rules about	SA	_____	_____
(68)___		dangerous situations.	A	_____	_____
			D	_____	_____
			SD	_____	_____
(69)___	77.	We confide in each other.	SA	_____	_____
(70)___			A	_____	_____
			D	_____	_____
			SD	_____	_____
(71)___	78.	We cry openly.	SA	_____	_____
(72)___			A	_____	_____
			D	_____	_____
			SD	_____	_____

(73)___ (74)___	79.	We don't have reasonable transport.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(75)___ (76)___	80.	When we don't like what someone has done, we tell them.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____
(77)___ (78)___	81.	We try to think of different ways to solve problems.	SA	_____	_____
			A	_____	_____
			D	_____	_____
			SD	_____	_____

Mothers of Pregnant Adolescents

Please answer each of the following questions.

(79)___ 82. Is this something you never thought would happen in your family?

(80)___ 83. a) What do you expect your daughter to do regarding mothering her child?

New Card
I.D. No. _____(1)(2)

Card No. _____(3)

Group _____(4)

(5)___ 83. b) Do you anticipate that these expectations will be met?

(6)___ 84. How do you feel about that?

(7)___ 85. What do you anticipate is going to be your role in parenting the child?

(8)___ 86. How do you think this pregnancy will affect the plans you have been making for your future?

(9)___ 87. How do you feel about that?