Order Number 1357280

African-American intergenerational teen pregnancy

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The University of Arizona, 1994

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AFRICAN-AMERICAN INTERGENERATIONAL TEEN PREGNANCY

by

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A Thesis Submitted to the Faculty of the

SCHOOL OF FAMILY AND CONSUMER RESOURCES

In Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS
WITH A MAJOR IN COUNSELING AND GUIDANCE

In the Graduate College

THE UNIVERSITY OF ARIZONA

1994

STATEMENT BY AUTHOR

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APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Betty J. Newlon — March 31, 1994

Betty J. Newlon
Associate Professor of Family and
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Date

This project is dedicated to

Joyce DeVoss

Philip J. Lauver

Oscar Christensen

Betty Newlon

Mary Hotvedt

Tom Schramski

Maureen Kelly

Donna Iams

Elizbeth Sproules

Michelle Scieame

---

ten most respected

role models, mentors, and teachers

Thank you for these most important messages:

Are you asking the right questions?

This could be why you are not getting the right answers.

The map is not the territory.

The third domain--obedience to the unenforceable--otherwise known as ethics.

ACKNOWLEDGMENTS

Special thanks to all for hangin' tough: 9 years, 8 summers, countless tears, and astronomical phone bills.

This project would not have been completed without you.

My love to all.

Donice Green

May, 1994

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ABSTRACT

Intergenerational adolescent pregnancy is of paramount concern to the African-American community. This study focused on intergenerational adolescent pregnancy, in the African-American community. Female members of African-American families who had experienced intergenerational adolescent pregnancy were interview using the McGoldrick & Gerson genogram interview (1985). The results indicate that while adolescent pregnancy occurs in successive generations, the motivations and expectations of each participant were different. These differences can be partially attributed to generational issues, although personal differences cannot be ignored. While more research is needed, it is clear that one size fits all social programs are inadequate to meet the diverse needs of this population. Professionals involved in this area need to seriously reconsider their assumptions as to the cause and effect of adolescent pregnancy in the African-American community. Reconsideration of old assumptions may fuel positive design and structural changes in the conception and delivery of social services to this population.

CHAPTER 1

INTRODUCTION

> Quite naturally, holders of power wish to suppress "wild" research. Unrestricted questing after knowledge has a long history of producing unwanted competition. The powerful want a "safe line of investigations," which will develop only those products and ideas that can be controlled and, most important, that will allow the larger part of the benefits to be captured by inside investors. Unfortunately, a random universe full of relative variables does not insure such a "safe line of investigations."
>
> -- Frank Herbert (1988, p. 210).

Unplanned adolescent pregnancies may cause a serious disruption in life cycle tasks and may complicate economic, social, and emotional choice (Furstenberg, 1976). When a young woman confirms the fact of an unplanned pregnancy, she is immediately responsible for making decisions that affect her future and that of her unborn child (Voydanoff & Donnelly, 1990). Resolution of an unplanned pregnancy falls within three main categories: adoption, abortion, or motherhood (Hayes, 1987). These resolutions carry immediate and long term consequences for the pregnant woman, her family, the father of her child, and his family (Voydanoff & Donnelly, 1990).

The reported rate of adolescent pregnancy during the 1980s decreased from previous decades; still approximately 9% or 850,000 adolescents became pregnant (Jones & Battle, 1990). This reduced the chance for the adolescent mother to complete her education and find gainful employment.

Nearly one half of all adolescents engaging in sexual activity use no contraceptives. Use of contraceptives revolves around three basic decisions: whether to use contraceptives, what form of contraceptive, and how often to use contraceptives (Voydanoff & Donnelly, 1990). Adolescent females who report the use of contraceptives with every act of intercourse have approximately a 13% unplanned pregnancy rate. Adolescents who sporadically use contraceptives were half as likely to become pregnant than adolescents who used no form of contraceptive (Zelnik & Kantner, 1980).

Adolescent pregnancy has a strong association with the African-American community as both the cause and result of poverty (Martin & Martin, 1986; Moynihan, 1971). When adolescent pregnancy is categorized by race, Anglos have the highest total number of adolescent pregnancy, while African-Americans have the highest rate of adolescent pregnancy. There is general agreement among researchers that the African-American adolescent pregnancy rate is two times that of Anglos (Voydanoff & Donnelly, 1990; Furstenberg, 1976; Taylor, 1993; Hayes, 1987).

While race appears to be a significant factor in adolescent pregnancy, socioeconomic conditions are also strongly associated with it (Hare & Hare, 1989a, -b; Voydanoff & Donnelly, 1990). Anglos have the highest total number of impoverished lower classes; however, African-Americans are largely over represented by percentage in the impoverished lower class (Ellwood & Crane, 1990).

Family structure appears to be another significant factor in African-American adolescent pregnancy (Voydanoff & Donnelly, 1990; Williams, 1991;

Furstenberg, 1981; Ooms, 1981; Hayes, 1987). Hayes cited the increase in single-parent female-headed households from the time of World War II to the present as a factor in adolescent pregnancy rates (Hayes, 1987). Hayes reported that one half of all African-American children reside in a household without a father (Williams, 1991; Voydanoff & Donnelly, 1990; Ellwood & Crane, 1990). There is a positive correlation between the absence of a father and early sexual intercourse for female adolescents. Adolescents with divorced parents reportedly have sexual experiences earlier than adolescents who have an intact family (Hogan & Kitagawa, 1985; Miller & Bingham, 1989; Voydanoff & Donnelly, 1990). Presupposing that parents can control their children's sexual activities, evidence suggests that mothers in divorced single-parent households can regain control over their sons' sexual activities although not their daughters' (Newcomer & Udry, 1987; Voydanoff & Donnelly, 1990).

In the United States there is a dim view of the effectiveness of adolescence pregnancy prevention programs. It has been shown worldwide that contraceptives have significantly reduced the rate of unplanned pregnancies when the following areas are addressed: an efficient means of delivery, minimal side effects, and detailed instruction on the use of the contraceptive (Mauldin & Ross, 1989; Westoff, Moreno, & Goldman, 1985; Grady & Billy, 1985).

Significance of the Study

Most research focusing on the subject of African-American adolescent pregnancy addresses the problem from a pathological-disorganized family premise (Martin & Martin, 1986). Most studies have failed to directly address adolescent

mothers and their families, thus completely discounting personal experiences. For mental/medical health professionals, educators, and federal/state policy writers the knowledge that can be gathered from females who have experienced this phenomenon will help in preventing future adolescent pregnancy. This familiarity will provide a basis to assist adolescents and help in shaping policies to better deal with the problems.

Statement of the Problem

The rate of unplanned pregnancies in African-American adolescents is two times that of Anglo adolescents (Voydanoff & Donnelly, 1990). Early pregnancy can impose significant social and economic difficulties for the adolescent's future and the future of the offspring (Furstenberg, 1976; Voydanoff & Donnelly, 1990). Exploring the thought processes and extenuating circumstances around the events of unplanned pregnancies may yield information of use in preventing other adolescents from becoming pregnant.

Questions for Consideration

Using evidence in genogram to identify family themes, this study was guided by the following questions:

1. What family dynamics are present in African-American families that experience unplanned adolescent pregnancy in successive generations?
2. To what extent do cultural and family myths influence timing and resolution of unplanned adolescent pregnancy in African-American families?

Definition

Because several terms are used throughout this study, the following clarification is provided:

Adolescents: Persons from 12 to 19 years of age (Planned Parenthood).

African-Americans: American citizens of color from African descent (Nobles, 1974, 1981)

Africanity family model: Family patterns of African-Americans in the United States are directly linked to family patterns in Africa (Martin & Martin, 1986; Nobles, 1974, 1981).

Boundaries: Invisible lines of demarcation in a family (Perry & Gawel, 1954, p. 30).

Coalition: Covert or overt alliance between two family members against a third family member (Perry & Gawel, 1954, p. 31).

Contraceptive: Any device or method employed to prevent pregnancy (Furstenberg, 1976; Segal, Tsui, & Rogers, 1989).

Extended family model: Family patterns in which African-Americans utilize members outside the nuclear family for social and economic security (Martin & Martin, 1986)

Family life cycle: Stages in life when power realignment typically occurs (Williamson, 1981).

Family mapping: Diagramming of a family's organizational structure, boundaries, and patterns of interaction (Perry & Gawel, 1954).

Family of origin: People with whom the identified participant lived before the onset of adulthood (Perry & Gawel, 1954; McGoldrick & Gerson, 1985).

Family ritual: Behavioral patterns in a family that are consistent in form and are continually used for a specific purpose (Perry & Gawel, 1954; McGoldrick & Gerson, 1985).

Family themes: Ideas that are present in more than one generation of a family that govern the perception of reality (McGoldrick & Gerson, 1985).

Generation: People who claim familial ties and have a minimum 12 years of age differential.

Genogram: A pictorial representation of family members births, deaths, events, traditions, and migrations (McGoldrick & Gerson, 1985). This is a form of family mapping.

Intergenerational: Term describing those themes, events, and attitudes that are transmitted both across and through all levels of family systems (McGoldrick & Gerson, 1985).

Matriarchy: Female dominance in a family or society (Martin & Martin, 1986).

Mental status examination: A systematic therapeutic examination employed for the purpose of investigating family systems (Perry & Gawel, 1954).

Pathological-disorganized family model: A concept advanced by Moynihan that African-American families have not positively adapted to life in the United States and have lost their African family values (Martin & Martin, 1986).

Patriarchy: Male dominance in a family or society (Martin & Martin, 1986).

Social exchange theory: An individual chooses to engage or terminate relationships based on cost/benefit analysis (Brehm, 1992; Perry & Gawel, 1954).

Strength-resiliency family model: A concept advanced by Martin & Martin (1986) that the African-American family has redefined itself to cope with economic and social factors in the United States.

Subsystems: Units within families based on age, gender, or interests (Perry & Gawel, 1954, p. 31).

Trauma or stressful life event: An external/internal event of such magnitude in its meaning to a person that the ego is overwhelmed and temporally made incapable of dealing with further assault (Goodman, 1993).

Triangulation: This is a specific type of coalition in which an adult encourages a child to form a coalition against another adult (Perry & Gawel, 1954, p. 31).

Unfinished business: Unresolved feelings and disowned experiences (Cory, 1991).

Vulnerable: Perceived condition of a person who experiences major stress and adversity (Goodman, 1993).

Assumptions

The validity of this study rests partly upon the following assumptions that:

1. Participants in this study speak English and were able to answer the interview questions.
2. Participants understood the questions as intended by the interviewer.
3. Participants provided accurate information as they perceived the question.
4. The data gathered was reliable.
5. Sample was representative of African-American families in which females had experienced adolescent pregnancy in successive generations.

Limitations

The clinical interview format has certain standard limitations. Specific limitations were identified as follows:

1. Participants may have answered in away to emphasize the positive.
2. Results of this study do not generalize to all African-American families that have experienced adolescent motherhood.
3. Results do not generalize to African-American adolescents who have not conceived during the period of time covered in this study or to African-American adolescents that have chosen termination or adoption as a resolution.
4. Participants may have had previous contact with the interviewer from the community at large. This contact may have biased responses.

Purpose of the Study

The purpose of this study was to identify patterns evidenced in an intergenerational genogram and to identify family myhthis that have influenced the timing and resolution of unplanned pregnancies that occur intergenerationally in African-American families.

Summary

African-Americans experience a disproportionate rate of adolescent pregnancy (Voydanoff & Donnelly, 1990). Identification of factors related to the occurrence of adolescent pregnancy could maximize the window of opportunity for appropriate and constructive intervention (Musick, 1993). An intergenerational genogram provides a framework for this process.

The following chapters include a review of the available literature, an overview of the methods and procedures used in this study, the results and analysis of the study, a discussion of the implications of the study, and finally the possibilities for future research.

CHAPTER 2

LITERATURE REVIEW

> Only the black woman can say "when and where I enter, in the quiet, undisputed dignity of my womanhood, without violence and without suing or special patronage, then and there the whole . . . race enters with me. . . ."
>
> -- Anna Julia Cooper, 1892
> (Giddings, 1988)

African-American Family Structure

There is considerable debate as to the construction of the African-American family and the role of the African American women in this family (Martin & Martin, 1986; Hill et al., 1989, 1993; Gutman, 1976; Hare & Hare, 1989a, -b; Hill et al., 1989, 1993). The major perspectives from which African-American families have been studied are as follows: pathological-disorganized, strength-resiliency, and Africanity (Martin & Martin, 1986; Hill et al., 1989, 1993; Billingsley, 1968; Frazier, 1967; Gutman, 1976; Du Bois, 1969; Bracey, Meier, & Rudwick, 1971; Moynihan, 1971). Currently debate inclusive to all perspectives is whether the African-American family is matriarchal. Historically matriarchy was considered a deviant pathological social construct by prominent researchers such as Du Bois (1969), Frazier (1967), and Moynihan (1971).

Moynihan (1971) suggested that through pathological-disorganized matriarchal family patterns African-Americans of lower class are headed for certain

demise. Moynihan stated that African-American women strip African-American males of masculinity by refusing to be subservient members of the family; a phenomenon he implied does not exist in Anglo culture. Moynihan went on to suggest that African-American women cease striving for success in the work force so as to allow African-American males a chance to succeed and take their rightful place as the undisputed household authority.

The strength-resiliency model indicates that the African-American family has organized itself in ways that promote positive gains, regardless of the dominant culture's resistance (Billingsley, 1968; Martin & Martin, 1986: Giddings, 1988). For an African-American family to survive in America it was necessary that both males and females participate in the work force. Because females had a greater chance of securing steady employment, they achieved equitable freedom and responsibilities. Furthermore, some researchers have suggested that African-American women continue to strive for success in the work force while encouraging males to do the same (Billingsley, 1968; Giddings, 1988). Martin & Martin (1986) asserted that for African-American women to become subservient to their male partners would be a step backwards not forwards for the African-American community. Some researchers viewed this sharing of power to be matriarchal (Moynihan, 1971).

In the African-American family, elderly adults often assumed responsibility for the caring of young children and other household duties (Gutman, 1976). Frequently grandparents resided with an adult child to provide these services and to save on living expenses. The strength and resiliency of families were reinforced

by the larger African-American community (Gutman, 1976). Formal organizations included churches, NAACP, sporting leagues, and schools (Billingsley, 1968).

Africanity is an amalgamation of theories that in essence assert that African-Americans have unconsciously continued traditional African beliefs and practices including those based on matriarchy (Martin & Martin, 1986). By applying the Africanity system, the African-American community looks within their own value system for spiritual guidance while discarding the value system cast upon them by the Anglo community (Asante, 1988; Nobles, 1974, 1981). As the African-American community develops a more proper perspective based on their own African values, they will be better able to handle the misinformation they have received from Anglo society. This misinformation has contributed to the use of addictive substances and given the African-American community a feeling of hopelessness and powerlessness. It is the job of the African-American community to re-program itself and discover it had a vibrant and healthy culture before slavery (Asante, 1988; Nobles, 1974, 1981).

Debate on the subject of African-American women and the role of matriarchy continues. There is evidence to support that most African-American higher education students are female. The more educated an African-American woman becomes, the less likely her chances of marriage. African-American women generally comprise the largest rate of single mothers across all age groups throughout American history. African-American women also comprise the highest rates of never married mothers across all age groups.

History of the African-American Family

Du Bois (1969), Frazier (1967), and Moynihan (1971) have all described the African-American family as a tangle of pathological disorganization that if left uncorrected will be the undoing of African-Americans in the United States. The crux of this issue is that many children in African-American families live without a father for most of their growth and development (Moynihan, 1971). These researchers contended that the economic deprivation experienced by African-American families has direct links to the lack of male supremacy in the family (Du Bois, 1969; Frazier, 1967; Moynihan, 1971). Frazier (1967) supported this argument with the contention that African-American families were relatively stable during slavery; destabilization took place primarily when a family member was sold. It was the advent of welfare that brought about mass disintegration of the African-American two parent family. Frazier said this was accomplished by slanting the qualification requirement to favor female heads of household. Moynihan (1971) expanded upon Frazier's (1967) conclusions in the "Moynihan Report." In this report, Moynihan concluded that the factors Frazier (1967) had identified as detrimental were increasing in severity. Moynihan (1971) asserted that, unless drastic measures are taken, the decline of the African- American family is imminent. Moynihan suggested massive cuts in welfare programs, the restructuring of welfare benefits to encourage two-parent families, economic incentive programs for African-American males, and encouragement for African-American women to become homemakers. Moynihan strongly suggested that the moral fiber of the African-American community be repaired and thus discourage violence, adolescent pregnancy, and poverty.

Frazier (1967) contended that during slavery, family ties remained intact despite the fact that under Federal law slaves had no rights to their own person or any persons borne to them (Melusky, 1991). During the period between 1798 through 1808 the breeding of African-American slaves was intensified. Slave owners were aware that the constitutional clause prohibiting the importation of slaves would be enforced after a 20-year moratorium. This time span gave slave owners the necessary time to import vast numbers of slaves and intensify the breeding of slaves so as to create a large self-replacing slave labor force. As the international slave trade became illegal; slave owners were now in possession of large and self reproducing labor force (Giddings, 1988; Gutman, 1976; Melusky, 1991). During slavery, it was common practice for slave owners and their Anglo sons to engage in sexual relationships with slave women (Giddings, 1988; Gutman, 1976; Lerner, 1972; Genovese, 1976). Slave owners frequently sold slave family members for profit regardless of family ties (Lerner, 1972). Slave owners were known to have punished female slaves by selling their children even when the slave owner was the father (Giddings, 1988; Lerner, 1972). Children from these unions were by law considered slaves (Melusky, 1991). The slave community generally accepted these children without the stigma of illegitimacy or rape (Genovese, 1976; Gutman, 1976).

In 1863 President Lincoln issued the "Emancipation Proclamation," which stated all slaves in Confederate held territories were "forever free" (Melusky, 1991). It was also strongly suggested that they enlist in the Union Army. However, during March 1864, in the town of Natchez, the Union Army Surgeon and Chief Medical Health Officer, A. W. Kelly, announced that "idle negroes"

posed a "serious danger" to the public health and threatened to spread the most loathsome and malignant diseases. As of April 1, 1863, only ex-slaves employed by "some responsible white person in some legitimate business" were allowed in Natchez. This action set forth the effective re-enslavement of the African-American community, despite the fact that in 1865 the Thirteenth Constitutional Amendment abolished slavery and prohibited involuntary servitude except for punishment of crimes (Melusky, 1991).

The justice department declined to investigate reports of involuntary servitude (Gutman, 1976). Furthermore, state laws based on the principle of A. W. Kelly were enacted requiring African-Americans to have work contracts at all times. These contracts contained stipulations that held all family members responsible for labor not completed. Under these contracts African-Americans were not permitted to travel without permission from the employer. African-Americans were also prohibited from selling/buying goods from any establishment except those the owner designated. These legal restrictions, along with the terror of lynching, effectively completed the re-enslavement of the African-American community (Gutman, 1976).

After the Thirteenth Amendment abolished slavery, the incidence of lynching increased significantly throughout the South (Giddings, 1988; Gutman, 1976). Ida B. Wells-Barnett described this period with horror. Entire communities were hung from trees, male genitalia sliced off, pickled, and sold for souvenirs after lynching parties (Giddings, 1988). African-American children were taught to avoid confrontation with Anglo males at all cost lest they be lynched. In terms of employment lynching became a means of terrorizing the African-

American community and enforcing work contracts (Giddings, 1988; Gutman, 1976).

The wages for the men were very low (Giddings, 1988; Gutman, 1976). They often could not afford to fulfill their contractual requirements (Giddings, 1988; Gutman, 1976; Lerner, 1972). Because of this, women had to accept domestic service employment or work as share croppers. With both parents working, other members from the extended family shared in the household chores and childrearing responsibilities (Giddings, 1988; Gutman, 1976; Lerner, 1972).

As factory jobs became available in the North, the great African-American migration began (Giddings, 1988; Lerner, 1972). African-American women were employed in these factories. They were the lowest paid of all employees; however, the wages were substantially greater than those paid in the South (Giddings, 1988). African-American male workers were the next cheapest labor available. During World War II, African-American men were called to serve in the segregated sections of the military, thus leaving ever-increasing jobs available for African-American women (Giddings, 1988; Lerner, 1972). African-American women were able to financially support their children without support from a male family head (Giddings, 1988).

Upon the end of World War II, the feminine mystique was born (Friedan, 1964). Women were encouraged to stay in the home, raise their children, and above all, allow males to be the undisputed authority in all family matters from the children to finances. The feminine mystique also interpreted dark-skinned women, women with large breasts, and women who were without benefit of a male authority in the home as unfeminine, amoral, and sexually available to all

men (Friedan, 1964). African-American women could not attain the feminine mystique ideal because of their physical appearance (Giddings, 1988). Consequently, they continued to participate in the work force and live in families without the benefit of an omnipotent male authority figure (Giddings, 1988).

The height of the women's rights and civil rights movements again affirmed African-American women's independence. The civil rights movement contained many more female leaders than male leaders, and throughout the history of the movement, this continued to be the case. African-American women in the civil rights movement were clear in their stand that issues of race and gender are intertwined and that advancement for African-Americans would only come through the advancement of all women (Giddings, 1988).

Sexuality in America

Sexual morals in Colonial Times were based on puritan ideals. While conduct did not always accurately reflect these ideals, censor was explicit and immediate for those engaging in immoral acts. Immoral acts were defined by law as any lewd or lascivious activity outside of the bonds of matrimony (D'Emilio & Freedman, 1988). Punishment consisted of lashes, branding, fines, and incarceration (D'Emilio & Freedman, 1988; Genovese, 1976).

Sexual activity between the races was illegal. Laws that later became known as "Misogyny Laws" prevented interracial marriage and consigned all children to the status of the minority parent (D'Emilio & Freedman, 1988). These laws effectively prevented the rise of a Mulatto class, an event that transpired everywhere else African slavery was practiced (D'Emilio & Freedman, 1988;

Genovese, 1976). Without an effective means of upward social mobility, the status of slaves changed very little over time (Gutman, 1976). Sometimes in the wills of slave owners, the slave mistresses and children were emancipated (D'Emilio & Freedman, 1988; Giddings, 1988; Lerner, 1972). These wills were often overturned on the grounds of insanity (D'Emilio & Freedman, 1988; Giddings, 1988; Lerner, 1972; Genovese, 1976).

While laws pertaining to interracial sexual relations between female slaves and owners carried penalties, they were rarely enforced in the South (D'Emilio & Freedman, 1988; Giddings, 1988; Lerner, 1972). Slave women were property and had no legal recourse for unwanted sexual activity. The wives of slave owners could legally prosecute their husbands for adulterous behavior with slaves; however custom was strongly against this (Lerner, 1972; D'Emilio & Freedman, 1988). The interaction between custom and law set up a divisive atmosphere on plantations throughout the South (D'Emilio & Freedman, 1988; Giddings, 1988; Lerner, 1972).

In justifying the sexual exploitation of slaves, Anglo men endowed female slaves with an overactive sexual libido that needed constant fulfillment. Anglo males also endowed male slaves with an overactive sexual libido towards Anglo women. This resulted in the fierce protection of Anglo women's virtue. Punishment for male slaves violating this virtue was castration (D'Emilio & Freedman, 1988; Giddings, 1988; Lerner, 1972).

Contraceptive Use in America

Contraceptive use was severely limited by passage of the Comstock Act in 1873 (D'Emilio & Freedman, 1988; Ware, 1989). It was illegal to use most types of contraceptive devices. The dissemination of birth control information was illegal (Ware, 1989). Contraceptives that were legal (condoms and withdrawal) required the husband's consent (D'Emilio & Freedman, 1988; Ware, 1989).

Rights for the use of contraceptives were championed by Margaret Sanger (Ware, 1989). She championed for the rights of women to control fertility. She founded the American Federation for Planned Parenthood, which today has over 1,000 clinics nationwide dedicated to family planning and reproductive freedom. The primary goal of Planned Parenthood is to give everyone the opportunity for family planning so every child is a wanted child (Douglas, 1970; Lader, 1973). Over the last 40 years Planned Parenthood has expanded to provide basic heath care services for males and females. Unfortunately, African-American women, while wanting to control fertility, took exception to Margaret Sanger proclaiming "more children for the desirable and less for the undesirables" (Ware, 1989). This attitude created feelings of distrust about family planning.

After slavery, many African-American women felt the greatest gift was to be able to keep their children. Unfortunately, due to a lack of medical care, the maternal and infant morality rate remained high (Giddings, 1988; Lerner, 1992). When clinics began to appear in the South, they were overwhelmingly "for Anglos only." In cities with clinics that did serve African-American women, incidence of uninformed consent for procedures such as sterilization and abortion were commonplace. This created distrust of the medical profession in general and

family planning specifically (Douglas, 1970; Lader, 1973). Because of these incidents, the concept of family planning for many African-Americans is considered a form of genocide (Martin & Martin, 1986).

The debate on the distribution of contraceptives to adolescents is of considerable importance to the African-American community (Musick, 1993; Furstenberg, 1976; Zabin & Hayward, 1993; Ravoira & Cherry, 1992; Voydanoff & Donnelly, 1990, Hayes, 1987). Most school-based family planning programs are implemented in predominantly African-American areas. African-American adolescent girls on average engage in sexual intercourse 9 months earlier than Anglos (Musick, 1993; Furstenberg, 1976; Zabin & Hayward, 1993; Ravoira & Cherry, 1992; Voydanoff & Donnelly, 1990). This discrepancy exists even when factors such as income and socioeconomic variables are controlled (Furstenberg, 1976; Zabin & Hayward, 1993; Voydanoff & Donnelly, 1990). It is generally accepted that the pregnancy rate for African-American adolescents is two times that of Anglos (Musick, 1993; Furstenberg, 1976; Zabin & Hayward, 1993; Ravoira & Cherry, 1992; Voydanoff & Donnelly, 1990; Hayes, 1987).

Family planning efforts to reach African-American adolescents seem to have had a positive impact in reducing unplanned pregnancies (Furstenberg, 1976; Zabin & Hayward, 1993; Ravoira & Cherry, 1992; Voydanoff & Donnelly, 1990). The greatest impact has been when family planning instruction has been coupled with greater opportunities in education and employment (Furstenberg, 1976; Zabin & Hayward, 1993; Voydanoff & Donnelly, 1990). It has been shown that this coupling significantly reduces the unplanned pregnancy rate for African-American

adolescents and is a major factor in delaying a second unplanned pregnancy (Furstenberg, 1976; Zabin & Hayward, 1993).

Among African-American women, the most widely used contraceptive is the pill (Furstenberg, 1976; Voydanoff & Donnelly, 1990). The Intrauterine Device (IUD) and the diaphragm are the methods of choice for women who cannot tolerate the side effects of the pill and may still want children (Furstenberg, 1976; Segal et al., 1989). Condom use in the African-American community is low, despite education on the risks of unsafe sexual intercourse (Furstenberg, 1976; Zabin & Hayward, 1993; Ravoira & Cherry, 1992; Voydanoff & Donnelly, 1990). African-American women who no longer wish to have children are electing sterilization in increasing numbers (Segal et al., 1989). Depo-Provera & Norplant have only recently been introduced to United States and utilization rates are still uncertain (Spicehandler, 1989; Segal et al., 1989).

Sexually Transmitted Diseases

Sexually transmitted diseases (STD) are a large problem for African-American adolescents (Center for Disease Control (CDC), 1989). The rates of infection for all Sexually transmitted diseases are significantly higher for African-American adolescents than for any other ethic/minority group (Katchadourian, 1989). Sexually transmitted diseases are defined as any bacterial or virus that is passes from one sexual partner to another (Hiatt, 1987; American College Health Association (ACHA), 1990). Sexually transmitted diseases can be transmitted between same-sex and opposite-sex partners (Hiatt, 1987; ACHA, 1990).

Complications that may arise from STD's are: infertility, severe pelvis inflammation, and death (ACHA, 1990).

The infection rate for genital warts is rising, with an estimated one million new cases appearing each year. Warts are treatable with surgery by either cauterization (burning) or cryosurgery (freezing) (Katchadourian, 1989). Genital warts may be linked to ovarian and cervical cancer.

Chlamydia has been linked to pelvic inflammatory disease; a condition that can lead to infertility. Chlamydia is treated with antibiotics, usually *tetracycline* (Katchadourian, 1989; ACHA, 1990).

Most strains of gonorrhea are responsive to common antibiotics; however, there are resistant strains. If left untreated, gonorrhea can cause pelvic inflammatory disease (Katchadourian, 1989; ACHA, 1990).

Herpes is caused by the herpes simplex virus (Katchadourian, 1989; ACHA, 1990). Herpes causes skin lesions and painful blisters that clear up spontaneously within a few weeks. Meanwhile, the virus enters nerve clusters where the body's immune system can not affect it. At present, there is no way of destroying the herpes virus. An infected person may have no further symptoms or may have a recurrence as often as twice a month to once a decade (Katchadourian, 1989; ACHA, 1990).

Contraction of syphilis is on the rise. Syphilis is treatable in the first two stages. The first stage has noticeable symptoms (chancre, pelvic swelling, and discharge). During the second stage, a general rash appears and other symptoms such as headache, fever, indigestion, muscle or joint pain are present. A latency phase occurs in the second stage. This latency phase may last between 2 years to

many decades. During this period the individual has no symptoms and is not infectious. The third stage of syphilis is a long and painful process that ends in certain death (Katchadourian, 1989; ACHA, 1990).

Acquired Immune Deficiency Syndrome (AIDS) is believed to be caused by the Human Immunodeficiency Virus (HIV), which can be transmitted through intimate sexual contact. In people infected with HIV, the body's immune system breaks down. The person becomes increasingly prone to a wide-range of life-threatening diseases. While some of these diseases can be treated, there is no effective treatment for the underlying immune deficiency. Ultimately, the immune system is destroyed and the infected individual dies (Katchadourian, 1989; ACHA, 1990).

Interviews in Research

The interview format is the cornerstone of mental health assessment. Some clinicians use intake forms to help assess prospective clients. However, these forms are not utilized without an interview. There are two major types of interviews: structured and unstructured (Cohen, Swerdlik, & Smith, 1992; Cormier & Cormier, 1991; Othmer & Othmer, 1989; Pope, 1979; Shea, 1988; Sullivan, 1954). Both types of interviews can be effective tools when employed correctly. Choosing which type of interview depends on the purpose of the interview (Othmer & Othmer, 1989).

Unstructured Interviews

Unstructured interviews involve the clinician taking an open ended approach to questioning (Othmer & Othmer, 1989). These questions have not

been pre-pared in advance, so the interview is driven by the client's verbal disclosures rather than by the clinician's questions. Unstructured interviews may cause some feelings of unease with clients as they wonder if what they are disclosing is of use to the clinician (Cohen et al., 1992; Cormier & Cormier, 1991; Othmer & Othmer, 1989; Pope, 1979; Shea, 1988).

Unstructured interviews give clinicians the opportunity to observe the client's self disclosure patterns. These observations may allow the clinician a clearer assessment of the client's ability to communicate. The clinician may be involved more in the interview process because there is not a great emphasis on asking all the questions that are on the intake sheet. However, clinicians may also be distracted by the unstructured interview format and not obtain meaningful information. Moreover, clinicians may not record the information given in a way that is simple to retrieve; this makes assessing clients' progress difficult and assessing the appropriateness of future therapeutic interventions hazardous.

Gathering the history of the clients' problems is one of the most important tasks for clinicians. The history may actually alert the clinician toward solutions. This is why interviewing has such an important role in mental health work. The use of unstructured interviews allows the client to tell what they think is important. A concern in using an unstructured interview is that clients may be in crisis or at least not optimally healthy during the interview. Clients may not be aware of how important certain information is to the therapeutic process and may omit meaningful information. Clients tend to accentuate the positive when initially meeting

the clinician. This tendency may shift clients' responses toward minimizing problems and leaving out obvious and meaningful information.

Structured Interviews

Structured interviews have the questions printed out in advance of the interview. These questions may be given to clients to review before the interview begins. This familiarity with the questions may help clients to give focused answers with greater depth in less time (Sanders, 1991). The questions are arranged from least intrusive to most intrusive. Well-constructed interviews may illicit the same information in a variety of questions, thus making a cross check for client accuracy possible. Structured interviews increase the likelihood of the clinician attaining relevant information quickly without missing areas of importance (Zuckerman, 1991; McGoldrick & Gerson, 1985; Sanders, 1991).

The questions usually are grouped into categories such as personal history, substance abuse history, present problems, and so forth (Zuckerman, 1991; McGoldrick & Gerson, 1985; Sanders, 1991). This process provides the clinician with a picture of the client's life at present, resources the client has used in the past, and frames the mechanisms with which the client makes choices.

The structured interview generally has space available for the clinician to take notes. When reviewing notes, structured interviews give information succinctly and in the context it was given. This reduces the amount of time clinicians need to review their notes and increases the relevancy of the notes being reviewed.

Mental health agencies tend to use structured interviews. Agencies are held accountable to quality assurance. Quality assurance personnel as well as county, state, and federal agencies frequently audit agencies' records. As an example of quality assurance, equal access to services is a particularly sensitive issue. Equal access essentially means that regardless of color, gender, or handicap, clients receive adequate and appropriate services. Records are randomly checked to assess any pattern of discrimination and to address any problems in record keeping. Structured interviews provide not only the answers but the questions that were asked during the interviewing process. This may help interpret the information in the context it was given. Interpretation is vital in clinical work. Issues such as child custody may be decided with the information from clinicians. It is vitally important that clinicians keep accurate records of interviews for all of these reasons.

CHAPTER 3

PROCEDURES

> Most discipline is hidden discipline, designed not to liberate but to limit. Do not ask **Why?** Be cautious with **How?** **Why?** leads inexorably to paradox. **How?** traps you in a universe of cause and effect. Both deny the infinite.
>
> -- Frank Herbert (1984, p. 9)

This chapter discusses the procedures and methodology used in this study. It includes descriptions of the sample selection, procedures for data collection, review of the instrument utilized, and methods of data analysis.

Sample Selection

The sample for this study consisted of a total of six female participants from two families; three participants per family, each representing one generation of her family. The participants are all African-American women who bore children during their adolescent years.

All participants were assured orally and in writing of the anonymity and confidentiality of their responses. In addition, they were free to withdraw at any time without incurring ill will.

Procedures for Data Collection

The recruitment protocol criteria for participation were the following: consent of one woman from each of three generations per family (three women per family) that had each borne children during adolescence. All of the women

must be at least 18 at the time the study; and there must be a 12-year minimum spacing between each intergenerational pair. This project was reviewed and approved by the Human Subjects Review Committee at the University of Arizona (Appendix A).

Telephone contact was initiated by the researcher. This was made possible because the researcher used a convenient sample. A preliminary interview was arranged with each participant.

At the initial meeting, each participant was given a copy of the Thesis Prospectus (Appendix B), Participant's Consent Form (Appendix C), Authorization Form (Appendix D), and Genogram Interview Questions (Appendix E). The researcher asked each participant to read over all materials immediately. The researcher then gave verbal explanations of all the materials. All participants were told they were free to leave the study at any time and that all the information would remain confidential and that their participation was voluntary. Participants were asked to keep copies of the materials for future reference. At this time an interview date was arranged with the participant and the researcher.

Prior to the genogram interview, all participants re-read and voluntarily signed subject consent and authorization forms. All participants were told that they were free to leave the study at any time without incurring ill will, all the information contained was confidential, and that their participation was voluntary.

Information was collected by the interviewer. The data used for this study were obtained using a direct face-to-face structured interview format. The interview was conducted in a mutually agreeable place. The participant responded to the interviewer's questions from Genograms in Family Assessment (Appendix

E). As the interview progressed, the interviewer would record the information using standard handwritten genogram symbols, written notes, and audio tape.

Instrumentation: The Genogram

The instrument used in this study is the Genogram. The Genogram is based on ethnography (Hulkrantz, 1960; Wilson, 1986; Page, 1986). Ethnography is an anthropological tool that looks for power structures in the family or community. Genogram were initially developed for family intake and assessment in a therapeutic environment (McGoldrick & Gerson, 1985). Genograms can be used in later stages of therapy as an intervention in family dynamics (McGoldrick & Gerson, 1985; Piercy & Sprenkle 1986). Therapeutic intervention was not intended for this particular use of the instrument. Participants were given a referral at no cost should unintended intervention take place.

Genograms are pictorial representations of family systems (McGoldrick & Gerson, 1985). Genograms may cover one generation or, as in this study, cover many generations of family members. Genograms are based in family systems theory. McGoldrick & Gerson have suggested using genograms for research purposes. One suggestion included the study of behavior pattern repetition across generations. This study addresses the behavior pattern repetition of adolescent pregnancy across generations.

The Genogram Interview (Appendix E) obtained the following data: births, deaths of all known family members, the marriages and divorces of these family members along with information on boundaries (as defined in Chapter 2),

substance abuse, occupations, educational levels, religious preferences, family myths, cultural messages, and family violence of any kind.

This study was designed to use intergenerational information from African-American women who had all experienced adolescent pregnancies. An interview with each woman provided data related to family atmosphere, family myths, cultural components, and extenuating circumstances surrounding their early pregnancy (McGoldrick & Gerson, 1985). The entire family was not interviewed, only the women who met the conditions were interviewed.

Sample Selection

The sample for this study was convenient. Initial contact was made by telephone calls from the researcher to the participants. A total of six African-American women participated in this study. The participants were from two separate families, and each participant represented one generation in her family. Each participant experienced adolescent pregnancy.

Procedures

The subjects utilized in this study were of a convenient sample. The thesis prospectus served as the initial contact letter and was served in person along with copies of consent, authorization, and genogram interview materials.

Each woman was contacted in person to confirm interest in the project and set an interview time. Each participant was asked where she would like to be interviewed. Four of the participants elected to conduct their interviews at their

place of residence. Two of the participants elected to conduct their interviews in family-style restaurants during nonpeak business hours.

Reliability and Validity

The validity is determined through the interview process. Results will be valid to the extent that participants responded in a voluntary manner. If the client is forced or coerced into giving information the validity of this information must be questioned. Is the language use understandable or is an interpreter used? Certainly if the client and/or interviewer have trouble understanding each other the validity must be questioned. By asking many different types of similar questions, answers can be corroborated. There must be sufficient time for the interview so details are not missed in an effort meet a deadline. Validity is limited to the extent the participants have the information requested about those events. The validity for this study was enhanced in the following ways: All subjects were informed of the parameters of the study, all subjects were informed of confidentiality, they gave verbal and written consent and authorization to participate in the study. They were informed that this was voluntary and that they could withdraw from the study without shame or malice at any time. Participants could request specific answers be withheld from disclosure in this study and that this request would be honored.

Reliability in data reporting can be further enhanced by the use of an audio tape recorder, thus allowing the interviewer to review the questions and answers repeatedly at her convenience. As the interview proceeds the subject becomes more relaxed and has an easier time in answering the questions. Asking

the least intrusive questions first allows an interviewer-subject rapport to develop. When the more intrusive questions are asked the subject has an easier time answering the questions. Objective reality is not the goal, the patterns are what are important. By talking individually to a small group of related people the patterns of their relationships become clearer. It is important to remember that this is not a qualitative procedure, there is no right or wrong answer. The answer is not as important as the patterns the answers reveal.

Methods of Analysis

The construction of genograms can be a time-consuming and laborious undertaking. McGoldrick and Gerson (1985), seeing this drawback, helped to create the computer program "Reunion." This program allows for the construction of lateral and collateral lines of descent. In this study, the lateral line of descent was used. Sample selection was very small in this study, so a composite genogram incorporating major elements of each family was created. This protected the confidentiality of the participants while still conveying the essential data collected.

Genograms may include written information such as dates of birth, marriage, divorce, and death. Also, information on substance abuse, mental illness, and other relevant issues can be notated using this program. In this study, such information is included in the text. The purpose of the composite genogram was to allow a visual interpretation of familial lines of descent.

CHAPTER 4

RESULTS

> . . . she had nothing to fall back on; not maleness, not whiteness, not ladyhood, not anything. And out of the profound desolation of her reality she may well have invented herself.
>
> --- Toni Morrison ---

This chapter discusses the findings and presents the actual pictorial genogram produced from information given by each participant.

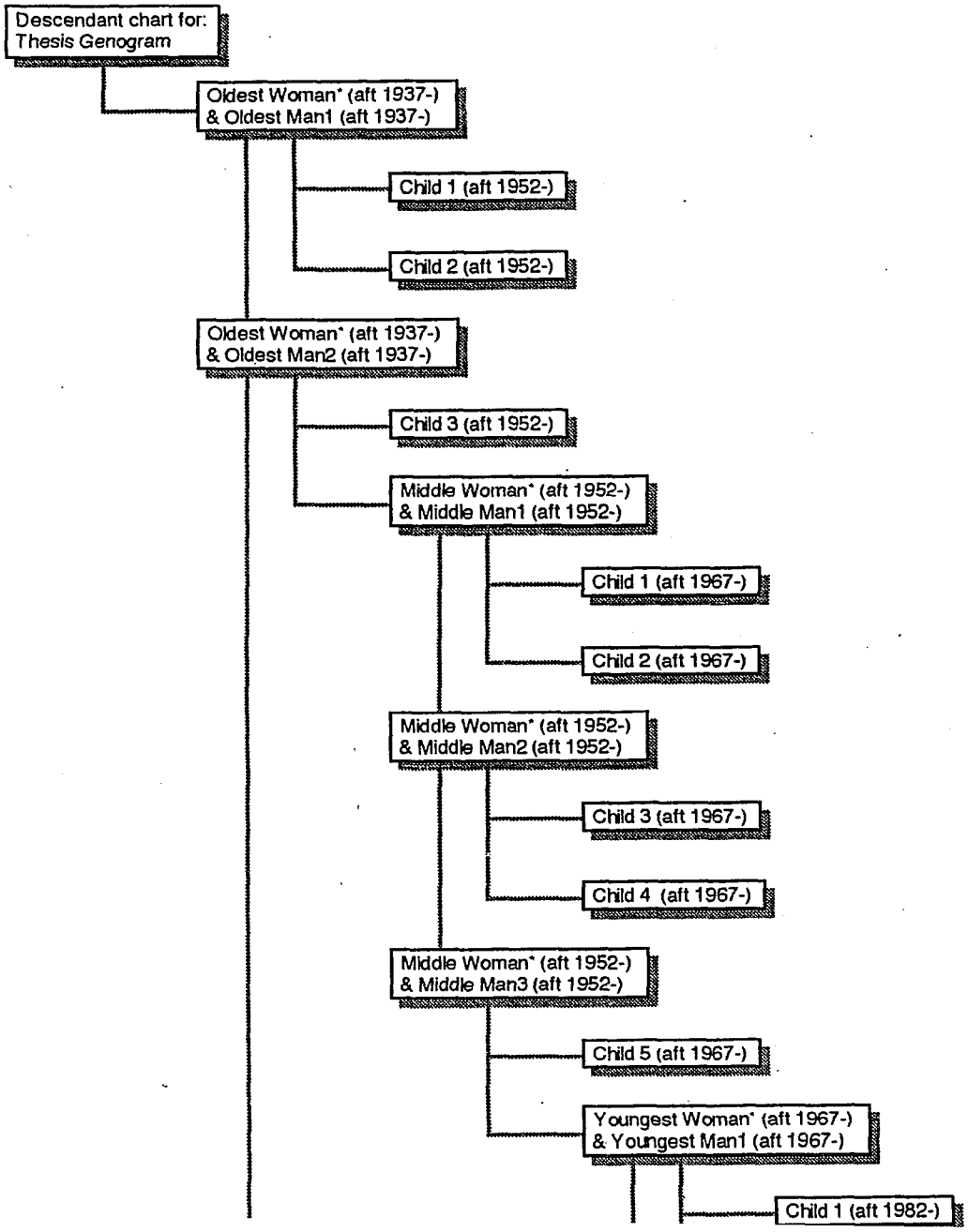
Sample

There were six female participants in this study. Each woman represented one generation in her family and met all the parameters for this study: Three African-American women from each of two families; each from a different generation (as defined in Chapter 2) who had given birth to at least one child before age 20. All participants were to be at least 18 years old. The actual participants ranged in age from 23 to 82. In order to preserve confidentiality, findings are reported by age groups named: oldest generation (participants 65 years of age and above), middle generation (45 and 53), the youngest generation (19 and 32). To the extent possible results are reported in the format of the written genogram interview. Where questions were answered out of order, the information was reported in the appropriate content heading.

Instrument

The instrument utilized was the intended genogram interview instrument by McGoldrick and Gerson (1986). The questions were asked in the order suggested by McGoldrick and Gerson. Often the participant would give information for the next few questions in the question that was being asked. Participants also gave information that was asked in other sections of the interview. The researcher chose to pursue the participants' line of thought and use the questions as follow up probes for information already given. This process may have improved reliability of the interview as information was given and then reconfirmed by the participant. Where participants had declined to answer questions and then gave that information elsewhere in the interview process, the researcher asked for specific permission to use the information. In all cases, this permission was verbally given.

The construction of the actual genograms was thought to include one genogram per family that participated. This proved impractical as each participant remembered different detail. Often times the information given by one family member did not mach the information given by other family members. Also collateral relationships were unclear for the participant when the researcher asked about preceding generations. Considering this, the researcher chose to construct a composite genogram representing both families' lines of descent (Figure 1). The composite genogram represents the major trends in each family. Using the composite genogram also ensured confidentiality of the participants as well. Other information was reported in the text. Since this study is primarily asking for


Descendant chart for:
Thesis Genogram
Oldest Woman* (aft 1937-)
& Oldest Man1 (aft 1937-)
Child 1 (aft 1952-)
Child 2 (aft 1952-)
Oldest Woman* (aft 1937-)
& Oldest Man2 (aft 1937-)
Child 3 (aft 1952-)
Middle Woman* (aft 1952-)
& Middle Man1 (aft 1952-)
Child 1 (aft 1967-)
Child 2 (aft 1967-)
Middle Woman* (aft 1952-)
& Middle Man2 (aft 1952-)
Child 3 (aft 1967-)
Child 4 (aft 1967-)
Middle Woman* (aft 1952-)
& Middle Man3 (aft 1952-)
Child 5 (aft 1967-)
Youngest Woman* (aft 1967-)
& Youngest Man1 (aft 1967-)
Child 1 (aft 1982-)

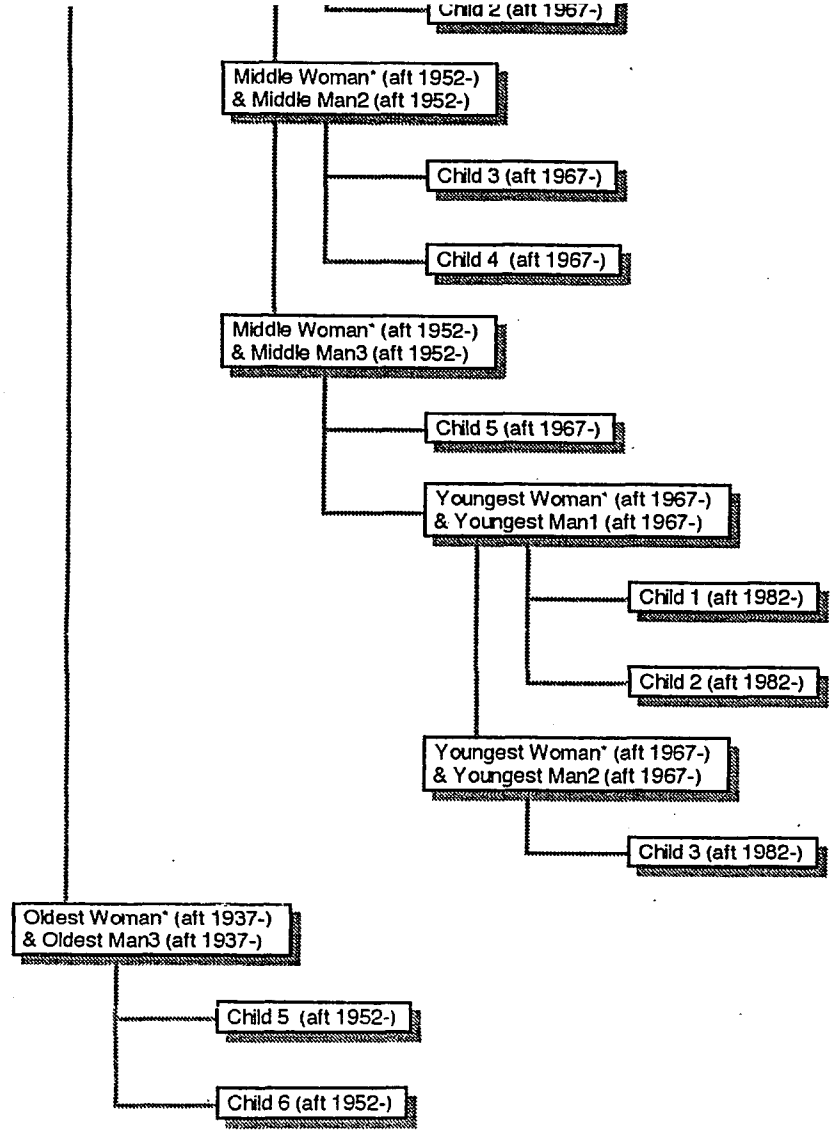


Figure 1. Composite Genogram

perceived family relationship this issue does not effect validity or reliability in this study.

Procedures

The sample used in this study was convenient in nature as outlined in Chapter 3. The researcher was interested in any pattern emerging from the genogram. Six women, three from each family, each representing one generation of that family were interviewed for this project. As stated, all participants were 19 or younger when they had their first child and were 18 or older when interviewed for this project. Authorization and consent were obtained as related in procedures for all subjects. Participants were contacted by the researcher by telephone and asked if each participant would be interested in this project. At the initial meeting, the researcher verbally explained the project to each participant. The researcher also had copies of the thesis prospectus, consent, authorization, and genogram questions that were given to the participant at this initial contact meeting. All items were reviewed verbally and participants were asked to take these materials home to review them further. These copies were for the participants to keep and could be referred to at anytime during the project should the participant have questions or concerns. The researcher was also available as resource for these questions and concerns and offered one follow-up session should participation in this process precipitate unforeseen negative consequences for the participant or the family.

The researcher stressed the importance of declining to respond to questions that participant did not want to answer. The researcher also stressed that this was

a voluntary process that could be ended at any time by the participant. The need to audiotape was thoroughly explained to each participant as the researchers tool to accurately report information. Confidentiality around the audiotape was assured verbally and in writing.

To the extent possible, the results of the interview are grouped into the same categories as the questions were asked (Appendix E). Where information overlaps efforts have been made to eliminate redundancy.

Immediate Household and the Facts

Each participant was asked the names, ages, and gender of all those residing in their household. All participants were able to complete this question, including the names and ages of pets residing in the home. When asked to name people in the generation preceding them not one participant could complete this question without some difficulty. Naming those in the family and their lines of descent proved extremely difficult for all participants. One participant commented: "I thought I knew this but now that you are asking, I realize I don't." A common occurrence was the naming of a relative, but being unsure if this was on the mother or father's side of the family and drawing a complete blank if that relative was two generations removed. This occurred even with participants who had assured this researcher that their knowledge of their family was vast.

None of the participants had anyone but family members residing in their home. Some participants had two and three generations in one home, while other relatives lived within walking distance and "might as well as live with us." All of these participants had experienced situations of having other people reside in their

home. Upon further discussion, these other people were in fact relatives but were distant relatives. All participants expressed a differential attitude toward these people than toward close family members. All participants' attitudes were decidedly negative toward relatives who did not have a close **emotional** tie with the family but had blood kinship claims to the family. This statement from a member of the oldest generation reflects the general message given to the researcher on this point: "Mr. Smith came up [from the South] and he stayed and stayed and **kept** staying." Actual close blood relationship did not rate as important as the visiting relations' relative standing in the family. Distant cousins could and often were held in higher esteem than closer blood relations who had strained conflict with the family.

All participants had relatives from the Deep South (Mississippi, Georgia, Alabama, Arkansas, Virginia, and North & South Carolina). The oldest participants recalled spending summers in the South and having cousins and other relatives come up from the South for weeks and months at a time. Older participants reported being amazed at the different attitudes that were prevalent in the South during the 1930s. Sexuality was not talked about but was practiced, and one participant reported that her mother used to vigorously remind her to "keep her dress down and her drawers up and legs crossed" when she was down with those "trashy niggers." Successive generations did not spend as much time in the Deep South; generally the relatives came to visit them up North or here in the Southwest.

Participants had drastically different views concerning adolescent pregnancy. Older women believed it was a moral issue while middle-generation women felt

that their mothers blamed them for their daughters' pregnancies. The youngest generation expressed incredulity that this situation happened to them.

The oldest generation's thoughts on prevention of adolescent pregnancy revolved around this thought expressed by a participant in this age group "if we taught them right, God before all, this would not be happening." The oldest generation viewed adolescent pregnancy as a moral problem and believed that morality and "just say no" should be taught in the schools and at home. This generation expressed the belief that being married mitigated the moral problem of adolescent pregnancy. A common sentiment of this generation is that, "if they're old enough for that, they're old enough to marry."

The women in the oldest generation agreed that peer influence was to blame for their own adolescent pregnancies. When asked about the moral training among their youth, these participants felt they had been influenced by "trashy niggers when they went down south (for extended visits)." This generation believed that peer influence was paramount in their "downfall" and praised the efforts of their family members to shield them from some of these influences.

The middle generation reported that information about sexuality was sparse, and any information that was given came from books. One participant relates learning about menstruation as follows: "I was outside with everyone [other neighborhood children] when I started to bleed. I ran inside to my mother hollering I had cut myself bad. My mother said 'you got it' and gave me some napkins [sanitary] and a book was on my bed that night. She never asked if I had questions or anything."

Middle-generation women expressed astonishment that their daughters "got caught in the trap." Middle-aged women wondered where they went wrong: "I told them everything, I bought them books, papers, and offered to get them birth control. I just don't know what happened." These women seemed baffled that their children were adolescent mothers. "Sex wasn't talked about with my mother. I talked about it with my kids. What happened?"

Younger-generation women reported constant talk of sexuality and horror stories of other girls who became mothers in adolescence. Their view of adolescent pregnancy was incredulity that this situation befell them. One participant of this generation commented "I just don't know how I got the second or third one. It's not suppose to happen that way. We only did it once."

Younger-generation women were particularly eager to speak to other young women and tell them to wait to have children. One participant in this group said "having kids makes everything you do that much harder and the more kids you have the harder it gets. I thought I would know more by my third one." The young women in this generation also expressed the position that one child was not so much of a problem as were subsequent children "if I had only the first one it would be so much easier." Not one of the participants in the younger generation discussed abstaining from sexual intercourse as a means to prevent other young women from becoming adolescent mothers. Giving contraceptive information to other adolescent young women was not of paramount concern to these participants. Their main focus was to tell other young women how difficult life can be when one chooses to begin a family in adolescence: "I would tell those

high school girls 'have sex if you want but don't get them babies cause they're yours and you can't wish them back.'"

Social and Family Context

All participants were involved in church activities as were their families from generations back. Both families recall Black Southern Baptist roots. Indeed, both families had preachers from this church in preceding generations. Both families experienced religious conversion sometime in the late 1960s. In both families, the vast majority of the extended family converted to the designated new form of Christianity. The reasons for these mass conversions are unclear; however, the importance of church cannot be disputed when looking at this sample.

The connection between church and family was emphasized time and again with statements: "Church was all day on Sunday and everybody whose anybody is there" and "my mama will not baby sit or give me money but she'll come get us for church, my Aunt too." The one issue that was least obviously connected with the church, was participants' views on abortion and adoption. Never once did any participant mention these choices are wrong because God said it was wrong or that these options are non-Christian. Abortion was talked about in an abstract style "I just don't believe in that but for my daughter . . ." The suggestion of adoption was met with "well, there's always someone who can raise an extra baby. They might not want to, but they will."

Another issue that seemed contradictory, considering the depth of religious feeling, was the issue of couples living together without benefit of marriage.

While the older generation believed that getting married mitigated some of the moral taint of adolescent pregnancy, everyone (including the older generation) was very cautious about a father of an unmarried woman's children living in the same house as the unmarried woman and her children. All participants agreed that boyfriends should be kept out of living in the house because "they might mess with" the children. Beyond this point, all participants expressed clearly that their first priority in relationships was their children and not their husbands, the children's father, or any boyfriend. All participants stressed the need to have a "grown" man, not some "boy." "I got me three kids and I'm not raising somebody else's boy. Hell, if his mama raised him so badly now there's nothing I can do about it and he needs to go." Considering all participants belonged to evangelical Christian faiths, this attitude was in direct contradiction to their church teachings. Evangelical Christian faiths stress virginity before marriage and the creation and maintenance of an intact nuclear family. Evangelical Christian dogma emphasizes the following hierarchy: Children submit to the woman, the woman submits to the man, and the man submits to God.

None of these women considered adoption or abortion as an option. Adoption seemed the least repelling as one grandmother related. "You have that baby for nine months and then you are suppose to give it up?!" Abortion was talked about as religiously wrong; however, it was more acceptable than adoption. As one participant explained, "no one has to know with that but if you get big, people will forever hound you about the baby." A few participants reported abortion as an option for the younger generation because "she was so young and had so much ahead of her. I don't believe in it, but still it's there."

All participants had some contact with doctors and helping professionals. Contacts with helping professionals were around issues pertaining to molestation, disciplinary problems, and major mental illness including substance abuse. Molestation in the family was reported by three participants from the middle and younger generations. This issue was talked about in the middle generation as an occurrence that may have happened to their daughters. ". . . but I don't know. She waited all this time and then said something. I just don't know for sure." The middle-generation women reported feeling uncomfortable with uncles and other male relatives. This situation was explained by the middle generation of women as being personal character flaws on their part as exemplified by this statement "I'm just not comfortable with that stuff. It doesn't mean he was trying anything.

The issue of molestation was described in detail by one member of each test family, glossed over by one member, and denied completely by one other member of each family. These responses were **not** along generation lines. At no time were the issues surrounding the reported molestation connected to early adolescent pregnancy. Currently literature in mental health asserts that females who have experienced molestation have a strong tendency to engage in sexual intercourse earlier than other females of the same age and race (Rencken, 1989; Rubin, 1990). This idea is expressed in numerous self-help and workshops examining molestation issues (Bass & Davis, 1988; Ratner, 1990). The lack of connection of these two topics is startling considering that all participants had had some mental health training and all of the participants had experienced counseling by a mental health professional at least once prior to this study.

Middle- and younger-generation women in this study had sought out counseling concerning disciplining their children. The youngest generation believed disciplinary tasks to be one of the most difficult in rearing the children. A participant from the youngest generation explained: "Uh-Uh those [the participants children] kids have a personality of their own and [it's as] if the devil got 'em [behavior problems] you just have two kids in one body." The youngest generation all remembered being taken to counseling by their mothers in the middle generation. The youngest generation reported that these sessions were primarily because their mothers could not "deal with me or control me. She wanted everything her way and I just could not have that." The youngest generation expressed that little benefit was gained at the time counseling took place, but now report some of the information related by the counselor then is useful now.

Middle-generation women reported seeking counseling for their daughters because "she was a wild child." Middle-generation women reported that counseling helped them to separate their self-respect from their daughters conduct. This process was impeded, reported the middle generation, when their daughters became pregnant. Middle-generation women felt they had taken all precautions necessary against adolescent pregnancy happening to their daughters.

Middle-generation women also expressed hostility toward their own mothers. Middle-generation women reported being told by their own mothers that the youngest generation's pregnancies were the fault of the middle generation. Participants in the oldest group did in fact express sentiments that parents today

do not sufficiently screen their children's friends and that this leads to "trashy" behavior.

This issue was a point of contention between the oldest and middle generation women. Surprisingly, this tension between older- and middle-generation women did not lead to seeking out helping professionals. Nor did this tension affect the relationships between the oldest generation and the youngest. The youngest generation reported that they receive as much emotional and financial support from their grandmothers as from their mothers. One participant she believed her mother did "as little as she can get away with and still be a mother" while her grandmother's sister "did everything for me and she didn't even have to." This closeness between women of one generation removed was also reported among the oldest women in my study. They reported being close with a grandmother or person from their grandmothers' generation and had conflict with their mothers.

When participants were asked to characterize family members using roles such as "scapegoat" and "sick one," all participants responded that these roles did not exist in their family. Then all participants, without exception, went on to describe family members that were held up as examples of exemplary behavior (the hero), examples of irresponsible "trashy" behavior (the bad one) and so on. As discussed above, all of the participants have some experience with counseling and so these characterizations in all likelihood were not new to these women. It seems apparent that there was evasion or resistance to labeling family members with these terms.

The participants each had different assigned roles in their family. There was no evidence of a pattern of "bad ones" or "trashy ones" becoming adolescent mothers while "good ones" and "successful ones" did not become early mothers. Family roles tended to be based on achievement in the spheres of work and education. Those who had negative labels "never worked a day in her life. You know, the kind that sits on their ass waitin' for a man." Those who had positive labels were "she got up went to school, went to work, and had that baby too. We all knew she was going somewhere and was going to be somebody. We always told her, 'don't be an educated fool. Get that paper cause they [employers] want to see it but work hard and you'll be somebody.'"

Not one participant reported a breech in the family so severe that communication was halted with that family member. As the interviews progressed, all participants named at least one person who was banned from family events and had been for at least 5 years from the date these interviews took place. These family members were **in all cases** the father of a child who was born while the mother was an adolescent. In fact, the youngest generation had no contact whatsoever with the fathers of their children and told this researcher that they had no intention of ever restoring contact with these men. When asked about what their children would be told, the thoughts expressed on the topic were articulated: "They have me and I tell them they should be lucky for that. They have my whole family. His [the fathers] are crazy anyway so they are better off. They don't ask about it much anymore. They know better." Middle-generation women had little, if any, contact with the biological father of their children but did maintain contact with their children's stepfathers. These men, while being divorced from the

middle-generation women, were invited to family gatherings and still had contact with the children they had helped to rear. For oldest-generation women, one participant was still married to the father of her children, while the other participant had not heard from the father of her children since the children "were too young to know and too old to care."

Counseling was sought for family members who had experienced major mental illness and or substance abuse that had occurred in both test families. Specifically, schizophrenia and depression were reported to have affected close family members. In all cases, the mental illness was reported to be in remission at the present time although difficult to witness when it had been untreated "She would just sort of go off sometimes; that's how she was." "She said she heard voices, but I don't know. She's fine now and lives with me. It [psychotic break] hasn't happened for a long time but I don't want her in that stress [living on her own] cause it could come back. She's doing so well that they're taking her off that drug, the new one [clozaril or remoxapride]."

Depression was at least partially attributed to hormones by all the participants in this study. The postmenopausal women spoke of needing their "patches to keep even [emotional balance]." In the other two generations only one participant had all of her reproductive equipment intact. The other women had partial and full hysterectomies performed usually for reproductive problems. These problems were described as painful and chronic, but the women were not sure as to the actual medical diagnosis. One woman in the youngest generation had her tubes tied to prevent further pregnancy but then had one ovary removed, but again she was unsure as to her diagnosis.

All the women took hormone replacement medication, although they could not be more specific as to the brand name and amount. The oldest women used patches, and the middle and younger women took oral medications. The problems experienced by these women may be moderate too severe in nature as the preferred method for delivery of hormone replacement is the patch (Wall, 1991). While other forms are often utilized the patch has the least amount of negative side effects and does not require daily compliance to a medication regime.

The depression experienced by these women included symptoms of crying, a general down in the dumps feeling, and feelings of listlessness where daily activities became difficult to complete. Each woman stressed that while activities were difficult to complete they were completed and at no time were they incapacitated to the point of needing hospitalization. Weight loss was not a symptom of depression for any of these women, in fact, considerable weight gain of at least 30 pounds was a prevalent symptom. All of the participants had tried at least one antidepressant medication at some time during their depression. These medications were all prescribed by doctors other than psychiatrists. Currently only two women continue to take antidepressants--one woman from the youngest generation and one woman from the oldest. The oldest participants reported that while the medications "helped a little bit" they were uncomfortable taking drugs for a disease that was only in their head. The oldest participant, who currently has antidepressants, explained: "He [doctor] says it helps my heart 'cause it helps me remember my other pills."

Both of the youngest generations reported experiencing drug and alcohol problems personally. Both sets of participants had family members that had

serious difficulties with substances abuse. Interventions involving professionals in substance abuse treatment were utilized in both families. Both families interviewed reported relatives who have been and are currently incarcerated on drug-related offenses. While drug abuse affected many family members there was no connection made between substance abuse and feelings of depression by the users or the family members of the users. Alcohol was the most popular substance of choice. While all participants reported that close family members and other participants were alcoholics, none of the other participants felt compelled to eliminate their own recreational alcohol use.

Marijuana, amphetamine, and narcotic use were also reported by participants. One participant from the oldest generation reported watering marijuana plants for a family member when that person was away on vacation. This participant reported having no idea that this plant was marijuana and only found this out when she asked a neighbor to water the plant because she would be away for a few days. Narcotic use for severe chronic arthritis or pelvic pain was reported by participants. Narcotics were used by all participants at some time in their lives to control pelvic pain; however, currently none of the participants used narcotics for this purpose. All participants informed the researcher that as far as they knew no one in their family was currently using narcotics to control pelvic pain. The oldest generation reported using narcotics and prescription strength anti-inflammatory and steroids to control chronic arthritis pain. None of the participants interviewed believed the use of these substances by the oldest generation was, currently or in the past, substance abuse behavior.

Historical Context

None of the participants knew how their family had come to be in America. One family reported having a West Indian ancestor; however, the participants of this family were unsure if that relative had really been West Indian and, if so, had no knowledge of how that relative came to reside in the American Deep South. There were no family stories about ancestors that were slaves or how family members became free in this country. All participants did have relatives who at one time were residing in the Deep South, where most African-American families have roots.

Family stories were learned from the "old folks sit'in up on the porch talkin'." These stories were not intentionally handed down through the generations but were passed on in the way this middle-generation participant described: "I remember stories, bits and pieces, but I don't know for sure I would listen to the old folks sit up talkin." "I would be coloring my book or something. They would shoo me away once they saw I was listening."

Secrecy surrounding historical events, drug use, and mental illness was common to both families that participated in this study. Like the issue of molestation discussed earlier, one participant from each family would be forthcoming about events--one participant would gloss over the events and one participant would respond that these events did not take place in their family, to their knowledge. As noted earlier, these positions regarding the reporting of events were not along generational lines.

Secrecy surrounding adolescent pregnancy was also common to both families. Cover stories (a retelling of events in such a way as to present

information in a more positive light) were used by all the participants regarding their own adolescent pregnancies and other adolescent pregnancies in the family. These cover stories included stating the age when their first pregnancy occurred as older than it actually was. They also reported the children's ages to be less than the actual age. The intent of these actions was to make the mother appear older than she actually was when she had the child. One middle-generation participant actually told this researcher that she was 25 years old when she had her first baby, although she was not married at the time she gave birth. This participant was thoroughly familiar with the parameters of the study, so she knew I was looking for women who were adolescents at the time of their first child's birth. Past this point her offspring would still be in adolescence, had this been the case and the offspring was in her early 30s. Furthermore, this participant did not notice this lapse and later in the interview talked about attending high school while pregnant and how difficult it was at that time to continue school. This type of cover story then relapse behavior occurred blatantly with the oldest- and middle-generation women. Youngest generation women did not engage in this type of behavior.

For oldest- and middle-generation women, it seems that secrecy and mis-representation of the facts are family issues passed down from generations. Women in the youngest generation appeared to have missed this lesson or to have incorporated it in a subtle fashion that is more difficult to detect. Certainly the youngest generation talked of having "accidents" with the birth of all their children

but this kind of discussion is common to young women who become earlier mothers across ethnic and racial lines (Rubin, 1990).

Summary

All participants in this study were adolescent mothers ages 19 or younger at the time of the birth of their first child. The genogram interview reveals family patterns that include molestation, substance abuse, abandonment, and medical issues. It may well be that these issues need to be addressed before positive intervention can be accomplished around the issue of early adolescent pregnancy in the African-American community.

CHAPTER 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

> At the quantum level our universe can be seen as an indeterminate place, predictable in a statistical way only when you employ large enough numbers. Between that universe and a relatively predictable one where the passage of a single planet can be timed to a picosecond, other forces come into play. For the in-between universe where we find our daily lives, **that which you believe** is a dominant force. Your beliefs order the unfolding of daily events. If enough of us believe, a new thing can be made to exist. Belief structure creates a filter through which chaos is sifted into order.
>
> -- Frank Herbert (1984, p. 131)

This chapter summarizes the study, draws conclusions based on the findings, and offers recommendations for future study.

Summary of the Study

The primary purpose of this study was to identify generational patterns pertaining to African-American adolescent pregnancy. Attendant to this purpose was the identification of areas within family systems where intervention may act to prevent or assist families in the management of adolescent pregnancy. The sample for this study consisted of six women from two separate families, each woman representing one generation in her family and that had experienced adolescent motherhood. The sample was a convenient sample known to the researcher.

The instrument used in this study was the genogram interview as developed by Gerson and McGoldrick (1986). This interview was utilized for its structure,

thus lending reliability to the results. This instrument covers global areas of functioning thus producing results that rendered a comprehensive representation of the participant's experience in a single interview.

Discussion and Limitations of the Results

There were several results of this study that will be discussed in this section. The main topics included in the results include interpretation of the results, the limitations of the study, generalizations, implications, and recommendations for future research.

The study was guided by two questions:

1. What family dynamics are present in families that experience unplanned adolescent pregnancy in successive generations?
2. To what extent do cultural and family myths influence timing and resolution of unplanned pregnancy?

This study did identify similarities in family patterns for families who had at least three generations of adolescent pregnancy. Both families had histories of substance abuse, molestation, and at least one long-term rupture of an important family relationship. Both families were unable to recount events that had brought their family to America but were able to trace their family to the Deep South region of America.

The method of reporting results for this study were different than expected. Certainly the researcher expected to be able to trace family relationships using one genogram per family. This proved impossible due to the different and at times conflicting information given by members of the same family. Also,

consideration for confidentiality overrides strict accuracy in small-scale qualitative research.

The researcher did find hostility in relationships along generational lines. The researcher did not find positive relationships between women two generations removed. Furthermore the hostility from the oldest generation toward the middle generation surrounding the pregnancy of the women in the youngest generation was startling to this researcher. This dynamic needs to be studied in depth by researchers interested in family dynamics.

Cover stories regarding the pregnancies were in place for all participants. The depth, complexity, and ingrained nature of these stories were noteworthy. It was as if these women had told theses stories so long that it was reflex to recount the cover story and not stories that more accurately reflected the events in question. Attendant to this point was how completely comfortable these women were in telling their stories; so much so that lapses back and forth between the cover story and relatively accurate events caused no visible signs of embarrassment or anxiety.

The depth of disclosure did not coincide with generational divisions. Perhaps this was a coincidence, but only replication of this study with a larger sample would confirm this. The circumstances surrounding this phenomenon were outside the scope of this study but merit further investigation.

The use of drugs, including alcohol by at least one family member was found in this study. Interestingly, while substance abuse was recognized as problem, it was discussed as a past problem, as if it had now been cured. As mentioned earlier all of the participants had experience working and utilizing

mental health services. None of these women could be described as having little knowledge in the area of mental health. Common frame works utilized in mental health intervention work include the 12-step and family systems approach. Both of these frameworks link substance abuse and traumatic family events as factors in adolescent acting out behavior. Adolescent pregnancy can and often is seen as acting out behavior. Furthermore, both conceptual frameworks describe how ancillary family members help to maintain an environment were substance abuse can continue to occur. Family issues surrounding substance frequently encompass such issues as molest, loss of a loved one, and prolonged physical and mental illness. Not one of the participants made reference or connection between the issues of substance abuse and the above ancillary issues. This result merits further study apart from replication of this study.

Another observation was that all participants denied that roles such as "the hero" or "the good one" existed in their family. Participants made no connection between family dynamics and these roles, yet each participant did in a round about way describe family members as holding certain roles. Statements such as "she is the smart one, at least she thinks she is [smart one]" and "I was always hard headed [difficult], just hard headed and just wouldn't listen to anyone[the rebel]" are a fairly clear indication of role definition in the family. These statements were always made at a point in the interviews that did not ask for this specific information. Again this phenomena merits further study. It may be that the participants resisted preexistent labeling of their family members or the question

may have been misunderstood. In any event only further research can clarify this point.

Limitations

There were numerous limitations of this study. These limitations lie primarily with in the sample size and the sampling method. The sample for this study was a convenient sample. All participants had some educational or professional background knowledge of mental health and related subjects. This knowledge may have skewed the responses of the participants. Also, these participants possessed more than the average person's knowledge of family dynamics that may have helped them to cope more effectively with the issue of adolescent pregnancy. Most participants had directly experienced psychotherapy, thus contributing to possible heightened awareness of family internal family patterns. The above are important factors to consider when examining the results of this study.

The small sample size is an important limitation. Results based on small samples tend not to generalize accurately to the population at large. In this study, the group identified for study was a relatively small group in the total population of America. Women comprise approximately 50% of the total population in America. African-Americans, male and female, comprise perhaps 12% of the total population of America with women comprising slightly more than half of the 12% (over 6%). While adolescent pregnancy occurs at approximately 2x the rate it does for Anglos the total African-American population effected by this phenomena is significantly less than 3%. Although the population studied is relatively small it does comprise hundreds of thousands of African-American women.

The samples in this study were not randomly selected but convenient to the researcher. Initial contacts, while observing a structured format, were conducted in a less formal vain than if the participants had been selected randomly.

Another limitation of this study was the availability of participants who met all the criterion for involvement. Southern Arizona has approximately a 1% African-American population. Those belonging to this population tend to have key family members living in other states. This, coupled with the need to only interview participants over the age of consent (18 years or older), put severe constraints on the pool of available participants.

Caution and prudence always need to be used when interpreting the results of any study. This study provided an in-depth one time view of two African-American families that have experience intergenerational adolescent pregnancy. Other African-Americans who have experienced successive generations of adolescent pregnancy may have varying family dynamics involved in their situation. African-American families that are not religious or have had family stories and traditions passed on from slave times to the present may look completely different from the participating families in this study.

Conclusions

This study was able to identify family patterns in two African-American families with three generations of adolescent pregnancy as evidenced by similarities in found in the genogram interviews. Knowledge gained about these patterns may be of use in developing appropriate intervention strategies for adolescent mothers and their families.

Recommendations

While this study was successful in achieving its goals, there are recommendations that may help future researchers and to further the depth and breadth of the research in this area:

1. The parameters could be redesigned to allow participation of families that only had two generation of women who were adolescent mothers. This would allow for a larger possible sample in areas that have a small African-American population base.
2. Should this study be replicated in an area that has a large African-American population, it may be useful to the researcher to interview all other family members interested in participating in the project. This would allow for a larger pool of information from which to base clinical interpretations.
3. The genogram interview may be shortened because participants seem to naturally flow from one topic to another. The redesigned version should include an average of two questions for each subject area. This would be a less structured interview than has been used in this study; however, it may be a more appropriate instrument. Participants would again be voluntary so the chances are excellent the participants will give more than sufficient information to adequately complete another project. This would be virtually guaranteed if the researcher widened the participant pool to include all family members interested in participation.
4. The historical questions asked in this study would make an adequate project in itself. This sample did not have information pertaining to their

families arriving in American. This is of considerable interest as Gutman (1976) and Genovese (1976) both commented on the prevalence of slave stories handed down among African-American families. It would be of interest to compare families who have such stories to those who do not and look for patterns in the family structure.

Summary

The results of this study suggest that intergenerational patterns have influence in the area of adolescent pregnancy. The results further imply that there are serious attendant situations in families that experience successive adolescent pregnancy. Family patterns of secrecy, substance use, molestation, and the rupturing of important family relationships are areas that may be examined to determine high risk adolescence. Once identified, professionals may well be able to intervene early enough to reduce the risk of future adolescent pregnancies.

APPENDIX A

HUMAN SUBJECTS COMMITTEE

LETTER OF APPROVAL

Human Subjects Committee

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

1690 N. Warren (Bldg. 526B)
Tucson, Arizona 85724
(602) 626-6721 or 626-7575

3 November 1993

Donice K. Green, Master of Arts Candidate
c/o Betty J. Newlon, Ed.D.
FCR: Counseling & Guidance
Esquire Apartments
1230 N. Park Ave., Ste. 210
Campus Mail

RE: **AFRICAN-AMERICAN INTERGENERATIONAL TEEN PREGNANCY**

Dear Ms. Green:

We received your above-cited research proposal. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b) (2) exempt this type of research from review by our Committee.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

William F. Denny

William F. Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee

APPENDIX B

THESIS PROSPECTUS

Thesis Prospectus

Proposed Title: One African-American family that has had a teenage pregnancy in three consecutive generations.

Problem Statement: What are the reasons that African-American women frequently repeat teenage pregnancy in successive generations? What family messages are passed down about motherhood. There may be cultural components that contribute and may help explain why teenage pregnancy is trasmitted intergenerationally.

Who: One African-American family in which at least one woman in each generation has had her first child under the age of twenty. At least one woman from each generation will participate in the interview process.

Measures/Instruments: Information will be gathered through an interview process and with the use of genograms.

Validity/Reliability: This information is based on self-report. While information from interviews can be highly subjective, in this project the interest in finding out each person's view of the circumstances surrounding her choice to have a child as a teenager.

Significance: The focus of this thesis is to take an in-depth look at one African-American family and its history of teenage parenthood. While this is only one isolated example it is possible to extract some general understanding of this phenomenon in the African-American community. These subjects may well give information on how best to help those that are teen parents currently and how to prevent other young African-American women from becoming accidental teen parents.

Candidate: Donice Green

Committee Chair: Dr. Betty Newlon

Committee Member: Dr. Joyce DeVoss

Committee Member: Dr. Phil Lauver

APPENDIX C

PARTICIPANT'S CONSENT FORM

PARTICIPANT'S CONSENT FORM

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE AND THE RISK OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

The following describes my participation in the project, what is required of me, and what benefits and risks of the project are:

1. Participants may withdraw from the projecxt at any time.

2. Participants may decline to comment on any question without risk of being disqualified from the study.

3. All information from this study will be kept confidentiall. Individual data from each participant will be kept confidential from the other participants. No information in the thesis or otherwise will be identified with the participant's given name.

4. Participants are asked to choose a fictitious name for use in this study.

5. Interviews will be audio-taped or recorded as handwritten notes, dependinbg on the participant's preference in this matter. All audio tape will be erased at the end of this study.

6. The purpose of this study is to identify intergenerational and cultural patterns that impact African-American teenagers' decisions to become parents.

7. The benefits of participation are (a) an opportunity to map intergenerational family patterns, and (b) an opportunity to share experiences of teen parenting in a manner that may benefit other teen parents in the future.

8. Risks of this project may be discomfort with audio tape or with certain questions the interviewer may ask.

9. The purpose of this study is to investigate the phenomenon of teen pregnancy in African-American families. Perhaps information can be gained to make recommendations on how to prevent unwanted teen pregnancies and what selrvices are needed to assist teen mothers. Under no circumstances are the intentions of the researcher to imply wrongdoing or shame on the part of the participants.

APPENDIX D

PARTICIPANT'S AUTHORIZATION FORM

AUTHORIZATION

BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR OR MYSELF AT ANY TIME. IN THE EVENT THAT NEW INFORMATION IS DISCOVERED DURING THE COURSE OF THIS STUDY WHICH MAY EFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT, IT WILL BE GIVEN TO ME WITHIN THE CONSTRAINTS OF LEGAL AND ETHICAL CONFIDENTIALITY. I UNDERSTAND THAT THIS CONSENT FROM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, DONICE K. GREEN, OR TO AUTHORIZED REPRESENTATIVES OF THE COUNSELING AND GUIDANCE DEPARTMENT.

I UNDERSTAND THAT I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

_____ _____

Participant's Signature Date

I have carefully explained to the participant the nature of the above project. I hereby certify that to thed best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in her participation and her signature is legally valid. A medical problem or language or education barrier has not precluded this understganbding.

_____ _____

Investigator's Signature Date

APPENDIX E

GENOGRAM QUESTIONS

Genogram
Questions

TO THE PARTICIPANT: PLEASE READ THE FOLLOWING QUESTIONS. mARK ANY QUESTIONS THAT YOU DO NOT WANT ANSWER MARK WITH AN "X" AND VERBALLY INFORM THE INTERVIEWER OF YOUR CHOICE. INTERVIEWER WILL RESPECT AND ABIDE BY ANY ALL REQUEST NOT TO ANSWER QUESTIONSS. ANY QUESTIONS THE PARTICIPANT MIGHT HAVE REGARDING THE INTERVIEW PROCESS OR A RELATED QUESTION TO THE PROJECT IN GENERAL, THE INTERVIEWER WILL ANSWER AT THE TIME OF CONSENT AND DURING THE INTERVIEW PROCESS.

Part I: Overview

The guidelines for the order in which dquestions will be asked are:

A. From the immediate household to the extended family and broader social systems.

B. From present family situation to a historical chronology of family events.

C. From obvious facts to judgments about functioning and relationships to hypothesized family patterns.

Part II: Qestions

A. The immediate family household

1. Who lives in the houseold?
2. How is each person related?
3. Where do other family members live?
4. What are the lnames, gender, and age of each person in the household and other family members?
5. How does each participant view issue of teen pregnancy?
6. How many other members of your family have been expecting or had girlfirends expecting a baby as teenagers?

7. What alternatives were considered to the situation?

8. What has been happening recently in your family?

9. What was the family atmosphere like when you were having your first baby?

B. The wider family context

1. Your mother was what number of how many children?

2. When was she born?

3. When and how did your mother meet your father?

4. Did they marry and if so when?

5. Were there other children with another father?

C. Social context

1. What roles have outside people played in your family?

2. Has the family had contact with community agencies, churches, or volunteer organizations?

3. Who outside the family has been important to you?

4. Has anyone else lived with your family and if so, when, how long and what contact do they have with the family at present?

5. What has the family's experience been with doctors and other helping professionalsl?

D. The facts

1. Please give the following information: dates of birth, death, marriage, separation, divorce, major illness, and cause of death for all known members of your family.

2. What is your sibling position?

3. What are the regional and religious backgrounds for the members of your family?

4. What are the occupations and educational achievements for the members of your family?

5. What are the current whereabouts of family members?

E. Historical perspectives

1. How did the family react to births in the family?

2. When and why did the family migrate to different parts of the country?

3. Which generation was the first to have an adolescent pregnancy?

4. Did family relationships change after the birth of a child to a teenage mother?

5. Has the circumstances surrounding early pregnancy changed through the generations?

F. Tracking family relationships and roles

1. Are there any family members who do not speak to each other or who have ever had a period of not speaking?

2. Are there any members who are in serious conflickt or have been in serious conflict over the issue of early pregnancy?

3. How did the father respond when iformed of being an expectant father?

4. Has anyone in the family member been focused don as the "caretaker," sick one," bad one," "mad one?"

5. Who in the family is seen as sthe "successful one" or "the failure?"

6. Who is seen as warm, cold, caring, or distant?

7. Who is emotionally closest to family members?

8. Who is emotionally fartherest apart from family members?

G. Questions about individual functioning

1. Has anyone had any serious medical or psychiatric problems?
2. Has anyone had depression, anxiety, fears, or loss of control?
3. Has anyone been sexually or physically abused?
4. Does any family member routinely use medications, and if so, what kind and how much?
5. Do you think any family members drink too much or have a drug problem?
6. Does anyone share your opinion?
7. Has any family member ever been arrested, and if so, when and why?
8. Has anyone ever lost their driver's license?

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