

2013

# Pregnancy Resolution Counseling with Adolescents

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Pregnancy Resolution Counseling with Adolescents

by

Michelle Taylor Skipper

A capstone project submitted to the faculty of  
Gardner-Webb University School of Nursing  
in partial fulfillment of the requirements for the degree of  
Doctorate of Nursing Practice

Boiling Springs

2013

Submitted by:

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Approval Page

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## Abstract

The results of a positive pregnancy test for an adolescent female mandate a time-sensitive decision to be chosen on the outcome of that pregnancy-whether to continue to pregnancy or terminate. Ambivalence regarding the pregnancy in adolescence is typically high, as the rate of unplanned pregnancies has been reported as high as 86%. In this project, Allanson's Abortion Decision Balance Sheet (ADBS) was modified to an age-appropriate literacy level and completed by nine adolescents in a public health department setting in the project "Pregnancy Resolution Counseling with Adolescents" (PRCA). Providing objective questions related to emotions regarding the pregnancy was proposed to decrease ambivalence hence aiding in pregnancy resolution decision-making. Findings were then compared to an equal number of medical records in pregnant adolescents who presented to the site prior to the initiation of the survey. There was no statistical significance noted in correlation between the group that completed the survey and the control participants who were not offered the survey. There was also no statistical significance noted with the pregnancy resolution decision among the participants when compared by age or race. Future plans are to replicate the study in a larger sample size and make further modifications to the survey tool geared toward the adolescent patient.

*Keywords:* Adolescent pregnancy, pregnancy ambivalence, pregnancy termination

## Acknowledgements

Today I stand surrounded by such a great cloud of witnesses that include my father, my grandparents, and so many from my church family. I am honored to be an heir of your faithfulness for many generations.

I am especially thankful for my friend and colleague, Dr. Robin Webb Corbett, for her compassion, acts of kindness, humor and candor as the chair of my capstone committee. The wisdom and involvement of Dr. Janie Carlton and Dr. Reimund Serafica have only added to the depth of this mentoring experience. Dr. Susan Lane has been such an advocate for my work with this vulnerable population. Thank you all for your belief and investment in my work. To my cohort colleagues, you have enriched my life more than you will ever know!

To those who have mentored me as a nurse practitioner, I owe gratitude as well. To the late Dr. Bonnie Friedman, and to my dearest friends Dr. Bobby Lowery and Dr. Ann King, your belief in me continues to inspire my soul. May that circle be unbroken! Teaching nursing to the next generation of clinicians at East Carolina has become a true joy in the trajectory of my career.

I owe a special gratitude to my family- to my precious husband, Bruce, I am so thankful to be your partner in ministry. I am also especially thankful for my loving extended family- for my mother and chief prayer warrior, Gladys Taylor, for my children and my grandchildren, my sisters, brother-in-law, and niece. I pray daily that Maggie, Hailey, Web, and Sealey will all grow up first to love God and to also love learning.

I am grateful for all of the young women who have allowed me to interact with them at such intimate moments in their lives, who have trusted me with their emotions, feelings, fears and doubts. I believe in each one of you and in your future dreams!

Finally, I am grateful for Gardner-Webb University that stands unashamed of the gospel of Jesus Christ and for the School of Nursing faculty who live out the belief that faith, service, and leadership indeed partner together for the good of our world.

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## **CHAPTER I**

### **Introduction**

The results of any laboratory test performed for a patient can have life-altering repercussions. However, few require as much adaptation by the patient as the results of a pregnancy test (Aktan, 2010; Maptule, 2006). Patients are typically polarized as either very satisfied or desirous of the result, or the opposite where they may be devastated, overwhelmed, and unsure of what pregnancy outcome option they may choose. Adolescent patients, in particular, may not be aware of resources available to them, their legal rights or have the cognitive ability due to their developmental stage to process the choices before them (Herman, 2007).

Adaptation, in the form of a pregnancy resolution decision, must follow the results of a positive pregnancy test. The patient must choose within a specified time frame either to maintain the pregnancy or terminate the pregnancy. Legal statutes which limit the gestational weeks during which a pregnancy may be terminated, and may also affect the rate of adaptation required. This time varies by state statutes. Successful adaptation, regardless of the pregnancy resolution choice, must occur such that the adolescent patient may continue along the expected trajectory in cognitive, physical, social, and psychological development (North Carolina Institute of Medicine (NC IOM), 2009).

### **Problem Statement**

With a complex decision such as pregnancy resolution, ambivalence has often been reported (Allanson, 2007). In response to the amount of emotional distress caused by abortion ambivalence, Allanson developed a decision-making tool which has been

piloted and tested in small sample sizes (Allanson, 2007). Review of the nursing and allied health literature failed to reveal a reliable and valid objective tool for pregnancy resolution specifically geared toward the pregnant adolescent patient.

### **Justification of Project**

While adolescent pregnancy rates are decreasing in the United States, interventions targeted to continue this decline remains a top health-related priority due to the number of adolescents affected and the consequences of early pregnancy and childbearing (Shew, Hellerstedt, Sieving, Smith, & Fee, 2000). Fifty percent of all pregnancies are described by the mother as ‘unintended’, and up to 86% of adolescent pregnancies are unintended (Coleman, 2004).

In 2007, Dr. Susie Allanson developed and implemented a tool titled the “Abortion Decision Balance Sheet” (ADBS). Forty statements, 20 to be considered Pro-Continue and 20 considered Pro-Abort, were asked of 96 women patients presenting to a publically funded termination clinic who agreed to participate. Fifteen percent of the patients in the sample were adolescent primigravidas (Allanson, 2007).

Adolescents may or may not access their primary care provider when concern arises regarding a possible pregnancy (Daley, Sadler, Leventhal, Cromwell, & Reynolds, 2004). Physicians, nurses and pharmacists surveyed in Akers, Gold, Borrero, Santucci, & Schwarz (2010) work demonstrated a wide range in comfort level discussing contraception in primary care settings, and consistently less comfort in discussing pregnancy resolution with adolescent patients. Peers were identified as the preferred source of pregnancy information for adolescents in an internet-based survey of 1,400 adolescents, while nurses were not identified as strong sources of assistance by

adolescents (Cassata & Dallas, 2005; Willis, Appelton, Magnusson, & Brooks, 2008). This lack of perceived support from nursing professionals strengthened the argument that tools need to be developed that can easily be accessed, used, and shared among adolescents. Tools that utilize popular social media sites or smart phone technology were believed to increase adolescent accessibility. Yet review of the two most popular smart phone markets, the Android and iPhone applications, found no available electronic tool for pregnancy counseling (L. Miller, personal communication, October 25, 2012).

### **Purpose**

The purpose of this Capstone Project was to determine “Does the use of the ADBS tool facilitate adolescent’s decision making in determining pregnancy resolution?” The secondary purpose was to pilot the modified ADBS tool in an adolescent population to add to the validity and reliability of the tool itself. Sister Calista Roy’s grand theory of adaptation provided the theoretical framework for administration of the ADBS tool to pregnant adolescent patients.

### **Project Question**

The primary question was:

- Will pregnant adolescents who complete the ADBS tool at the initiation of pregnancy counseling demonstrate stronger ambivalence with their pregnancy resolution decision than those not offered the tool, as evidenced by increased correlation between the ADBS tool results (Pro-Continue vs Pro-Abort) and pregnancy resolution decision?

The modified ADBS tool was administered over a 30 day project intervention timeline via an online survey tool in a health department setting. Convenience sampling

was used to determine the number of patients enrolled. An equal number of medical records for adolescents receiving pregnancy counseling at the same health care agency prior to use of the ADBS tool were used for comparison.

### **Definition of Terms**

North Carolina General Statute 48-2 defines the age of majority as 18 years; hence, a minor patient was therefore defined as a patient under the age of 18 (Center for Adolescent Law, 2009). Pregnancy resolution was defined as one of three options available which included childbirth, placing the child for adoption after childbirth, or pregnancy termination (TOP).

### **Nature of the Problem**

Detrimental health outcomes have been identified with each of the pregnancy resolution options. Review of the literature did not show mutual agreement on the long-term effects of the decision to abort an adolescent pregnancy. In fact, four studies reviewed showed abortion decisions provided substantial relief of stress and emotional upheaval as early as three weeks post-decision (Bartell, 2005; Bender, 2008; Peacock et al., 2001; Smith, 2004). Ambivalence related to the decision was shown as a positive factor, as patients who waited, ranked themselves more satisfied with their eventual decision (Bender, 2008). A 25 year longitudinal study completed in New Zealand by Fergusson, Horwood, and Ridder (2006) negates these findings and documented long-term mental health consequences and regret. Conversely, Erlich (2003) showed adolescents who made pregnancy termination choices without parental consent (but approved in the judicial system) were satisfied with their choices over the next 10 years.

Adolescents who continued a pregnancy through delivery and motherhood were more likely to grow up in homes that offered lower levels of emotional support and cognitive stimulation. These adolescents were also less likely to earn high school diplomas. Giving birth during adolescence was also associated with limited educational attainment (Maynard, 2008). Yet other studies showed rates of juvenile delinquency decrease in adolescent females who continued a pregnancy, including rates of marijuana and alcohol use (Hope, Wilder, & Watt, 2003).

### **Summary**

Unintended pregnancy leads any patient, but particularly an adolescent, to a choice with life-changing consequences and sequelae. Offering empathy to a patient in need and providing a concrete tool to process the pregnancy resolution decision may aid adolescents in a timely decision making manner and successful adaptation.

## CHAPTER II

### Research Based Evidence

Interdisciplinary review of the literature was conducted using multiple databases to answer the following research question: “Does the use of the ADBS tool facilitate adolescent’s decision making in determining pregnancy resolution?” The review sought to discover and evaluate available tools used in adolescent pregnancy counseling, based on Sister Calista Roy’s Adaptation Model as a theoretical framework. The review was not limited solely to nursing literature, but also drew on constructs and frameworks from religion, psychology, social sciences, feminist, and adolescent theory. The review was conducted primarily in the Cumulative Index to Nursing and Allied Health Literature database (CINAHL) available from two university-based library websites. Keywords included adolescent pregnancy, abortion, and termination of pregnancy, adoption, pregnancy counseling, and pregnancy resolution.

While adolescent pregnancy rates in recent years in the United States have decreased, interventions targeted to continue this decline remain a top health-related priority due to the number of adolescents affected and the consequences of early pregnancy and childbearing. (Shew et al., 2000). Interventions have been launched at local, state, and national levels with the intent of reducing the number of adolescent pregnancies (Sarantaki & Koutelekos, 2007; Willis et al., 2008).

## Review of Literature

Pregnancy resolution options reviewed for adolescents included termination or continuation of the pregnancy. After childbirth, adolescents may choose to rear the child, or relinquish the child to another family through the adoption option.

Abortion rates in adolescents in the United States decreased by two percent in the years 1998 to 2007, yet remain among the highest rates in developed countries (Pazol et al., 2007). Adolescents may choose not access their primary care provider when concern arises regarding a possible pregnancy (Daley et al., 2004). Physicians, nurses and pharmacists surveyed in Akers et al. (2010) work demonstrated a wide range in comfort level discussing contraception in primary care settings, and consistently less comfort in discussing pregnancy resolution with adolescent patients. Peers were identified as the preferred source of information for adolescents in an internet-based survey of 1,400 adolescents, while nurses were not identified as strong sources of assistance by adolescents (Cassata & Dallas, 2005).

The availability of home pregnancy testing actually decreased opportunities for provider-patient counseling. Adolescent patients who consistently took home pregnancy tests had higher rates of sexual activity and ambivalence about pregnancy. They were also likely to use contraception less consistently and incorrectly (Kelly, Sheeder, & Stevens-Simon, 2004). Daley's et al. (2004) study of adolescent females used interviews with focus groups in an urban setting to identify missed opportunities and barriers to contraception education, and identified a negative pregnancy test visit as a crucial time of intervention. Kumar, Baraitser, Morton, and Massil (2004) interviewed 21 women, not exclusively adolescents, who cited the need for prompt referral once a positive test is

received. “Most women seeking an abortion prefer not to discuss their decision but expect information and prompt referral. Delays in referral cause distress and later abortions and should be avoided” (Kumar et al., 2004, p. 51). Kavanaugh and Schwarz (2009) found 27-29% of women made pregnancy resolution decisions to terminate pregnancy while awaiting the results of the pregnancy test itself.

### **Provider Factors**

Pregnant adolescents reported fear of judgment from their health care practitioners. Few rigorous studies of provider attitudes were found, particularly for advanced practice nurses. Agencies who received Title X funding were mandated to provide counseling on all options (Weitz & Cockrill, 2010), although up to 60% of pregnancy counselors in one government based study gave no information on adoption at all and 40% gave inaccurate information. There was a 19% increase in adoption plans when adequate, accurate information was given (Henman, 2005).

Lipp (2010) documented attitudes of nurse midwives and nurses who worked in abortion related settings. Nearly 100% of the nurses and nurse midwives admitted ‘conceding’ some judgment related to the patient’s unplanned pregnancy. They used maxims such as ‘there but for the grace of God go I’ to assist in ‘concealing’ their opinion on the choice the adolescent has made to terminate. Abdel-Aziz, Arch, Al-Taher (2004) documented in their study (n=140) that general practitioners (physicians and nurse practitioners) who had higher rates of personal religiosity had proportionally higher disagreement with their patient’s choice to terminate a pregnancy. The authors also identified the lack of scholarly work documenting provider attitudes (Abdel-Aziz et al., 2004). O’Reilly (2009) cautioned nurse practitioners specifically to provide value based

education and counseling, including follow-up care, as decisions of pregnancy resolution magnitude would not often be completed in the brief time typically allotted to office-visit interactions. Other disciplines such as social work may provide other opportunities for follow up care (O'Reilly, 2009).

### **Patient Factors**

Review of patient factors identified two major themes: (1) persons of influence in the pregnancy resolution decision, and (2) long-term impact on mental health after decisions to terminate pregnancy are made.

Studies by Ekstrand, Tydén, Darj, and Larsson (2009) and Evans (2001) found partners and secondary parents as the major influences on adolescent pregnancy resolution. These studies, however, were completed in Sweden and Australia respectively. Evans' (2001) work also identified that patients' partners were the most influential in all three pregnancy resolution options, followed by mothers of the adolescent, especially mothers who had had an abortion in the past. Sisters who had abortions were also highly positively correlated with patients choosing termination as a means of pregnancy resolution. Zavodny (2011) also identified partners as the primary source of influence.

The effects of culture, as well as perceived violence in the relationship, also appeared as factors. Marquina and Bracho (2007) measured grief in Hispanic adolescents related to their abortion. This was shown to be directly correlated with relationships, which included some measure of intimate partner violence, and lack of social support from the partner for continuation of the pregnancy. Latina women were also influenced

by their perceived roles in their family of origin in determining pregnancy outcomes (Kaplan, Erickson, Stewart, & Crane, 2001).

Review of the literature did not show agreement on the long-term effects of the decision to abort an adolescent pregnancy. In fact, four studies reviewed demonstrated abortion decisions provided substantial relief, defined as stress and emotional upheaval, as early as three weeks post-decision (Bartell, 2005; Bender, 2008; Peacock et al., 2001; Smith, 2004). Ambivalence related to the decision was shown as a positive factor, as patients who showed higher rates of ambivalence ranked themselves more satisfied with their eventual decision (Bender, 2008). A 25 year longitudinal study completed in New Zealand by Fergusson et al. (2006) documented long-term mental health consequences and regret. Conversely, Erlich (2003) found emancipated adolescents who made pregnancy termination choices without parental consent (but approved in the judicial system) were satisfied with their choices over the next ten years.

### **Available Tools for Pregnancy Counseling**

As identified in the O'Reilly (2009) and Daley et al. (2004) studies, lack of time to counsel adolescents was a barrier identified by providers to promoting thorough and accurate information. Patient education materials typically presented three options which were termination of pregnancy, pregnancy continuation, and adoption available in a local resource area. Few objective tools were identified in the literature review for use in pregnancy counseling. In 2007, Allanson tested her tool, entitled the "Abortion Decision Balance Sheet" (ADBS), with 96 women presenting to a privately-funded termination clinic. This tool incorporated 40 statements, 20 to be considered Pro-Continue and 20 considered Pro-Abort, which provided a numeric measure of the patient's ambivalence

related to the decision. Demographics of the participants included a mean age of 26.7 years, 71% were single, 66% were employed, and 53% listed a religious affiliation (Christian and non-Christian). Fifteen percent of the subjects were adolescents. Study findings did not support her hypothesis that abortion-related distress was related to maternal attachment and grief. Patients whose responses strongly correlated with either 'Pro-Continue' or 'Pro-Abort' scores reported the highest amount of post-termination stress, measured by Impact of Event Scale (IEP) and Positive and Negative Affect Schedule (PANAS) at a three month follow-up interview (Allanson, 2007, p 52-53).

### **Gaps in Literature**

Other tools that measured influences on pregnancy resolution decisions, particularly those focused on adolescent pregnancy, were not found in the literature review. In addition, no tools undergirded by nursing theory were found related to the adolescent pregnancy resolution decision.

### **Theoretical Framework**

Roy's theoretical model of adaptation consists of four major elements: adaptation, person, environment and health. The goal of nursing in her model is "to promote the health of individuals and societies" (Roy, 2008, p. 18) and that people, sick or well, will interact with their environments in a positive way that promotes their health and well-being (Butts & Rich, 2011). Roy (2008) purports,

"The goal of nursing is to promote adaptation for individuals and groups in the four adaptive modes, thus contributing to health, quality of life, and dying with dignity by assessing behaviors and factors that influence adaptive abilities and by intervening to enhance environmental interactions."

(p. 29)

The Roy Adaptation model contains the following scientific and philosophical assumptions:

Scientific:

1. Systems of matter and energy progress to higher levels of complex self-organization.
2. Consciousness and meaning are constitutive of person and environment integration.
3. Awareness of self and environment is rooted in thinking and feeling.
4. Humans by their decisions are accountable for the integration of creative processes.
5. Thinking and feeling mediate human action.
6. System relationships include acceptance, protection, and fostering of interdependence.
7. Persons and the earth have common patterns and integral relationships.
8. Persons and environment transformations are created in human consciousness.
9. Integration of human and environment meanings results in adaptation

Philosophical:

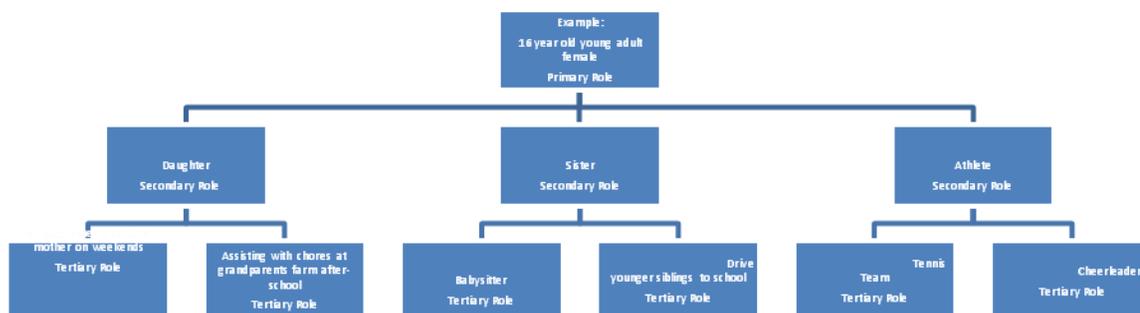
1. Persons have mutual relationships with the world and God.
2. Human meaning is rooted in an omega point convergence of the universe.
3. God is intimately revealed in the diversity of creation and is the common destiny of creation.

4. Persons use human creative abilities of awareness, enlightenment, and faith.
5. Persons are accountable for the processes of deriving, sustaining and transforming the universe (Roy, 2008; Butts & Rich, 2011).

Roy's four adaptive modes are divided into the functional categories of physiological, self-concept group identity, role function, and interdependence with individual and group criteria defined for each category. The understanding of the nursing process is based on six steps: assessment of behavior, assessment of stimuli (focal or contextual) formulation of nursing diagnoses, goal setting, intervention, and ending with evaluation. Roy's theory proposes "that a person is constantly interacting with a changing environment; when he or she cannot respond effectively, nursing is needed; when nursing has allowed the person to respond effectively, and therefore has adapted, nursing is no longer needed" (Roy, 2008, p. 32). Assistance in identifying the primary persons or spheres of influence will help pregnant adolescents decrease ambivalence and thus concretely process their pregnancy resolution decision in a more timely and satisfactory manner. Use of an objective tool, such as the ADBS, may help the adolescent objectify a very subjective decision. The questionnaire data may also give the maternal social worker a baseline understanding of the adolescent's method of adaptation, coping measures and support systems.

Adolescents, defined as ages 12 through 18 by Erikson (1963), are developmentally classified as in the identity versus role confusion stage, where the role is perceived by the individual and heavily influenced by peer groups. Roy asserts the total number of roles one has developed at any given time is defined as the individual's role set, which includes primary, secondary, and tertiary roles. The 19 through 21 years old is

defined as in the young adult stage of intimacy versus isolation. This stage, as well, has strong influence from peers and partners in decision making concerns.



*Figure 1.* Adolescent role set exemplar

The adolescent was considered the person in the primary role, and due to their development stage, may not have ever considered the secondary or tertiary roles in their role set as shown in Figure 1. An unintended adolescent pregnancy immediately causes ambivalence due to role confusion and role changes. Much of the decision on pregnancy resolution is directly influenced by the adolescent's assessment of their ability to add the parent role as a new primary or secondary role (Roy, 2008, pp. 362-363).

Figure 2 documents other areas of influence that may affect the pregnancy resolution decision in Roy's theoretical framework. This includes domains of interdependence, physiologic-physical, self-concept, and that of role function.

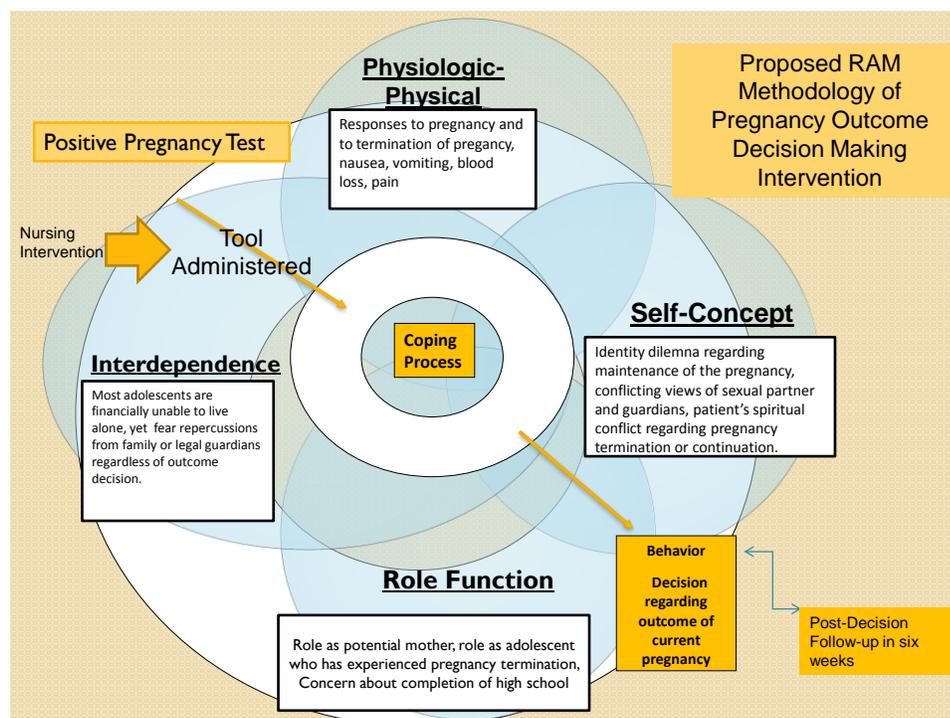


Figure 2. Proposed RAM Methodology of Pregnancy Outcome Decision Making Intervention

### Summary

The literature review was conducted across several disciplines and with multiple search parameters. In this review of the literature, it was found that pregnancy resolution counseling has been researched with adults, but it has not been explored extensively with adolescents in a public health setting. Hence, the theoretical foundation for the project was based on these works, all which were rated with the Forsyth Nursing Scale. All studies, both quantitative and qualitative, used were ranked 'five' or higher. This further justifies the need for an objective tool to use in pregnancy resolution counseling with adolescents.

## **CHAPTER III**

### **Project Description**

The purpose of this Capstone Project was to determine “Does the use of the ADBS tool facilitate adolescent’s decision making in determining pregnancy resolution?” The secondary purpose was to pilot the modified ADBS tool in a solely adolescent population to add to the validity and reliability of the tool itself. Pregnancy testing and counseling was offered at the site daily without cost to patients who scheduled an appointment. Sample size was determined by the number of adolescent pregnancy counseling patients who presented for care during the 30 day timeframe, and who consented to participate.

### **Project Implementation**

Following the completion of the online ADBS, a comparison was subsequently completed on an equal number of medical records from adolescent pregnancy counseling patients of the same health care agency prior to the study and use of the ADBS questionnaire. Comparative statistics were used to determine if the tool facilitated the adolescent’s decision making with pregnancy resolution more positively than those patients who had not completed the tool. Protocol at the health department site required follow-up communication with all patients who presented with a positive pregnancy test at approximately six weeks; hence documentation of their pregnancy outcome decision was available. Correlations were made between the pregnancy outcome choice suggested by the ADBS score, the decision reported at the initial pregnancy counseling visit and the decision reported at the six week follow-up.

### **Protection of Human Subjects**

Participation in the project was completely voluntary; assent and parental consent was obtained from each participant (if aged 13 to 17), and consent was obtained for those participants between the ages of 18 and 21. Enrollment was then established for a 30 day period after:

1. Approval of the PRCA project was received from the Institutional Review Board.
2. Orientation was provided to the nursing and social work staff on the project and the proposed tool.

Due to the highly sensitive nature of the test results, counseling and decision-making, in tandem with concern for the emotional safety of the participants, two additional measures to provide protection were included. First, the project administrator remained in close proximity to the participant while the online tool was completed. Secondly, if any emotional distress was observed, a licensed professional counselor was available by phone for assistance. The counselor's contact information was also provided to the participants if emotional distress occurred after contact with the project administrator. No deception was intended, nor was incentives offered for participants. Cards were given to each participant at the conclusion of the survey with telephone contact information if they chose to withdraw their data from the project.

All data was kept in a locked cabinet separated physically from the area where the survey was administered. Only the project administrator had access to the area. The survey was offered on-line via computer that had standard firewall and virus protection for security of results. Only the project administrator had access to the password required

to begin the survey. Participants were assured of confidentiality throughout the process and that names would be de-identified. Participants were also offered the opportunity to receive a copy of the final analysis if desired. The tool was administered in a private room. Health department personnel were not aware of which patients participated in the study.

Summary Table on Subpart D, 45 CFR 46 and 21 CFR 50: Additional DHHS Protections for Children Involved as Subjects in Research; Additional Safeguards for Children in Clinical Investigations (FDA) (*Rev .12/04, 11/06, 1/07*) was also used as a guideline for voluntary enrollment of participants. Collaborative Institutional Training Initiative (CITI) modules for the protection of human subjects were completed by the project administrator.

### **Setting**

The project site is a state and county-funded public health department in rural southeastern North Carolina. The site was purposely chosen as standardized pregnancy counseling was provided to all patients who presented for pregnancy testing, as opposed to the family practice, pediatric, and obstetrical offices in the community where pregnancy testing was also offered. Participants at the site where the project was implemented often receive public assistance at the same site where pregnancy counseling services were received. The assent and consent forms clearly stated that participation in no way interfered nor assisted the patient with receipt of any public assistance.

### **Instrument**

In 2007, Allanson used The Abortion Decision Balance Sheet (ADBS) to measure satisfaction with the patient's pregnancy outcome decision. Forty statements, 20 to be

considered Pro-Continue and 20 considered Pro-Abort, were used for 96 women patients in a termination clinic who agreed to participate (Allanson, 2007). The ADBS tool was developed as an objective decision-making tool in 1995 based upon previously available tools which measured ambivalence, fantasy and maternal attachment, without conceptualizing any course of action for the patient.

The tool was piloted with 20 women in 1995, and the 2007 study with 96 women represents the largest sample in which the tool has been used (Allanson, 2007; Allanson, 1999, p. 263; Allanson & Astbury, 1995). Reliability and validity was not reported for either study nor was it available from the author.

Overall, complexity and ambivalence in pregnancy outcome decision-making was measured in two ways. First, simply comparing the mean score of the Pro-Continue versus the Pro-Abort questions was determined to predict pregnancy outcome choice. Secondly, if the difference in scores of both sections were not statistically significant, then this was correlated to a higher score of ambivalence and complexity in decision-making.

One of the major limitations in Allanson's work was the type of settings used for administration of the tool. Tools were only administered in settings where the patient presented for pregnancy termination. Other limitations include the college level literacy required and the ability to read English as the primary language. Further study on the reliability and validity were also recommended by the author. Permission to use and modify the ADBS tool was received by the project administrator (Appendix A).

### **Project Design**

The 2007 Allanson tool was assessed for reading level with the Flesch-Kincaid Scale and found to be at a 14<sup>th</sup> grade level. The language of the tool was subsequently modified to a 6<sup>th</sup> grade reading level and offered as an online survey (Appendix B). The first four questions were demographic in nature. The remaining questions were 20 Pro-Continue and 20 Pro-Abort questions, which were ranked either “Very much what I believe”, “A little like what I believe” or “Not at all what I believe.”

### **Methodology**

Prior to the project intervention, content validity and expert review of the modified tool was completed by four nursing experts considered nationally to be experts in the area of adolescent or maternal health. Formative evaluation was completed by two methods. First, a pilot group of five adolescents, who were not participants in the study, was given the tool and asked for comments on the reading level, user friendliness, and time needed to complete the tool. Secondly, time needed to complete the tool was monitored by the computerized program used for the tool administration. Findings from the pilot group were used to refine the project. Summative evaluation was based on correlation ratios from the ADBS tool, decision reported at pregnancy counseling visit, and decision reported at six-week post decision follow-up contact.

### **Data Collection**

Patients received their appointment for pregnancy testing prior to the knowledge that participation in a PRCA project might be requested. After the laboratory personnel had completed the pregnancy test, the patient was escorted to a registered nurse or maternity social worker for discussion of the results. At the conclusion of that

interaction, the patient was asked if they would be willing to participate in an online survey regarding pregnancy resolution options. If the patient was aged 13 to 17, they were then informed that parental consent to participate would be required along with their assent to participate. Patients aged 18 to 21 were offered consent forms (Appendix C). After consent was received, the patient was logged into the computer-based survey by the project administrator.

In the first 10 days of the established 30 day collection period, zero participants presented for care who would consent to participate, or presented without a parent (needed for assent and consent). Review of the appointment schedule showed the majority of the patients making appointments were between the ages of 19 and 21. Hence, an addendum to the Institutional Review Board was submitted, which asked that the age of participation be increased to age 21. After approval, data collection continued. A total of nine participants voluntarily completed the online survey and were contacted by the agency at the six week post-counseling for comparison of their survey result and their eventual pregnancy outcome decision.

### **Limitations**

Several limitations of this project were noted. One limitation was concern for the number of patients who might not truthfully report their six week pregnancy resolution decision despite reassurances that confidentiality was maintained. Prenatal care is no longer provided at the site where the survey was offered; hence, confidentiality and HIPAA regulations prevented the project administrator from contacting other providers of prenatal care to confirm enrollment.

Lastly, changes to the wording of some survey items led to questions from the participant during the survey itself. Recommendations from the Institutional Review Board were to substitute the phrase ‘termination of pregnancy’ for the word ‘abortion.’ Three participants asked for clarification on this definition while completing the survey.

### **Timeline and Budget**

Timeline	Objectives	Budget
Spring Semester 2012	<ol style="list-style-type: none"> <li>1. Receive permission for use of ADBS tool</li> <li>2. Complete necessary documentation as required by the agency for implementation.</li> </ol>	<ol style="list-style-type: none"> <li>1. Administrative costs only such as copying or faxing documents. (\$50)</li> </ol>
Summer 2012	<ol style="list-style-type: none"> <li>1. Committee approval of the project.</li> <li>2. IRB Approval</li> <li>3. ADBS questionnaire digitalized for use on laptop computer</li> </ol>	<ol style="list-style-type: none"> <li>1. Administrative costs to transfer the quiz into electronic format. (\$50)</li> <li>2. Office space at health department (no anticipated cost)</li> <li>3. Time to administrator (12 hours weekly)</li> <li>4. Telephone to contact patients at the six-week follow up time.</li> </ol>
Fall 2012	<ol style="list-style-type: none"> <li>1. Pilot the ADBS tool in electronic format with five non-patient participants</li> <li>2. Use of the ADBS tool for thirty days</li> <li>3. Six week follow-up data.</li> <li>4. Review of charts prior to initiation of the ADBS tool.</li> <li>5. Analysis of findings.</li> </ol>	<ol style="list-style-type: none"> <li>1. Time to administrator (32 hours weekly for four weeks.)</li> <li>2. Statistical assistance with interpretation of data.</li> </ol>
Spring 2013	<ol style="list-style-type: none"> <li>1. Evaluate goals &amp; objectives.</li> <li>2. Complete final written report for submission.</li> </ol>	<ol style="list-style-type: none"> <li>1. Complete professional poster and PowerPoint for presentation to capstone chair, committee and University community. (\$100)</li> </ol>

### **Summary**

In summation, nine participants consented to participate in the project and completed the online survey tool without technical difficulty or emotional distress noted. No participants contacted the project administrator, the committee chairperson, or the contact person for the IRB to ask for removal of data from the project. Subsequently, nine medical records were reviewed and compared with the project participant group in two areas: (1) their reported pregnancy resolution decision reported to the staff person from the health department at the time of the visit and (2) the reported resolution decision reported at the six-week follow-up interval.

## CHAPTER IV

### Results

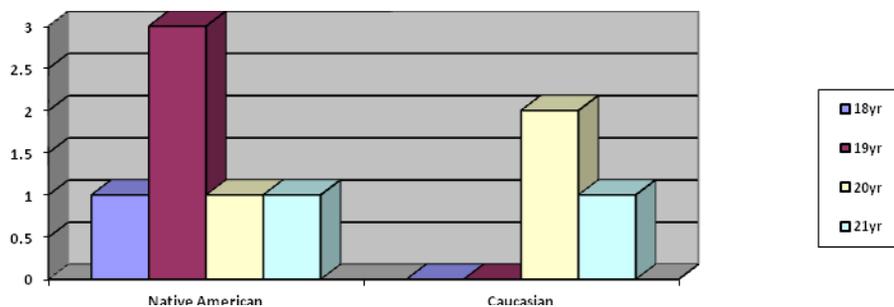
Data reported includes results from three groups: the pilot group, the project participants, and the medical record review group. It includes demographic information, length of time to complete the survey, time the participant was aware of their pregnancy, estimated weeks of gestation, and ADBS scores.

#### Pilot Group

Five participants (n=5) completed the online survey as the pilot test group. The average age of the participant was 18.5 years of age. Three participants identified themselves African-American and two were Caucasian. Mean time to complete the survey in the pilot group was 14 minutes, with a range of five minutes to nineteen minutes.

#### Project Participants

At the health department site, the number of participants for the study was nine (n=9). Of these nine participants, six were Caucasian, and three identified themselves as being of Native American descent (Figure 3).



*Figure 3.* Comparison of project participants by age & racial demographics

Twenty-three patients in total were asked to participate, however 14 either declined or were ineligible due to lack of an available parent to consent for participation. Of those who did consent, the mean age was 19 years, two months.

Three participants had no prior knowledge of their pregnancy prior to the visit to the health department. Within the other six participants, three participants had known they were pregnant for less than one week, two for less than one month, and one participant had known of her pregnancy for more than one month.

Estimates of gestation were based on the patient's last normal menstrual period. Six participants estimated themselves to be within four to eight weeks gestation. One estimated herself to be between nine and twelve weeks gestation. One participant estimated herself to be greater than 16 weeks gestation, and one participant chose the 'I have no idea how far along I am' option on the survey.

The mean of the nine participants at the health department for tool completion was six minutes, 39 seconds. The survey was offered to both groups (pilot group and participant group) on a laptop computer with high-speed internet accessibility. Pro-Continue versus Pro-Abort scores for each participant are shown in Figure 4.

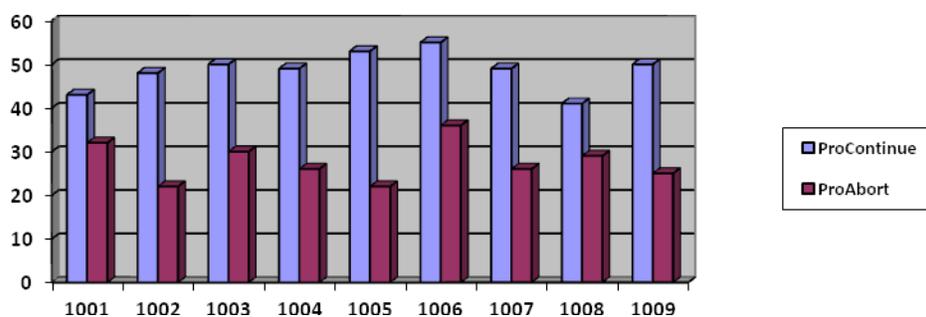


Figure 4. Pro-Continue versus Pro-Abort scores in project participant groups

Measure of central tendencies, mean, median, and mode in the “ProContinue” and “ProAbort” show that more persons want to continue their pregnancy than abort. Nearly twice as many people stated their plan was to continue their pregnancy than abort. In the measures of dispersion variance and range, the dispersion between the choices are nearly identical. Thus, the variation in willingness in both “ProAbort” and “ProContinue” is almost the same. Again the measure of skewness showed that “Procontinue” is symmetric (measure of skewness = 0) but “ProAbort” is positively skewed (measure of skewness = 0.612). No statistically significant difference was found in survey scores or eventual pregnancy resolution decision when compared by age or race.

Of the nine participants, eight reported to the health department staff person their intent to continue the pregnancy. One participant reported to the staff person their intent to terminate the pregnancy. Survey results correlated to their reported intent to the health department staff person in all of the participants, except one participant. However, the degree of difference in Pro-Abort versus Pro-Continue scores for this particular participant was also the smallest, suggesting the most amount of ambivalence.

At the six week telephone follow-up with the nine participants, six reported enrolling in prenatal care with a local healthcare provider. Two participants reported terminating their pregnancies, and one participant had not made a pregnancy resolution decision.

Three ‘ProContinue’ and one ‘ProAbort’ questions were identified as having 100% congruence within the complete set of participants.

#### Pro-Continue

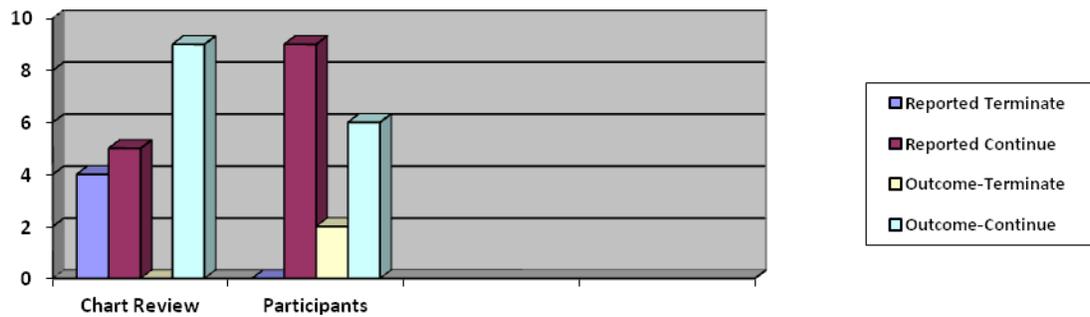
- I am ready for the changes that would happen in my life if I have a baby right now.
- I think of the pregnancy as a baby already.
- I know I would be a good mother now.

#### Pro-Abort

- I believe that it is my right to choose when or if I have a child.

### **Chart Review Group**

Nine records were pulled randomly from patients in the same age range who had presented to the health department for pregnancy counseling prior to the initiation of the ADBS tool. The mean age of the patients in the control sample was 17 years, 8 months. Ethnicity of the patients varied, with three were self-identified as African-American, one Hispanic-American patient, three Caucasian, and two Native American. Five reported to the health department staff member their intent to continue the pregnancy, while four reported intent to terminate the pregnancy at their first visit when the pregnancy test was reported. However, all nine patients reported at follow-up telephone visits that they had enrolled with a local prenatal care provider. Comparison of the reported resolution plan and the reported resolution at six weeks is summarized in Figure 5.



*Figure 5.* Comparison of reported resolution plan and reported resolution with chart review group and participant groups

### Summary

Since p-value associated with both “ProContinue” and “ProAbort” is  $<0.05$ , the null hypothesis is rejected and secondly, the results conclude that the means of both the groups are significantly different from 0. Hence, there was not an observed statistically significant difference in the reported pregnancy resolution outcome between the groups who did or did not complete the online survey tool.

## **CHAPTER V**

### **Discussion**

For an adolescent female, determining the outcome of a pregnancy is not a decision made in isolation. Decreasing ambivalence regarding the pregnancy was proposed to aid in the pregnancy resolution decision with the use of the ADBS tool. With the consistently high rates of unplanned pregnancies in the adolescent population, interventions that facilitate decision making in this age group are vital.

### **Implications of Findings**

While there was positive correlation between the participant group and the medical records review group between their reported decision and eventual decision, this difference was not found to be statistically significant, most likely due to the small sample size.

In comparison of these findings to earlier findings presented by Dr. Allanson with the original ADBS tool, fewer women in this project chose to terminate their pregnancy. However, the tool has been only administered twice, both times in clinics which provided termination on-site. The tool has, to date, not been tested in sites which offer pregnancy counseling on all available options.

The participants completing the ADBS tool showed moderately high levels of ambivalence as measured by the ProContinue versus the ProAbort score. Only two participants showed statistically significant low ambivalence. Yet all reported confidence in their decision making at the time of counseling. Perhaps this high level of ambivalence is due to this particular sample group, validity of the modified ADBS tool, or a product of the developmental stage of adolescence.

Qualitatively, participants reported the tool was easy to understand and helpful in their pregnancy resolution decision-making process. Future work with this tool would incorporate an in-depth interview at the six week follow-up contact to measure their perception of assistance from the tool itself. In addition, the tool could be readministered at the six week follow-up visit to assess tool reliability. Questions would measure how much ambivalence was reduced, comfort increased, and their perceptions on other tools and methods that would assist in the pregnancy resolution decision.

### **Application to Theoretical/Conceptual Framework**

Roy's framework of adaptation was offered as a theoretical model for pregnancy resolution decision making in four spheres: physiologic/physical, self-concept, interdependence, and role function. Each question asked in the survey was classified into one of these four areas. Continued modification of the survey tool, factor analysis of the tool, and increased sample size should delineate which questions were more statistically significant in the eventual pregnancy resolution decision. Once these are identified, then counseling options and adaptations of the tool could be geared to the spheres of influence most critical to the adolescent age group.

### **Limitations**

The generalizability of the findings is extremely limited due to the sample size of nine participants. The age of the participants was in the latter range of adolescence and young adulthood. Including more young participants would have led to a stronger sample. Advocating for waiver of parental consent might have garnered participants aged 13 to 17.

Following completion of the survey, most participants reported little ambivalence about their pregnancy-resolution decision. They reported simply getting the pregnancy test performed at the health department as a ‘proof of pregnancy’ for other public agencies such as WorkFirst, WIC, and Medicaid offices. Establishment of reliability and validity of the tool will be necessary for continued use.

### **Delimitations**

The major delimitation to the project was the established timeframe for enrollment of participants. This was a planned restriction of the scope of the project due to the lack of time and resources.

### **Implications for Nursing**

While nurses are considered one of the most trusted professional groups in the United States, data from the literature review demonstrated adolescents still fear breeches in confidentiality and may not report their pregnancy resolution decisions to their nurse or healthcare provider (Perruchi, 2012). Nurses, particularly advanced practice nurses, must be aware of internal bias, promote all options for pregnancy resolution, and maintain practices that assure patients of confidentiality.

The rate of unintended adolescent pregnancy, while showing recent decreases, still calls for any and all available counseling methods. A comprehensive literature review identified no electronic applications of counseling tools which reviewed all options. While there were many electronic applications that promoted continuation of the pregnancy, none identified termination or adoption as a primary means of pregnancy resolution. Development of user friendly graphic electronic tools geared toward the

adolescent and young adult female should be available with smart phone technology in today's market.

Replication of this study with a larger sample size including varying levels of socioeconomic status, ethnicity, support status, age, gravidity, relationship with father of the baby (FOB), access to prenatal care on site, access to written information or electronic information on site, and varied literacy levels would further refine and strengthen future work. Qualitatively, a follow-up study to ascertain differences in cognitive processing for adolescents/young women completing an electronic survey versus no survey for decision making skill, would contribute to nursing knowledge.

Nurses, in all levels of practice are called to be advocates for health policy. Allocation of state or federal funds, or grant money, geared toward development of technological advances, such as smart phone applications, would expand the knowledge base of decision-making for adolescents. This would not only aid adolescents in pregnancy resolution decisions, but empower and educate them on the goals of family planning in general. Translation of this work into other languages, as well as inclusion of other culturally appropriate languages, would add to the strength of these tools for a broader, diverse population of young women.

Translation of a tool into an electronic application is not necessarily cost-prohibitive, and can likely be done for less than one thousand dollars. (Miller, personal communication, March 7, 2013). However, many electronic applications do not include tracking software or support after the application is used. Ethical development of this type of electronic application would need to include references to agencies that could provide professional counseling and appropriate referrals.

## **Recommendations**

Future implications for nursing practice include analysis of barriers to pregnancy testing at the site where the project was implemented. The county ranks second highest in the state for the rate of adolescent pregnancies, yet very few patients under the age of 18 made appointments at this site. No patients under the age of 18 presented with a parent or legal guardian, while most patients older than 18 presented alone.

Though no participant withdrew from the survey, in future studies, the project administrator would decrease the number of questions to those questions that were found with the most statistical significance to the pregnancy resolution decision following factor analysis. This would facilitate the development of tool validity. .

The author would also repeat the study in other settings such as primary care practices or school health sites. Repetition of the study in a rural health care agency that provides prenatal care on-site for its patients would also be recommended. Once statistically significant data is gathered on the most critical criteria for decision-making, the tool could be formatted into an electronic application.

## **Conclusion**

Determining the outcome of a pregnancy requires adaptation with immediate and long-term sequelae. Any assistance that can be easily and ethically provided to an adolescent facing a pregnancy resolution decision should be shared in a format that provides ease of understanding as well as confidentiality. Reducing ambivalence in the decision making process by an objective means should facilitate women in their pregnancy decision making.

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## Appendix A

### Permission for Use of ADBS Tool

## Use of ADBS Tool

Dear Dr. Allanson-

Greetings! I am a nurse practitioner in rural North Carolina, and in the preparation stages of my doctoral project at\_\_\_\_\_. I am writing to ask permission to use and/or modify your Abortion Decision Balance Sheet in my capstone work. The tool would be administered to adolescents (ages 13-19) at the time of their pregnancy counseling visit, and follow-up to mandated pregnancy outcome counseling they already receive. I plan to compare the survey results to their eventual outcome decision.

I would be glad to share my results with you after the work is completed, and credit you with the original work.

Sincerely,  
Michelle Taylor Skipper

Saturday, May 12, 2012 11:11 PM

Hi Michelle,

Pleased that it may be of use. I would be delighted for you use it. I'd also be interested in your results. I understand that in some parts of US it is quite difficult for women to access abortion and contraception.

All the best with your research.

Kind regards,

Susie Allanson

## Appendix B

## Modified ADBS Tool

Q1 I am \_\_\_\_ years old today.

Q2 I consider myself:

- American Indian and Alaskan Native (1)
- White or Caucasian (2)
- Hispanic (3)
- Black or African-American (4)
- Native Hawaiian or other Pacific Islander (8)
- Asian (7)
- Multi-racial (5)
- Other (6)

Q3 When did you find out that you were pregnant?

- Just now during this visit to the health department (1)
- Less than one week ago (2)
- More than one week ago (3)
- More than one month ago (4)

Q4 I am supposed to be about \_\_\_\_\_ weeks pregnant.

- 4-8 weeks pregnant. (1)
- 9-12 weeks pregnant (2)
- 13-16 weeks pregnant (3)
- More than 16 weeks (4)
- I have no idea how far along I really am. (5)

Q5 The following questions will ask about some of your thoughts or beliefs about your current pregnancy. Please click on one choice per line. If you are not sure, you can leave it blank or ask the project administrator there with you to help you with what some words may mean.

Please think about this pregnancy and your beliefs now. Please answer the following questions based on those beliefs. Thank you for taking the survey.

Other people in my life would deal with it if I keep this pregnancy. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am ready for the changes that would happen in my life if I have a baby right now. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The relationship with the father of my baby is good. I believe he is willing to help me. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have enough money to have a child right now. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do want a child, now or in the future (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This might be the last chance I have to get pregnant. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other people say I should keep this pregnancy. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm scared that if I end this pregnancy I might not be able to have babies in the future. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ending this pregnancy would complicate the relationship I have with the baby's father.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>(9) I'm scared that ending this pregnancy might damage my emotions. (10)</p>	○	○	○
<p>Ending this pregnancy is against my beliefs. (11)</p>	○	○	○
<p>I know women who ended a pregnancy and they felt really bad that they did it. (12)</p>	○	○	○
<p>I think of the pregnancy as a baby already. (13)</p>	○	○	○
<p>I know I would be a good mother now. (14)</p>	○	○	○
<p>I already have some good feelings about being pregnant. (15)</p>	○	○	○
<p>I'm scared that ending this pregnancy might mess up my body physically. (16)</p>	○	○	○
<p>I have ended a pregnancy in the past which was a bad experience. (17)</p>	○	○	○
<p>I know women who are single mothers and making it OK. (18)</p>	○	○	○
<p>Women who are close to me are trying to get pregnant or are already pregnant. (19)</p>	○	○	○
<p>Other people already know that I am pregnant. (20)</p>	○	○	○

Q6 In thinking about this pregnancy, I believe that:

Other important people in my life would be hurt if I keep this pregnancy. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not deal with the changes in my life of having a baby right now. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My relationship with the father of my baby is complicated or new. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't have enough money to have a baby right now. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't ever want children. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm too young to have a child. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other people say I should end this pregnancy. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am really scared of childbirth. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keeping the pregnancy would put my relationship with my baby's father at risk. (9)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know that the way doctors end a pregnancy is safe. (10)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I believe that it is my right to choose when or if I have a child. (11)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I know women who have ended a pregnancy and done well. (12)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
This pregnancy is not a real baby yet. (13)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I'm worried that I would not be a good mother now. (14)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I think that there is something wrong with this pregnancy. (15)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am afraid of the pain of having a baby. (16)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't want to be involved with the father of my baby anymore. (17)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would be a single mother. (18)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Keeping the pregnancy would interfere with my career, job, study or future plans. (19)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I don't want other people to know that I am pregnant. (20)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q7 Please type in the personal identification code (the PIN Number) given to you by the researcher.

## Appendix C

### Assent and Consent Forms

#### Assent Form

**Project Title:** Pregnancy Resolution Counseling with Adolescents

**Investigator:**

**Project Administrator:**

My Name Is: \_\_\_\_\_

#### What Is This About?

I would like to talk to you about your thoughts on being pregnant. We are doing a project using a computer survey to learn about decision-making for teenagers who are pregnant. We hope to help nurses learn more about teenagers and decision-making.

#### Did My Parents Say It Was Okay?

Your parent or legal guardian has said it is okay for you to help us learn about decision-making and has signed a form that is like this one.

#### Why Me?

We would like you to help us with our project because you are a female who has a positive pregnancy test. You are between 13 to 17 years old.

#### What Will I Have to Do?

We would like you to complete one computer survey today and to be available in six weeks for one telephone call.

#### What If I Want to Stop?

You do not have to say “yes”, if you do not want to do this. The health care you receive or the way people treat you will not change if you say “no”. Even if you say “yes” now and change your mind after you start the project, you can stop and nothing will change related to your health care or the way people treat you. The help that you get from the health department or social services will not be changed based on any decision you make related to the project.

#### Will Anything Bad Happen to Me?

There is very little risk or harm involved in this project. You may experience anxiety or stress related to the questions of decision-making and people in your life that support you, but this risk

is no more risk than everyday life. A referral to your primary health care provider, social worker, or a therapist will be provided to you if you appear to need it or if you request the referral.

### **Will Anything Good Happen to Me?**

You may learn about decision-making, your environment, and people who support you which may help you make decisions about this pregnancy. The information may be useful in creating programs that help teenagers.

### **Will I Get Anything for Being in the Project?**

This will not cost you or your parent(s) any money. You will not receive any money or gifts for participating.

When we are done with the project, we will write a report about what we found out. We will not use your name in the report. Your name or any identifying information about you will not be used in this project. You can ask questions at any time. You can talk to me or you can talk to someone else at any time during the project. Here are the telephone numbers to reach us:

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(Principle Investigator Name)	Phone Number	E-mail address
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(Project Administrator Name)	Phone Number	E-mail address
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If you want to be in this project, please sign your name.

I, \_\_\_\_\_, want to be in this survey project.

(Print your name here)

\_\_\_\_\_

(Sign your name here)

\_\_\_\_\_

(Date)

## Parental Consent Form

**CONSENT FOR A MINOR TO ACT AS A HUMAN PARTICIPANT: LONG  
FORM**

Project Title: **Pregnancy Resolution Counseling with Adolescents**

Project Director:

Participant's Name: \_\_\_\_\_

**What is the project about?**

This is a doctoral capstone project. Your child is being asked to take a computer survey about decision-making related to their pregnancy. We hope to describe the way teenagers make decisions. We also hope to describe the way the environment and support impact decisions.

**Why are you asking my child?**

Finding out you are pregnant can be a big adjustment. This project will look at your child's thoughts and beliefs about being pregnant. We would like your child to take part in this survey because she is a female who has a positive pregnancy test, between 13 and 17 years of age.

**What will you ask my child to do if I agree to let her be in the project?**

Your child will be asked to fill out three surveys that will take about 15 minutes. This survey will ask questions about decision-making, environment, and support. Your child will also complete one form with personal information.

**What are the dangers to my child?**

There is little to no risk to be in the project. Your child might have anxiety or stress. This risk is no more than everyday life. Your child will have the contact information for the project administrators if she feels anxiety or stress. If she requests it or if the project administrator feels she needs it, she will be referred to her primary health care provider, social worker, or a therapist.

If you have any concerns about your child's rights or about how she is being treated, please contact \_\_\_\_\_ at the Institutional Review Board at \_\_\_\_\_. Dr. \_\_\_\_ can also be

contacted if you have questions, suggestions, or want more information. Questions can be answered by \_\_\_\_\_. She may be contacted at \_\_\_\_\_.

**Are there any benefits to my child as a result of participation in this project? Are there any benefits to society as a result of my child taking part in this project?**

Your child may learn about her decision-making, environment, and people who support her. The findings of this project may give us information about teenagers' decision-making. The information may be useful in creating programs that help teenagers. By doing so, we hope to improve health for teenagers.

**Will my child get paid for being in the project? Will it cost me anything for my child to be in this project?**

This will not cost you or your child any money. You will not receive any money or gifts for participating.

You can talk to me or you can talk to someone else at any time during the project. Here are the telephone numbers to reach us:

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(Principle Investigator's Name)	Phone Number	E-mail address
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(Project Administrator's Name)	Phone Number	E-mail address
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**How will my child's information be kept confidential?**

Information will be kept in a locked file cabinet. Computer data will be password and firewall protected. Your child's name will be not being written on the surveys. At the end of the project, the results will be written in a report. A copy of the findings can be given to you and your child. Her name will not appear in the project. All information gathered in this project is confidential unless disclosure is required by law.

**What if my child wants to leave the project or I want her to leave the project?**

You have the right to choose not to allow your child to participate. You may pull her out of the project at any time without penalty. If your child does withdraw, it will not affect you or your child in any way. If you or your child chooses to pull out of the project, you may ask that any data that can identify your child be destroyed.

**What about new information/changes in the project?**

If important new information about the project which may change your decision to allow

your child to continue to be in the project become available, this information will be given to you.

**Voluntary Consent by Participant:**

By signing this consent form, you are agreeing that you have read it or it has been read to you. You fully understand the contents of this document. You consent for your child to take part in this project. All of your questions about this project have been answered. By signing this form, you are agreeing that you are the legal parent or guardian of the child who wishes to be part of this project.

\_\_\_\_\_

Date: \_\_\_\_\_

Participant's Parent/Legal Guardian's Signature

Consent Form: Long Form for Participants over Age Eighteen

## CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

**Project Title:**                **Pregnancy Resolution Counseling with Adolescents**

**Principal Investigator:**

**Project Administrator:**

Participant's Name: \_\_\_\_\_

### **What is the project about?**

This is a project about decision-making in pregnancy. We hope to learn about the way teenagers make decisions when they find out they are pregnant.

### **Why are you asking me?**

Finding out you are pregnant is a big adjustment. This project will look at your thoughts and beliefs about being pregnant. We would like you to help us with our project because you are a female who has a positive pregnancy test. You are between 18 and 21 years old.

### **What will you ask me to do if I agree to be in the project?**

You will be asked to complete a computer survey that will take about 15 minutes. The survey will ask you questions about decision-making, environment, and support. You will need to be available for a telephone call six weeks following the survey.

### **What are the dangers to me?**

There is little to no risk to be in the project. You may feel anxiety or stress. These risks are no more than everyday life. You will have the contact information for the project administrator if you feel anxiety or stress. If you request it or if the project administrator feels you need it, they will refer you to your primary health care provider, social worker, or a therapist.

If you have any concerns about your rights or about how you are being treated, please contact Dr. \_\_\_\_\_ of the Institutional Review Board at \_\_\_\_\_.

### **Are there any benefits to me for taking part in this project? Are there any benefits to society because of me taking part in this project?**

You may learn about your decision-making, environment, and support. The project may help other teenagers in the future. The findings may tell us about teenagers' decision-making. The information may be useful in creating programs that help teenagers.

**Will I get paid for being in the project? Will it cost me anything?**

There are no costs or payments to you for being in this project.

You can ask questions at any time. You can talk to me or you can talk to someone else at any time during the project. Here are the telephone numbers to call us:

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(Principle Investigator Name)	Phone Number	E-mail address
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(Project Administrator Name)	Phone Number	E-mail address
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**How will you keep my information confidential?**

Information will be kept in a locked cabinet. Computer data will be password and firewall protected. Surveys will not include your name. At the end of the project, the findings will be written in a report. A copy of the report can be given to you. Your name will not appear in the project.

**What if I want to leave the project?**

You have the right to choose not to be in the project. You may stop (or withdraw) at any time. The care you receive or the way people treat you will not change based on your decision to participate in the project. If you do withdraw, it will not affect you in any way. If you choose to pull out from the project, you may ask that any of your data that can identify you be destroyed.

**What about new information/changes in the project?**

If important new information about the project that may affect your choice to be in the project becomes available, this information will be provided to you.

**Voluntary Consent by Participant:**

By signing this consent form, you are agreeing that you have read it or that it has been read to you. You fully understand the contents of this document. You are openly willing to consent to take part in this project. All of your questions concerning this project have been answered. By signing this form, you are agreeing that you are 18 years of age or emancipated. You are agreeing to participate in this project described to you.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I am 18 years of age or older.

Yes  No

or

I have emancipation status and have shown the legal document from North Carolina to the project administrator prior to the project.

Yes  No