

THE EXPERIENCES OF PREGNANT ADOLESCENTS

**A QUALITATIVE INVESTIGATION OF THE EXPERIENCES OF PREGNANT
ADOLESCENTS: DYNAMICS OF CONTROL AND RESISTANCE**

By

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Abstract

This research examines experiences of control and resistance during adolescent pregnancy. The research consisted of in-depth interviews with eight pregnant adolescents in Southern Ontario. The study shows how young women experiencing early pregnancy encounter a loss of control due to the structural and cultural barriers to independence which exist in a patriarchal society. They lack structural power in the form of money and knowledge and lose cultural power through stigmatization and the physical changes associated with pregnancy. It further demonstrates how young women respond to this loss of control. Specifically, they not only react with resignation, but also with evasion, manipulation and active resistance in the attempt to gain personal power.

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CHAPTER ONE: INTRODUCTION

Adolescent pregnancy has been a continual concern in North American society for the past century. At the government level, concern is expressed over the cost of young parenthood to society and the provision of specialized programs for young mothers. At the societal level, concern is raised over the promiscuous behaviour of young women and their ability to care for their children.

Pregnant and parenting teenagers exist in a patriarchal society. Within it, they act as a challenge to societal values around femininity and family. They have broken norms regarding female sexuality as their pregnancies demonstrate their participation in premarital sexual activity. They have also broken cultural norms regarding family and reproduction. They have begun families which lack a father/husband and they are children at the same time that they are parents.

As a result of challenging these customs, they are subject to social disapproval in various forms. Sociological, psychological and social welfare literature, social service

and health policies and programs for pregnant and parenting adolescents all tend to approach adolescent pregnancy as a problem in need of control. Pregnant teenagers exist on the other side of this social activity. They live in a world where their behaviour and very presence are seen as problematic and where they are constantly supervised.

I was led to this area as a result of working with pregnant and parenting adolescents in a residential care facility. My experience with programs which did not meet the needs of the young women who were using them initiated the desire to begin research in this area. My disappointment with the "objective" and judgemental nature of the literature furthered this desire. Previous literature has failed to look at adolescent pregnancy from the perspective of the pregnant teenager. This led to the desire to find out, in a more qualitative manner, what the experience of being young, single and pregnant in our society was like.

I wanted to use a grounded theory approach to develop an understanding of how pregnant teenagers view their situation. Initially, my plan was to examine the love/hate relationship which a pregnant teenager has with her body during and after pregnancy. I was interested in learning more about how she experiences the pregnancy and the necessary identity challenges such an experience brings. My initial interviews were directed in this area. Very quickly I began

to find that the young women with whom I was speaking could not restrict their discussion to their perceptions of and presentation of their bodies alone. They began talking about their more general experiences of being young and pregnant. Through the discussions we were having, the issue began to move away from the body in general toward a focus on the body in terms of the specific issues of control, resistance and struggles for independence. The common themes which evolved from their discussions showed how their reactions to their bodies fit into a larger theoretical framework. The experiences of these young women are grounded in a patriarchal society which seeks to control young women and maintain their dependence. These women reflect a triple jeopardy in this context; young, female and pregnant.

The young women interviewed saw their own situations as problematic. This appeared to be not so much due to the fact that they were young and pregnant, but more a result of negative societal assessment. The organizations in which they participated restricted them and obstructed their success. They were prevented from attending their usual schools because of a lack of day care facilities and the inflexibility of educational programs. They were economically penalized and lacked support for their position. They felt that they faced the world alone; surrounded by hostile strangers and judgemental friends. They desired acceptance.

This thesis takes a new look at teenage pregnancy. It examines the issues of control experienced during adolescent pregnancy and teenagers reactions to this control in terms of both its structural and cultural manifestations. It shows how young pregnant women lose control to others and experience a loss of control over their own bodies. Further, it looks at how they respond to this loss of control with attempts to regain power over their own destinies.

Chapter two provides an integration of two bodies of literature related to this research. First, literature from the sociology of the body is examined. This literature sets up the theoretical framework for my analysis. It looks at the social control of women and women's social experiences of pregnancy. In particular, it looks at the role of beauty ideals in the social control of women and the medicalization and objectification of pregnancy. Pregnant teenagers are subject to social control as a result of their subordinate position in society. In particular, as females in a patriarchal society they are subjected to societal restrictions regarding standards around femininity and sexuality. This literature aids our understanding of the various processes which restrict young women's activities in our society.

The literature on adolescent pregnancy is examined in light of this theoretical position. Research on adolescent

pregnancy is situated in the context of a patriarchal society where teenage pregnancy is regarded as a moral transgression. The literature in this area accepts the societal definition of adolescent pregnancy as a social problem. Sociological studies tend to concentrate on identifying causal variables, evaluating the effects of adolescent pregnancy and suggesting policy and prevention strategies for managing female sexuality. This literature fails to look at adolescent pregnancy from the point of view of the teenager and, as a result, falls short of developing a complete understanding of the issues involved in early childbearing.

Chapter three provides a more detailed discussion of the methodology. As so little is actually known about how pregnant teenagers view their own situations, the research presented here attempts to examine the experiences of pregnant adolescents, as described in their own words, from their own social position. To this end, I conducted in-depth interviews with eight young women who were pregnant at the time of our discussions. As a result, quotations used throughout this work are not necessarily grammatically correct, as I have attempted to maintain the individual personalities of the young women who shared their stories.

Chapter four presents the issues of control faced by young pregnant women. It looks at the various ways in which they lose control or perceive a loss of control over their own

bodies and lives. This chapter examines the various ways in which these young women experience a loss of control. These include social monitoring, control of knowledge and information, and control of resources. As well, this chapter examines the loss of control related to changing, pregnant bodies.

The various attempts young women make to regain control are reviewed in chapter five. The analysis explores the reactions of resignation and evasion which they use to minimize the negative sanctions they experience. Further, the chapter will examine the more active reactions of manipulating others, resisting others and planning for the future.

Finally, chapter six provides a general discussion of the issue of adolescent pregnancy in light of the present research. Concluding remarks are presented. As well, the implications for future research are explored and policy recommendations for adolescent pregnancy programs are made.

The examination of adolescent pregnancy needs to move away from the study of incidence, causation and consequences. A critical examination of adolescent pregnancy needs to take place which looks at the conceptualization of the issue and the position of pregnant teenagers within the larger society. As researchers, we need to refocus our attention to examine how and why we problematize adolescent pregnancy rather than add to the material which stigmatizes these members of our

society. This process begins with the experiences of teenagers who are pregnant.

The value of this research is in its ability to act as a snap shot; to look into the lives of young women experiencing pregnancy. This is an important contribution to the existing literature. It serves as a reference for continual research in this area, it adds the experience of young pregnant women to the bulk of analytical information already available and it encourages future research to include the experience and knowledge of the young women that are being studied.

CHAPTER TWO: LITERATURE REVIEW

Two bodies of literature are relevant to the study of adolescent pregnancy. The first is literature which deals with the control of women and their bodies and women's experience of this control during pregnancy. The second is the vast amount of research on adolescent pregnancy. This review will cover both areas in the attempt to develop an understanding of the numerous processes influencing the social experience of pregnant adolescents.

The literature on the social control of women and women's experiences of pregnancy explains the social processes surrounding these young women in their daily lives: beauty standards, norms regarding body shape and size, the medicalization and objectification of pregnancy, and the challenges to identity experienced in pregnancy. This is important to aid our understanding of the way the young women in the present research feel about their bodies in a social context. It also helps develop an understanding of their place within our society.

The literature on adolescent pregnancy reflects

societal concerns regarding adolescent pregnancy and reviews the causal factors, effects and outcomes of early childbearing. This research reflects our societal conceptions of adolescent pregnancy as problematic and marks a starting point for this research. It is important to compare women's own experiences as pregnant adolescents with the existing research findings.

PART I: WOMEN, CONTROL AND THE EXPERIENCE OF PREGNANCY

It is impossible to complete an analysis of pregnant adolescents' experiences without recognizing their social position as women in our society. A growing body of literature identifies the control of women in patriarchal societies. This review will touch on this research in an attempt to identify the ways in which women exert control over and lack control of their bodies. This work is important to the area of adolescent pregnancy as adolescents are particularly vulnerable to social control after just going through a period of physical readjustment with their bodies. They may still feel out of control. As well, pregnant adolescents have already experienced a major loss of control over their physical bodies as they may regard the pregnancy itself as a betrayal by their bodies. This review will look specifically at control relating to women and femininity and

the social controls around pregnancy.

Social control can be defined as the ways in which society

responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable in some way or another (Cohen, 1985: 1).

The response may come in terms of punishment, deterrence, treatment, prevention, segregation, justice, rehabilitation, reform or societal defence. Women, historically have been categorized as deviant, problematic, etc. and have been subjected to various forms of social control within patriarchal society.

Green, Hebron and Woodward (1987), in an analysis of leisure as an arena of social control, define the social control of women "as an on-going process, one element in the struggle to maintain male hegemony which sets the limits of appropriate feminine behaviour". They note that women's negotiations and choices take place within a framework of material and ideological constraints, including economic dependence and behavioural ideals created along gender lines. In terms of the manifestation of this control, we can think of a continuum which varies from non-coercive social control, or control through consent, to actual physical violence.

"Control by consent" is most clearly described by research on the social construction of femininity and the creation of disciplined and docile bodies through the pursuit of feminine ideals. The literature identifies the various ways in which female bodies and female sexuality are controlled through a system of ideals.

The body, according to Susan Bordo (1989), is "a medium of culture." It is a representation of our cultural rules, in the form of practical daily rites and rituals, particularly rules regarding gender. At the same time, the body is also a direct subject of social control. It becomes habituated to the rules of cultural life so that culture becomes represented in the physical. The discipline and normalization of the female body is regarded historically as one of the most persistent and flexible strategies of social control.

Through the pursuit of an ever-changing, homogenizing, elusive ideal of femininity--a pursuit without a terminus, a resting point, requiring that women constantly attend to minute and often whimsical changes in fashion--female bodies become what Foucault calls "docile bodies..." (Bordo, 1989: 14).

Women become restricted through their adjustment to external regulation, subjection, transformation, and "improvement." Through the normalizing and time consuming processes of diet,

make-up, and dress women become "less socially oriented and more centripetally focused on self-modification" (Bordo, 1989: 14).

Sandra Lee Bartky (1988) in an examination of the modernization of patriarchal power, identifies three categories of disciplinary practices through which the feminine body is produced. The first category aims at the production of a body of certain size and shape. The ideal body is "taut" and "slim." Massiveness, power or abundance are met with distaste. The second category concentrates on the mastery of a "specific repertoire of gestures, postures and movements" which transmit constriction, grace and a modest eroticism all at once. The final category directs the display of the female body "as an ornamented surface." Feminine embodiment is achieved through skin care, hair care and the mastery of make-up application and clothing selection.

The result of these disciplinary practices is the construction of the feminine body, an institutional ideal, a "spectacle" in which most women are required to participate. In everyday practice, these restrictive ideals turn into a preoccupation with looks and presentation. Bordo (1990) indicates that concern with fat, diet and slenderness are the norm for women.

Indeed, such preoccupation may function as one of the most powerful "normalizing" strategies of our century, ensuring the production of self-monitoring and self-disciplining "docile bodies," sensitive to any departure from social norms, and habituated to self-improvement and transformation in the service of those norms (85).

She provides an analysis of the contemporary preoccupation with slenderness as it functions within a modern, "normalizing" machinery of power in general, and, in particular, as it functions to reproduce gender relations. Images of unwanted bulges and erupting stomachs act as a metaphor for anxiety about internal processes out of control, uncontained desire, unrestrained hunger, and uncontrolled impulse (89). The ideal is a body that is contained, firm, and seemingly protected against eruption from within, indicating that internal processes are under control.

Body size is morally coded in our society, indicating the individual's capacity for self-containment and self-control. The body indicates one's social identity and place, with the firm body as a symbol of "correct attitude." While showing that the individual cares about oneself, the "fit" body indicates willpower, energy, and the control over impulse (94-95). Fat is indicative of laziness, lack of discipline, unwillingness to conform, and absence of all managerial abilities that confer upward mobility.

With regard to women in particular, the slender body is a metaphor for the correct management of desire and hunger. Female sexuality is in need of control or management in patriarchal society and the control of women's hunger indicates the control of this impulsive female sexuality.

Importantly, however, women themselves may experience these processes in the opposite manner. The slender body may symbolize not social control, but the liberation from a domestic, reproductive destiny. Soft body parts symbolize helpless infancy and maternal femininity and powerlessness. The androgynous ideal may represent freedom from a reproductive destiny:

taking on the accoutrements of the white, male world may be experienced as empowerment by women...as their chance to embody qualities--detachment, self-containment, self-mastery, control--that are highly valued in our culture. The slender body...symbolizes such qualities (105).

The tightly managed body has been held up as the contemporary ideal of specifically female attractiveness. It is this experience which lends women's consent to the process of control.

Chapkis (1986), in an analysis of women and standards of beauty, explains the relationship between body image and social control:

Among women, feeling fat, like feeling out of shape, has long been a metaphor for feeling powerless. Dieting and fitness training can be seen as attempts to regain control (13).

She relates that exercising control over the body compensates for the sense of having a life out of control. Taking control of the kind of body image to be presented to the world can be experienced as empowering.

In The Beauty Myth, Naomi Wolf (1991) describes the details of this process. She reports the extremes to which women go to achieve the feminine ideal: cosmetics, liposuction, chemical peels, self-starvation and cosmetic surgery. She notes that "success" is defined according to appearance for women and that the "ideology of beauty" is a last remaining vestige of patriarchal control over women who have achieved relative liberation in modern society. Ideals of beauty act to control not appearance, but behaviour, as the ideals of youthfulness, innocence and sexual ignorance restrict women's independent activity in all areas of life, particularly employment, diet, sexuality, and reproduction.

These conceptualizations are particularly relevant to pregnant adolescents for two reasons. First, their bodies have only recently entered the category of "woman" and they are specifically interested in and concerned with creating an acceptable female image. Second, their pregnant bodies

deviate from acceptable dimensions for young women.

The experience of pregnancy in modern patriarchal society also reflects women's experiences of loss of control. Traditionally, this has been an area where women's bodies and experiences are medicalized and distanced from the individual. Surprisingly little has been researched and written in this area. Although there is a large amount of scientific or "objective" information regarding the biological process of pregnancy, very little exists which examines women's subjective experiences. Recent work on women's experience of pregnancy contributes to our understanding in two ways: the medicalization of pregnancy and women's experiences of self during pregnancy.

First, the medicalization of pregnancy and childbirth and the scientific monitoring of pregnancy have recently been examined in terms of social control. With the evolution of modern medicine, women's bodies have become defined and controlled by medical science. Pregnancy has come to be viewed as a process in need of management, where "normal" equals problematic. The discourse of pregnancy defines pregnancy as a medical problem, in need of assistance, regulation and management (Rothman, 1984).

In Recreating Motherhood, Barbara Katz Rothman (1989) examines "motherhood" in light of new reproductive technologies. Her analysis of the physical relationship in

pregnancy shows that the medical profession does not see fetuses as fundamentally a part of their mothers' bodies, but as "entirely separate beings 'planted' in the mother" (39). She relates how science developed the view that women are actually hazardous to pregnancy through their ability to introduce their fetuses to potentially threatening substances and activities. Rothman states:

Not only are mothers not protective, mothers are a potential source of harm. Babies need protection, not by their mothers, but from their mothers (95).

The result of this was the development of the modern practice of closely monitoring pregnancy. Women began to be assessed and evaluated on a monthly basis regarding their competence as mothers. The focus for healthy fetal development created the need for mother's compliance and willingness to follow the greater knowledge behind doctor's orders.

The list goes on and on. All kinds of things, known and unknown, can harm babies in utero. Mothers must watch themselves. And we all must watch mothers (96).

This is true historically as well as in the modern period which is marked by "reproductive choice." Queniat (1992), in an analysis of the changing concept of "risk" in

pregnancy, asserts that modern developments in the area of risk prevention act to replace more direct forms of control. She notes that the definition of risk in pregnancy historically has shifted from a concentration on risk to the mother to a primary concern with fetal risk. As medical expertise increases, particularly in new reproductive technologies, and as the ability to monitor fetal development increases, concern turns away from the mother to the development of a healthy baby.

This control of the body also means, in a more dubious way, the control of women. Indeed, medical expertise today is no longer strictly centred around the mother but rather around the fetus (170).

With guilt and maternal concern as primary motivators, women's behaviour is even more closely monitored and managed to ensure a positive outcome (Queniart, 1992).

Further, control over knowledge and information about the process of pregnancy and birth are still in the hands of the physician, most commonly male. Iris Young (1990) touches on this issue in her examination of subjectivity and experiences of alienation during pregnancy:

The relationship between doctor and patient is usually structured as superior to subordinate. Physicians often project an air of fatherly infallibility and resist having their opinions challenged (171).

This control tends to devalue the subjective and privileged relationship which a woman has with the fetus and with her own body and results in making the medical evaluation the primary analysis for pregnancy.

Rothman (1989) emphasizes the need to recognize the subjective relationship women have by asserting that pregnancy is a social as well as a physical relationship.

When a baby uses her bladder as a trampoline, the woman responds. She responds not only by making another trip to the bathroom; she responds socially, with annoyance, amusement, irritation, anger, sometimes even with pleasure at the apparent liveliness of the baby, and most often by the end of the pregnancy with a longing to end this phase of the relationship (98).

For Rothman, modern society violates the continuity of pregnancy by allowing men's reality to influence the ideology of reproduction. Our treatment after birth acts as if the baby was delivered from the outside, as if the hospital was the origin of the child, the beginning of life. In reality, social relationships begin before birth for both parents and child.

Emily Martin (1987) in a unique study of women's experiences of their bodies, The Woman in the Body, attempts to gain an understanding of women's reactions to the scientific objectification of their experiences. She sets out

to ask how women see themselves and their society and analyzes the picture of reality they convey when they talk about their experiences of menstruation, childbirth and menopause. She attempts to gain an understanding of the scientific conceptions of women's bodies to see whether or not women's own conceptions reflect an awareness of these ideas and whether they accept or resist them.

Martin concentrates on the language women use when discussing their experiences and found that the central image is: "Your self is separate from your body." Further, the body is seen as something the self has to adjust to, cope with and control. The body sends the self signals. Menstruation, menopause, labour and birthing are viewed as states that the self goes through or as "things that happen to you," rather than actions the self engages in. Physical events, such as labour contractions, are seen as existing outside of, or separate from, the self. She concludes that women's conceptualizations of their bodies and themselves are fragmented and alienated. In particular, experiences of pregnancy and delivery reflect a sense of "passively being done to." The images created in reports describe a "separation of the self and the body."

Martin's discussion on women's resistance to the fragmentation and oppression of their bodies is particularly interesting. She reports that most women do not seem

particularly aware of the underlying fragmentation of their bodies, and that resistance tends to take the form of "a kind of reluctance, a feeling that something is not right, and tortured efforts to reconcile experience with medical expectations" (89). She does, however find some ways in which women express opposition to the oppression. Sometimes women are resigned to accepting that "things just are as they are" and that "nothing can or should be done." Other times women may lament their situation, focusing on "grief, pain or unhappiness, with or without perception of structural factors outside the individual's control." Often, the response is one of non-action: "not participating in an organization, not attending a clinic or not using a term because it is perceived to be against one's interest." Most commonly, Martin saw this manifested in hospital avoidance during early labour:

I had learned my lesson to stay home and move around, instead of at the hospital where they tuck you in bed and you can't move...I learned to stay home with the fourth one. I stayed home until about one o'clock in the afternoon. And then I called my husband at work and said I can't wait any longer, I have to go. He got there at about 4:20 and I had the baby at about 4:30, so it wasn't too long that time. I had learned to wait that time instead of sitting in the hospital (Teresa Cresswell as quoted by Martin, 1987: 186).

More directly, women may become involved in sabotage, in the

attempt to "foil some process or behaviour perceived to be detrimental but intended not to be detected." Martin reports that women would actively break hospital rules during labour. This included eating and drinking when they had been told not to, removing fetal monitors when hospital staff left the room or going for long walks to avoid intrusion. They may further act in resistance, "refusing to accept a definition of oneself and saying so, refusing to act as requested or required." She describes situations where women outrightly refused doctor's advice on pain medication, episiotomy and hysterectomy as well as situations where women publically and privately complained about the medical treatment they were receiving. Finally, women may become involved in outright rebellion, "forcing or persuading other people to change the way they talk or act, beyond the single instances of resistance." Martin characterizes both the women's movement and the health movement in this way. This response occurred the least frequently in her study as most of the women she spoke with were not involved in activist activities.

Young's analysis of pregnancy concurs with Martin's findings:

The pregnant subject, I suggest is decentred, split or doubled in several ways. She experiences her body as herself and not herself (1990: 160).

As pregnancy begins, it is often experienced as a change in the body. The woman becomes different than what she has been. Previous understandings of "self" and "other" become blurred as do the lines between inside and outside.

Pregnancy challenges the integration of my body experience by rendering fluid the boundary between what is within, myself, and what is outside, separate. I experience my insides as the space of another, yet my own body (Young, 1990: 163).

This alienation from the body is further exacerbated by the cultural separation of pregnancy from sexuality. For women who derive self worth from a culturally approved appearance, pregnancy may be experienced as alienating, ugly and fat (Young, 1990: 166).

The accompanying changes of pregnancy may not, however, always be experienced as negative. Young (1990) found that many pregnant women think of themselves as creative participants. They are the process of change. Though not in a position of control over the process, a woman may completely enjoy the transformation.

The combination of losing control to the medical profession during pregnancy and losing control over one's own bodily actions often leads to a feeling of being out of control. This is not necessarily a positive or negative

experience, but challenges one's integration.

The literature deals with women's experiences of control, both in terms of feminine ideals and reproduction. The pregnant adolescent experiences these controls also, but begins from a position of social deviance and relative powerlessness. The research described here attempts to understand these young women's particular experiences of control and further analyzes their reactions to this control.

PART II: THE PROBLEMATIZATION OF ADOLESCENT PREGNANCY

For the past 25 years, adolescent pregnancy has been a prolific area for research. Countless publications have examined, interpreted and presented analyses on this "major social problem." The traditional discourse of adolescent pregnancy takes a social welfare view of young women and pregnancy. Adolescent pregnancy is regarded as a social problem and is analyzed with the intent to prevent, manage and control female sexual behaviour. Sociological research in the area of adolescent pregnancy reflects this discourse. As a result, several problems exist in the literature to date. The vast majority of research follows a model which serves to distance research from the experience of the pregnant adolescent, concentrates on the negative ramifications of

early pregnancy and develops the tools necessary for the social control of adolescent female sexuality.

The emergence of the birth control pill in the 1960s, combined with an existing reservoir of moral panic regarding youth and sexuality, was the impetus for the reclassification of this social phenomenon. What was previously regarded as a moral indiscretion was transformed into a social and medical problem. Constance Nathanson (1991), in a historical examination of social responses to adolescent pregnancy, explains how the development of a presumably safe, silent and effective means of birth control, combined with the 1960s problematization of youth, increased the visibility of pregnant adolescents. Illegitimacy, with its implication of moral transgression, became one of the gravest socio-medical illnesses: unwanted pregnancy. Early pregnancy was viewed as both untimely and socially misplaced. The solution offered by the pill helped the emergence and recognition of adolescent pregnancy as a serious public problem: deviant sexuality and deviant reproduction.

That "adolescent pregnancy is widely recognized in our society as a complex and serious social problem" (Hayes, 1987: 1) is not news. What is important, however, is that sociological analysis of this phenomenon has accepted this position also. It has worked from this position, rather than question and analyze the position itself.

The question of why society views adolescent pregnancy in this manner is absent in the literature. Instead, sociology has accepted this interpretation and has accepted that it is an area in need of research and control. What must also be noted is that the research and literature were not passive recorders of the problematization of adolescent pregnancy. The often flamboyant and exaggerated rhetoric used in identifying adolescent pregnancy helped to shape the discourse of teenage childbearing and fuelled the sense of social crisis by "providing evidence that early childbearing was hazardous to adolescent parents" (Furstenberg, Brooks-Gunn and Morgan, 1987: 6).

The approach taken by those analyzing the issue of adolescent pregnancy has led to various methodological and epistemological issues. The development of research questions and methods, the interpretation of the results and the implications for policy development have all served to distance research from the interests of young women and young parents.

The Formulation of the Question

Traditionally, adolescent pregnancy has been approached from the perspective of social scientists, the medical profession, social workers, policy makers and the

government. These specialists have established the boundaries of research by determining the research questions and the approach to the issue. Questions for study have not usually originated from the experience of pregnant and parenting adolescents. Instead, questions are based on the welfare of society. For example, much research has fallen into the category of policy research, with the main focus being the development and/or analysis of social policy for dealing with adolescent female sexuality (for example, see Miller et al., 1992; Moore and Burt, 1982; Hayes, 1987).

The result has been the development of a literature rich in quantitative data: demographics, incidence statistics, birth rates, causal variables, international comparisons, statistical outcomes and financial expense. Every detail of adolescent women's sexual and reproductive experience is catalogued in the form of a compelling "statistical portrait": young, ethnic minority, lower class, dependent on welfare, dysfunctional family, high school drop-out.

The approach has resulted in the objectification of pregnant adolescents. Notably lacking is qualitative research which attempts to understand the subjective experience of adolescent pregnancy. Literature on adolescent pregnancy views its "subjects" as objects, belonging to a distinct category, different from other people and in need of special

attention and theoretical explanation. They are not regarded as agents or knowers, but as social deviants.

The Focus on Causation

Early work in the field has been concerned with determining the causal factors related to adolescent pregnancy. In the attempt to identify which girls in particular are at "risk" of adolescent pregnancy, much of the research in this area has concentrated on identifying the traits connected with early sexual "promiscuity" and risk-taking behaviour. What tends to happen in such approaches is that the young women become separated from their experiences and cast into two simplistic roles: bad girl and social victim.

One picture which emerges from the literature is that of the wanton, misguided girl who lacks the moral strength to control her own sexuality or who uses it for furthering her own position. She is motivated by personal desires, emotional needs, a lack of morality and peer pressure.

First, personal attitudes, needs and motivations have all been analyzed with regard to adolescent sexuality and pregnancy. Black and DeBlassie (1985) in an analysis of contributing factors of adolescent pregnancy, report that adolescents become pregnant in hope of receiving more

attention from family and friends, to spite overprotective or domineering parents, or to produce an object capable of providing affection. Schneider (1983) in an attempt to identify the "high-risk" adolescent in Canada, lists poor self image, both physically and emotionally, a strong sexual curiosity and low moral development. Those at highest risk are deemed motivated by "self-pleasure and personal gain" (Bolton, 1980).

Second, adolescent pregnancy has been associated with the attempt to fill an emotional void. Young women involved in sexual activity are seen to be involved in a search for pleasure to escape some fear and satisfy a sense of personal inadequacy. Bolton (1980) in a comprehensive review of adolescent pregnancy research, identifies adolescence as a period of decision making and identity searching. At this period, adolescents are physically mature prior to being psychologically mature, and therefore, he claims, they make irresponsible decisions regarding their sexuality.

Third, a lack of morality is identified as a major causal factor. Female sexual activity has been equated with power struggles in the family. Teen girls are said to be involved in rebellion, using their sexual power to gain a sense of control (Bolton, 1980). Pregnancy has also been viewed as the result of sexual bargaining, as the adolescent female attempts to obtain commitment, affection and

exclusivity from her partner (Black and DeBlassie, 1985).

Literature has been concerned with determining the underlying influences of sexual morality and norms regarding the distribution of sexual information which influence female sexual activity. In one of the earliest studies of adolescent pregnancy, published in 1961, Clark Vincent examined unmarried mothers with an attempt to understand the major influences on such an outcome. His conclusions emphasize a lack of control and guidance of female behaviour. Minimal parental discipline within the family, freedom to make decisions at an early age and minimal exposure to church and moral teaching regarding sex were all related to teen female sexual activity.

Finally, peer influence is cited as one of the major influences on the decision to engage in sexual activity. Intense peer pressure, accompanied by a lack of moral guidance, is regarded as the key factor determining early sexual behaviour (Schneider, 1983). McCullough and Scherman (1991) surveyed 37 pregnant teenagers and teen mothers to assess basic needs and the factors that may have contributed to their becoming teen parents. When looking at initiation of sexual activity, they found that curiosity and peer pressure were the most common reasons for participating.

The second characterization of the pregnant adolescent which emerges from the literature is that of the innocent girl led astray by unfortunate circumstances or taken advantage of

by a cruel society. Family history, sexual abuse, powerlessness, lack of education and the lack of contraception are all viewed as causal factors.

The inability of the family to protect the adolescent female is fully explored in the literature. Before Their Time, an oral history of four generations of black women in the United States demonstrates the theory of the repetitive cycle of teen parenting. Sander (1991) conducted in-depth interviews with four women from one family who were all young mothers and daughters of young mothers. The family illustrates a consistent pattern of early unplanned pregnancy, the inability to meet children's needs, and teenagers satisfying those needs in terms of sexual relationships and eventually becoming young mothers also.

One study examines the influence of parental beliefs as a causal factor on adolescent sexual behaviour and contraceptive use. The authors conclude that parents' normative beliefs have considerable impact on contraceptive use (Baker, Thalberg and Morrison, 1988). Young women whose parents were most restrictive in their beliefs regarding adolescent sexual behaviour tended to hold the belief that sexual involvement was negative. Rather than limiting sexual activity, however, these young women participated in the behaviour, but avoided contraceptive use.

These findings are further supported by a study which

attempts to improve the predictability of adolescent female sexual behaviour. After surveying 385 young women using community health clinics in the United States, the investigators found that parents' beliefs and the motivations to comply with parents were significant predictors of adolescent sexual behaviour. Negative parental attitudes to sexuality are shown to result in covert sexual behaviour, and a reluctance to seek assistance or contraceptive information. Sexually active females are more likely to use contraception regularly if they believe their parents support them in their decision and if they are motivated to comply with their parents wishes and expectations (Jorgensen and Sonstegard, 1984).

The incidence and effects of sexual abuse on adolescent pregnancy and parenting are now being examined in the literature. Boyer and Fine (1992) conducted a study of 535 pregnant and parenting teenagers in Washington State to examine a possible connection between adolescent pregnancy and sexual abuse. Their findings confirmed their suspicions. Sixty-six percent of their respondents reported a history of some form of sexual abuse. Sixty-two percent of these had experienced molestation, attempted rape or rape prior to their first pregnancy. The connection was further examined in a theoretical analysis based on the experiences of professionals in the area of adolescent pregnancy. Sexual abuse is found to

compromise adolescent development, interfere with the establishment of intimate relationships and impede the development of a sense of physical integrity. The authors suggest that a

...heightened need for intimacy, coupled with the sexualization of affection, may lead (the adolescent) to seek warmth and closeness through repeated sexual encounters; this behaviour is typically characterized as promiscuity (Donaldson, Whalen and Anastas, 1989: 294).

These studies have suggested that a history of sexual abuse has a direct impact on the initiation of sexual relationships, contraceptive use and decision making. After surveying pregnant teens and teen mothers, one study concludes that sexual abuse victims may have difficulty in accomplishing the developmental tasks of adolescence. The feelings of powerlessness, disgust, and shame that result from abuse, may lead to attempts to seek closeness through repeated sexual encounters. This behaviour increases the risk of pregnancy (McCullough and Scherman, 1991: 814-815).

Connected to this is the categorization of adolescent pregnancy as a problem of the powerless. High rates of adolescent pregnancy have consistently been identified among low income and minority populations. Girls in these groups are described as having low self esteem and reduced life goal

expectations. Rainwater (1970) explains that pregnancy serves the low income female by establishing her legitimacy as a mature female as evidenced by a growth in self-esteem at the onset of pregnancy.

The social positioning of women in our patriarchal society is another factor related to adolescent pregnancy. Hudson and Ineichen (1991) prepared an analysis of adolescent pregnancy in Britain. They suggest that traditional roles for women and men in society have placed young women in a position where they have been encouraged to be emotionally and economically dependent. Motherhood continues to be the quintessential female role: "children need their mothers, mothers need their children, all women need to be mothers" (Hudson and Ineichen, 1991: 15). This directs gender identity development for girls, equating biology and motherhood with normal femininity.

Carol Ireson (1984) tests such a theory in the United States. The results of a questionnaire she distributed to young women awaiting pregnancy tests or contraceptive instruction support Hudson and Ineichen's assertion, stating "pregnant teenagers are more likely than others to be oriented toward traditional sex roles" (194). The study asserts that pregnant teens show more traditional sex-typing of activities, lower expectations and occupational aspirations, lower grades, and are more likely to have dropped out of school.

Corresponding to this is society's treatment of sexuality. In an early cross-disciplinary examination of adolescent pregnancy, Osofsky (1968) looks at the role of societal attitudes toward pregnancy prevention. He suggests that the risk of adolescent pregnancy is increased by a lack of effective sex education in the schools, sexual misinformation and the lack of availability of contraception and abortion.

This is supported by the findings of others which examine how the unavailability of information and contraception contributes to early, unwanted pregnancy. Black and DeBlassie (1985) conclude that many teens get pregnant because of misunderstanding and ignorance of the menstrual cycle and contraception. Unprotected sex is further attributed to a lack of comfortable contraception for teens (Schneider, 1983). Finally, difficulty arises for young women as any contraceptive preparation may be viewed negatively by prospective partners and may indicate that the girl is sexually experienced or "loose" (Hudson and Ineichen, 1991).

The Effects of Adolescent Pregnancy

The literature on adolescent pregnancy examines the outcomes in various areas. The biological, psychological, economic and social effects have been studied in detail. This

literature is a direct result of "researcher-defined" studies and tends to concentrate on negative outcomes.

The biological implications of adolescent pregnancy are of primary concern in much of the literature. This literature typifies the medicalization of pregnancy, concentrating on objective medical issues and excluding women's own experiences of the pregnancy and delivery.

Research has concentrated on identifying the physical and health consequences of early childbearing. Such studies focus on the labour process and the effects on the development of the children of teen mothers, indicating that the teenage body is at particular risk from the stresses of childbearing and labour. Bolton (1980) and Osofsky (1968) both review available medical analyses of adolescent pregnancy. The risks identified include a high incidence of toxemia, anaemia, "extreme" weight gain, hypertension, prolonged and difficult labour, cervical laceration, disproportion of fetal and pelvis size, c-section, post-partum infections, prematurity and perinatal mortality or "fetal wastage". These medical problems are reported to be compounded by the immature physical state of the adolescent and the increased stress experienced in the uterus, pelvis and thyroid. These concerns are believed to reflect the fact that the body of the pregnant teenager faces the stresses of pregnancy before being acclimated to the alterations of puberty (Bolton, 1980).

Teenagers are viewed as further complicating their medical situations by participating in numerous risk-taking behaviours and bad habits. Research conducted of pregnant teenagers using public health clinics in Saskatchewan identifies malnutrition due to poor eating patterns, smoking, drinking, drug use and unprotected sexual intercourse as further problems (Ferguson, 1983). As well, teen experiences of social, emotional and economic stress act to increase the potential for difficulties (Osofsky, 1968). Finally, research concludes that further negative impact results from the reluctance to accept prenatal care, the denial of pregnancy until the second trimester or later, and indifference to physical symptoms (Bolton, 1980).

The psychological consequences of adolescent pregnancy are examined as intrusions upon the traditional patterns of adolescent identity development. Difficulties such as stress, anxiety and inhibited identity formation are often present in the pregnant and parenting adolescent who expresses more self doubt, uncertainty, loneliness and helplessness than adolescents who do not experience pregnancy (Black and DeBlassie, 1985). After reviewing the psychological research, Bolton (1980) expresses concern over the social and emotional growth of young mothers. Areas of concern include the blockage of developmental tasks, family dysfunction, emotional conflict and the reduced likelihood of success in future

relationships.

An important element in the analysis of the outcomes of adolescent pregnancy has been the concept of "cost" or economic expense. In terms of the structure of our society, the pregnant adolescent becomes dependent upon society economically. Pregnant adolescents and teen mothers cost money. Much of the research is framed in such a way as to highlight the expense involved in "the problem."

One of the primary areas where the effects of adolescent pregnancy and parenthood are seen is education. Early pregnancy is associated with limited educational and occupational attainment due to an inability to cope at the day to day level. Further, there is some evidence that such teens have experienced previous educational difficulties which are only complicated by the pregnancy (Osofsky, 1968). Black and DeBlassie (1985) report that the majority of teen mothers never finish school.

This decreased educational attainment is shown to result in decreased occupational attainment and decreased income. Hudson and Ineichen (1991) have identified a lack of day care facilities, the absence of fathers as second care givers, and the historical exclusion of pregnant and parenting teens from public education as deterrents to young mothers, preventing them from earning an income and becoming independent. As a result, most young mothers find themselves

dependent on welfare at some time during their lifetime and many become stuck in a pattern of welfare dependency (Ferguson, 1983). Consistently, studies conclude that poverty is the major issue facing teen aged mothers (Bolton, 1980; Vincent, 1961; Sander, 1991; Hudson and Ineichen, 1991).

For many teen parents, this poor mobility is compounded by the difficulties facing their children. Higher rates of infant mortality, higher rates of birth defects and greater levels of retardation, spinal injury, head injury, asphyxia and epilepsy, plus the increased potential for reduction in intelligence consistently appear in research on the children of teen mothers (Bolton, 1980). These risks, along with the inability to consult and utilize the minimum of social services, serves only to intensify experiences of emotional and economic stress (Osofsky, 1968). Often, the moment of birth is viewed as representing the beginning of a life-long downward spiral as life choices continue to be reduced and status continues to decline (Hudson and Ineichen, 1991).

Moore and Burt (1982) demonstrate that one of the main consequences of this economic downward spiral is the cost to government. They assert that the families of young mothers are over-represented among those receiving government assistance and they note that the United States government spends almost nine billion dollars per year on cash, food and

health benefits paid out by government agencies.

The positive outcomes of adolescent pregnancy are generally absent or only lightly touched upon in the research. The focus on causation, negative outcomes, and prevention have excluded an attempt to understand the rather complicated interrelationships of pleasure, risk, responsibility, empowerment, danger and growth which arrive with unexpected early pregnancy. The concentration on incidence has been used to highlight the increasing frequency of early pregnancy within society. Research has failed to note the dropping rates of teenage pregnancy.

Only recently has a major study been published which shows the positive life experiences of young mothers, indicating that most young women complete high school, find employment and escape public assistance. In a 17-year follow up study of women who had been young mothers, Furstenberg, Brooks-Gunn and Morgan (1987) examine the long term effects on families created through early childbearing. They look at the adult experiences of young mothers, paying particular attention to education, employment, marital relationships and fertility patterns, as well as the life-course experiences of their children. Their findings generally support the negative experiences noted above, but also assert that most young women who have children in adolescence enjoy some positive outcomes. The authors conclude:

The popular belief that early childbearing is an almost certain route to dropping out of school, subsequent unwanted births and economic dependency is greatly oversimplified, if not seriously distorted (46).

Unfortunately, as a result of the conceptualization of adolescent pregnancy as a social problem, such studies are rare and further explanation of positive outcomes is neglected. This leaves a bleak, incomplete picture of the results of adolescent pregnancy.

Implications for Understanding Adolescent Pregnancy

Most literature in the area of adolescent pregnancy concentrates on developing an understanding of its causes and effects. The aim of such work has been the prevention of pregnancy through the restriction of adolescent sexuality and adult-defined responsible behaviour. The goal has been the prevention or solution of the "problem" of adolescent pregnancy through the development of intervention and management strategies. The desired outcome is the reduction of early pregnancies and the production of responsible parents who can be independent from social assistance.

The concentration on the determining factors of adolescent pregnancy results in the invisibility of the

individuals who have the greatest interest in the research. Further, it develops a literature which effectively silences the voices of pregnant teenagers. The methods and analyses

create a wholly external relationship between inquirer and object of...inquiry so that the latter appears to exist altogether independent of the practices and project through which she knows it. They constitute a standpoint within the texts of the discourse, severing them from their ground in an original world of active subjects (Smith, 1987: 129).

By treating the "subject as object," this research has remained outside of the experiences of the women it is studying and has not recognized their experiences as a valid basis for research.

This objectification is made even more evident through the use of value-laden terminology. "Unwed mother," "illegitimacy," "single mother," and even "adolescent pregnancy," and "pregnant teenager" are all loaded with negative moral connotations. These terms are often used casually, allowing the moral impact to take place without comment. The use of such terminology serves to stereotype young pregnant women, distancing them even further from the research.

One result of the conceptualization of adolescent pregnancy as a problem and the scientific analysis in terms of

cost to individual and society is a set of policy recommendations and strategies for intervention which are based outside of the individual and which regard the agents of change as specialists and experts. The focus of these changes is on the economic and social benefits for society, instead of on the young pregnant women who need these services.

The solution to the "problem" most often involves control or "management." Many studies suggest that it is necessary to prevent adolescent pregnancy and "control adolescent fertility" through education, availability of birth control, encouraging abstinence or through "empowerment for role alternatives" (Rodman, 1985). Others suggest that the real issue rests with management of the pregnancy through efficient medical and psychological intervention (Moore and Burt, 1982). Still others feel that intervention in the parenting process is important (Dore and Dumois, 1990) or that "treatment" of the young mother is necessary to encourage "adult" development, establish skills in interpersonal relationships and create effective decision-making skills (Barnett and Balak, 1986).

While the agents of change are usually identified as service providers, the objects of change are usually identified as young women. Recommendations include the education of girls about their bodies, the freedom to get the pill or an abortion and programs for unwed mothers. Male

participants continue to be neglected. Discussions of their sexuality and prevention models which aim at changing their behaviour are absent.

The basic model, then, is one which centers on the control of the adolescent female and her behaviour regarding her body. The literature concludes that early pregnancy must be stopped and although the suggested solutions vary, they all entail intervention into the sexual behaviour of adolescent women: stop young women from having sex, stop young women from getting pregnant, make sure that pregnant teens and young mothers have lots of "help".

While there are social costs which need investigation, such knowledge is incomplete if we do not focus on the experiences of the young women themselves. Few studies have concerned themselves with understanding adolescent pregnancy from the perspective of the pregnant adolescent. Studies have tended to objectify pregnant adolescents and have concentrated on negative outcomes, often ignoring the perspective of young women completely. In many ways, the true subject of adolescent pregnancy research is not the pregnant adolescent at all, rather, it is the family, society, program, community, government in which she circulates. Questions and conclusions tend to be framed with regard to the development of appropriate policies and programs or are aimed at the analysis of the impact of adolescent pregnancy on the family or

society, even noting the strong negative impact of adolescent pregnancy on the family environment (Nathanson, Baird and Jemail, 1986) and that "society and the government have little if anything to gain from a trend toward the early initiation of premarital sexual activity" (Moore and Burt, 1982: 61).

This literature exemplifies the patriarchal approach to women's bodies that is described in the body literature. It reflects a patriarchal bias which denies women's authority on their own bodies. Further, it denies and/or restricts women's control of their own bodies and their sexuality.

Exploration of this issue must move away from the development of interventionist strategies based on the needs of society toward the development of a greater understanding of the perceptions and experiences of the pregnant adolescent in society. The present study contributes to the literature by returning to the experience of the pregnant adolescent. It attempts to tell the story from her perspective and highlights the effects of control and intervention on her. Developing a greater understanding of the young women who are having children, their motivations, needs and desires, can only help to increase our understanding of the contributing factors of adolescent pregnancy in general. Further, this understanding may have implications for policy and program development which may affect pregnancy outcomes by identifying what young mothers need and desire for future success.

CHAPTER THREE: METHODOLOGY

As discussed in the previous chapter, research into adolescent pregnancy has ignored the lived reality of the young women experiencing pregnancy. Very little research exists which attempts to understand this experience from the perspective of the pregnant teen.

The importance of beginning with women's experiences has been identified by many feminist scholars. Questions for analysis must originate in women's own experiences and must assert the validity of women's experience of the world. Feminist research "generates its problematics from the perspective of women's experiences. It also uses these experiences as a significant indicator of the 'reality' against which hypotheses are tested" (Harding, 1989: 27). Women's ideas and experiences must be seen as valid in their own right (Klein, 1983). The importance of hearing women's voices and examining their lives is paramount to the development of a more complete inquiry into social phenomenon.

Sociology has focused on public, official, visible, and/or dramatic role players and definitions of the situation; yet unofficial, supportive, less dramatic, private, and invisible spheres of social life and organization may be equally important (Millman and Kanter, 1987: 31).

Adolescent pregnancy has been approached from the perspective of the greater community; from the interests of "society" and government. It is now imperative that we hear the voices of the young women most directly involved. With the pervasive characterization of adolescent pregnancy as a social problem, and the resulting attempts to manage the incidence of early childbearing, the question must focus on the pregnant adolescent's perspective: What is the pregnant teenager's experience of her world?

RESEARCH DESIGN

Qualitative methodology "is concerned with understanding human behavior from the actor's own frame of reference" (Bogdan and Taylor, 1975: 2). Following this tradition, my intention in this research was not to search for "causes" or "factors" or to analyze the impact of adolescent pregnancy on society and its structures. My purpose was to attempt to uncover young pregnant women's own interpretation of their own world, "to explicate rather than explain" (Smith,

1987: 126). The research presented here provides descriptive information and allows for the pursuance of analytical explanations.

The Interview

With the goal of attaining detailed, descriptive data, I decided to use in-depth, unstructured interviews with a small number of participants. The value of this technique is in gaining "an intimate view...from the perspective of one who has experienced (the situation)...herself" (Bogdan and Taylor, 1975: 7). The long, unstructured interview has its special virtue in its ability to "capture how the respondent sees and experiences the world" (McCracken, 1988: 65).

The interview guide was designed to elicit discussion in general topic areas (see Appendix A). Meetings were informally structured and questions were open-ended to promote conversation rather than to measure specific variables. The guide was broken down into 6 general areas: background, relationships, being female, current pregnancy, past pregnancies, and sexual history. Discussion was guided initially by the participant and often went beyond the boundaries of set questions. In several cases, conversation went in a completely different direction than the interview guide. For example, discussion in the area of "background"

often elicited very emotional and detailed descriptions as participants revealed their family histories and plans for the future. This usually led to discussion which covered or overlapped with many of the topics in other sections. Questions were used to draw the conversation back to a general area when conversation strayed completely from the purpose of the study. Questions regarding the current pregnancy did not generally have to be asked specifically, as the initial question of "how did you feel?" often initiated a detailed description which covered the other categories. In most cases, the area of past-pregnancies was dropped after the initial question. For those who had previous pregnancies, discussion was much longer than the guide implies as the conversations turned out to be highly emotional, providing much detail on personal history. The question regarding sexual abuse was often worked into earlier discussion, as experiences of sexual abuse were often mentioned much earlier in the interview process.

In a few cases, the participants were unable, initially, to remember much about the specific questions asked. This appeared to be quite rare and was usually not a major problem. The length of the interviews allowed us to explore areas where memories were sketchy and most often, after more specific questions were asked and the participants explored their own memories, they were able to provide more

details. "I don't remember" was also a safe way for some of the participants to avoid discussion of particularly sensitive issues. One young women stated that she did not remember much at all about her sexual past. In fact, she indicated to me that she had actively blocked this information and was not interested in exploring it at all at the present time. Once a participant indicated that she was going to limit her answer it was difficult to get much more from her without destroying rapport. I had to limit my questioning in some areas in order to get more detailed information in others.

All in all, my awareness of the issues involved in adolescent pregnancy, from both the literature and from my experience working with this population, allowed me to be particularly sensitive to the participants and to build a strong rapport with them. In some cases, this led to the young women wanting to present themselves in the best possible light. In one case, this meant that a young woman withheld information regarding her sexual involvement in the past and present. After much discussion, however, she eventually provided more details. In another case, the participant felt the need to present herself as tough and independent, and was often unwilling to present any negative feelings. This case was uniquely difficult and resulted in limited detail, even after repeated interviews.

Each participant was interviewed twice, for

approximately one hour each time. The interviews were tape recorded and transcribed to hard copy for analysis. Through the use of multiple interviews and by allowing respondents to comment on previous discussions I was able to double check the information I was getting and my interpretations of this information. After the initial interview, I would review the recordings and generate further questions for the next meeting. Most often this entailed attempting to draw out more detail in specific areas or clarifying responses which I did not immediately understand.

The potential for error in interpretation when using such a method is balanced by the potential of the methodology to develop a greater insight into the experiences of the respondent. Such an approach allows participants to define issues of importance. By using their own words, rather than a theoretical model to drive analysis, it increases the potential for better understanding the respondent's own point of view.

The Sample

Study participants were volunteers. They were recruited through a variety of programs for pregnant and parenting teenagers in the Hamilton/Burlington area. Initially, I contacted numerous agencies and programs,

including the Board of Education in both communities and the Children's Aid Society for the region. I was eventually directed to 4 specific programs where I could contact pregnant teens. These consisted of two residential/educational facilities, one school-based program and one teen prenatal program. Once these programs were identified, I contacted the program supervisors and proposed the study to them. They, in turn, provided me with the opportunity to present the study to groups of pregnant teenagers. In one case, this involved presenting my ideas to a whole group and asking for volunteers. In the others, I met with interested individuals on a one-to-one basis on the program premises and volunteers either accepted immediately, or called later and expressed interest. Initially, nine young women volunteered for the project. One withdrew at the time of the initial interview.

The eight participants are described briefly below:

Andrea¹:

It feels different though than not being pregnant... It's a real big change. I forget how I felt when I wasn't pregnant.

Andrea was 15 at the time of the interviews. She was 32 weeks into her pregnancy and completing her grade 9 credits

¹In order to protect the identity of the participants, all names presented in the study are pseudonyms.

in a residential program for young mothers. Her family life was not stable and, although she reported having a good relationship with her mother, she had spent the last two years in group and foster homes. Her father does not talk with her. Prior to the pregnancy, she was living with a foster mother who was quite supportive. Andrea had been sexually abused by a baby sitter when she was about 8 years old. She has a 17 year old boyfriend, the father of the baby, who has supported her throughout the pregnancy and who plans to help her parent the baby. He was her first sexual partner and they had not used any birth control, except withdrawal, for the entire year of their relationship.

Karen:

I have this awful life.

Karen is an extremely shy 19 year old. At the time of the first interview, she had been living on her own or with foster parents, for about two years. She left home because she had been sexually abused by her stepfather since she was 11. The father of the baby had been a casual acquaintance who denied responsibility for the pregnancy. They had not been using birth control. She had been anorexic for the 3 years prior to the pregnancy, and, in her seventh month, she weighed 125 pounds. She had a previous pregnancy at age 13, which her

mother forced her to abort. Karen was trying to finish high school through a special program for young mothers and was planning on going to college to become a hairdresser. She was not supported by her family.

Emily:

I'd call myself a...a 15 year old woman. I don't know if that's possible. I'm still young, but I think that I'm mature enough to be a woman...I guess I feel like a woman, but young.

Emily is a petite girl of 15 years. She was 9 months pregnant at the time of the interviews and was living in a residential program for pregnant teenagers. Her parents were divorced and prior to the pregnancy, she had been living with her mother, stepfather and six siblings. Emily got pregnant having sex with another boy to spite her ex-boyfriend. They had been using a condom. She did not realize she was pregnant until she was 5 months along, and she is still not certain about the paternity. The "other guy" has accepted responsibility for the baby and has supported Emily through the pregnancy. He would like to get married, but she is resisting: "maybe when I'm older." She is trying to finish her high school quickly and then plans to stay home with the baby.

Sandra:

I'm outgoing. Not now though. I refuse to go anywhere looking like this.

Sandra is a 17 year old who was living weekdays at a residential school for teen mothers and weekends with her parents. She was planning to return to her parents' home with the baby after the delivery. Sandra got pregnant with her boyfriend of two years while she was taking the birth control pill irregularly. He was planning to help her raise the baby, but they had no plans for marriage. She was completing high school at the time of the interviews and was planning to attend university the following fall.

Kelly:

I'm pretty easy-going I think. I'm friendly. I get along well with people. I have a knack with kids that everybody seems to notice. I really like being with kids.

Kelly is a confident 18 year old, 8 months pregnant, who lives at home with her parents. She is supported by her 20 year old boyfriend whom she was planning to move out with when they were financially stable. She and her boyfriend had both dropped out of school and they were working together on correspondence courses to get their high school diplomas. The pregnancy had occurred when Kelly was making the transition

off of the pill to another method of birth control.

Brenda:

I have the personality of "Rosanne's" daughter...the one with the curly hair...butchy attitude. I love sports and stuff like that. I have a really outgoing personality. I'm an open person. That's all I can really say about myself. I feel confident about myself...sometimes...well most of the time...but sometimes I don't.

Brenda is a 16 year old girl who was 9 months pregnant and was living in a residential program for pregnant teenagers at the time of the interviews. She had been living with her father prior to the pregnancy, which was the result of a sexual assault by a stranger. Brenda has never had a sexual relationship. Her home is several hundred kilometres away, and she is keeping the pregnancy secret from all but the closest of family. She is giving the baby for adoption when it is born.

Natalie:

I feel like a girl. I mean, I don't try to act like a woman because I'm pregnant, because I'm still a child...being a child and being pregnant. I don't think it's bad at all. It's not tough at all. Not for me, because I wanted this baby...I just wanted a baby.

Natalie is a very independent 16 year old in her eighth month of pregnancy. She was born in Ghana, but was living on her own in Canada before she got pregnant. Her parents were separated and neither one of them lived in the country. Natalie got pregnant because she wanted a baby. This was her second pregnancy. She had a miscarriage shortly before. The father of the baby was minimally involved. He was already parenting another child and Natalie did not really want his help. At the time of the interviews, she was completing school in a residential program and was waiting to move to her own apartment.

Nadine:

I'm going to do everything and anything for this baby. If it means to give up my teenage life, then it is and I do know how other parents might feel. There's a lot of immature 13 year olds who don't give two shits, right, and there's a lot of people who aren't and are just like me and want to be the parent of their baby.

Nadine had turned 14 the day before the first interview. She was one week away from her due date. Prior to the pregnancy, she had been living with her father. Her parents were divorced and she grew up back and forth between her mother and father. Neither of her parents were supporting

her with the pregnancy, and she had sought legal advice and moved into a residential program until delivery. She intends to parent her baby and she was actively developing a plan to do so. The father was a casual boyfriend, 14 years old, who denied involvement. He had been her fifth sexual partner and they had not used any birth control. Nadine had been raped by a friend when she was 12. She was a virgin at the time.

This group of women is not intended to be representative of all young pregnant women. They do, however, reflect the general findings on the backgrounds of young pregnant women. Their familial backgrounds tend to represent the high incidence of unrest or difficulty found in the backgrounds of pregnant adolescents (Bolton, 1980). Consistent with the recent statistics of sexual abuse and adolescent pregnancy, four of the participants, half of the sample, indicated that they had been sexually abused at some point in their life. This abuse ranged from inappropriate touching from another child to violent rape which resulted in the pregnancy for one of the respondents. This is consistent with current incidence statistics in the general adolescent female population (Government of Canada, 1993).

None of these young women were ignorant of sexual biology or the risks inherent in their behaviour. They all felt they had access to birth control and all but one had used some form of birth control at some time in their sexual

history. Aside from the young woman who was pregnant as a result of a rape, all of the young women had more than one sexual partner. The number of sexual partners ranged from 2 to 5, with most of the girls having at least 3 sexual partners. Only one of the participants reported ever having a sexually transmitted disease.

A few difficulties with regard to participation should be noted. First, pregnant adolescents are an over-studied group. In this particular community, during the time of the study, there was difficulty recruiting volunteers, as pregnant and parenting adolescents are closely monitored. Many young women feel like "guinea pigs". I spoke with several young women who decided that they just did not want to be "studied" or monitored any further. This limited the number of volunteers for the study and possibly results in the study overlooking issues of importance to young women who would not participate. Second, many young women are in a state of denial during the early phase of their pregnancies. It is common for young women to avoid contact with health care professionals or programs until they themselves are sure that they are pregnant. This does not often occur until the second trimester and sometimes even later. As a result, it is often difficult to contact young women in the early stages of their pregnancy. Because of this, all of the interviews I conducted were with women in their third trimester, anxiously awaiting

delivery. This limits the scope of the study to covering the previous stages of the pregnancy in a retrospective way, possibly eliminating the needs and concerns of someone in the early stages of pregnancy. Third, it is almost impossible to avoid being involved with some program or other as a pregnant teenager. For this reason, I was unable to find anyone to talk to who was not involved in a special program for teen mothers. The sample does represent the majority of pregnant adolescents who are involved in outreach programs, but does not deal with the young women who, for whatever reasons, avoid involvement in such programs. Finally, as a result of the often chaotic experience of early pregnancy, pregnant adolescents tend to be a rather transient population. Consequently, I was unable to maintain contact with all of the young women I began to interview.

While the sample is not completely representative, and the small sample size limits the "statistical" generalizability of the findings, the use of a small sample and in-depth interviewing does maintain the potential for "analytic" generalization, or the generalization to theory (Yin, 1989). It is not the intention of this study to test hypotheses, so a probability sample is not necessary. The purpose of using a detailed qualitative approach is to explore the teenagers' perspective on their pregnancies in order to bring their viewpoint back to the research in this area. The

manageable sample size allowed this investigation to uncover important insights to this issue which were previously unidentified.

ANALYSIS

When approaching the data, I felt it was most important to hear the voices of the young women with whom I spoke. My intention was to let the participants speak for themselves. The method of analysis I chose to use was the constant comparison method developed by Glaser and Strauss (1967) as adapted by Kirby and McKenna (1989),

...examining how data items and the grouping of data items generate specific and general patterns. This is done primarily through the constant comparison of data items with other data items until sections that "go together" or "seem to describe something" can be identified (as a category) (130).

The approach utilizes pieces of data, "bibbits"² and "categories", as the stepping stones to the development of grounded theory through repeated analysis and comparison of

²Kirby and McKenna (1989) define a "bibbit" as "a passage from a transcript, a piece of information from fieldnotes, a section of a document or a snippet of conversation recorded on a scrap of paper that can stand on its own but, when necessary, can be relocated in its original context" (135).

the interview data in the formulation of patterns (Kirby and McKenna, 1989: 137).

Initially, my intention was to examine the pregnant adolescent's experience of her body during the pregnancy. I was interested in seeing how they conceptualized the contradictions in their bodies and their means of dealing with those contradictions. As the interviews progressed, however, I learned that these young women did not necessarily view their bodies as contradictory. They did have certain concerns and difficulties in dealing with their bodies, but all in all, they did not view being pregnant and being a teenager as being incongruous.

Rather than pursuing this angle, then, I attempted to step back and allow the data to direct the analysis. The interview data were coded and divided into "bibbits" or passages from the text which reflected issues regarding the body and experiences of importance to the participants (Kirby and McKenna, 1989). Initially these were grouped in "categories" according to the major themes of controlling bodies, self-control of the body, denial of body, negative body experience and positive body experience, and were organized in a series of folders for each category. It became clear that many important experiences went beyond the experience of body and that these experiences were tied to other experiences. As well, many important experiences did

not fall into the above categories.

The "bibbits" were continually examined and reorganized in what Kirby and McKenna (1989) call "living with the data." They were read and re-read, compared against each other for similarities and differences, and compared back to the literature on adolescent pregnancy. What began to surface was a sense that the young women were struggling against their dependence on those around them. Many of their comments and discussions reflected their desires for and attempts to regain independence. This eventually developed into a theme of control. The young women I spoke with continually expressed the feeling that everyone was telling them what to do, trying to control them. This led me to look at ways in which they experienced this control. Looking again at the "bibbits" and comparing them against each other, I began to look for patterns in experiences and perceptions of control.

Things became complicated as I began to realize the many contingencies that were involved. In many cases, the young women were controlling their own behaviour and bodies. In other situations, control by others was sometimes accepted and sometimes resisted, sometimes both. Control was often viewed positively and regarded as necessary, but a fine line was drawn with regard to how far such control should be carried. Further, it became apparent that the young women I spoke with were not passive recipients of the perceived

control. Their resistance became evident as they spoke of regaining control and seeking independence. The new categories began to reflect the patterns which emerged in their experiences of control and the ways in which they reacted to it: knowledge, advice, resources and environment, stigma, loss of control of body, resignation, evasion, manipulation, resistance and planning for the future. This research, thus, came to centre on the perceptions and experiences of control in the lives of these pregnant adolescents and the types of reactions they had to this control.

CHAPTER FOUR: LOSING CONTROL

Both the literature on adolescent pregnancy and the experiences of the young women I spoke with reflected issues of control and resistance. On the one hand, pregnant adolescents are subject to social control by the members of the society around them and they perceive a loss of control associated with their pregnancies. On the other hand, they act in various ways to resist and to regain personal control. This chapter will deal with the ways in which they feel society controls them and their perceptions of losing control over their own bodies. The next chapter deals with the forms of resistance they adopt as a result.

Young pregnant women experience social control as the result of belonging to a group whose bodies our society attempts to regulate. They have broken the moral codes of female sexuality and have challenged traditional definitions of childhood and family. These transgressions have made them susceptible to social sanctions which attempt to regulate their behaviour. As women, they lack control due to their subordinate position in a patriarchal society and their

limited power. Their pregnancies increase their vulnerability to control because of the social control of reproduction by a largely male medical profession. Their age further compounds their dependence due to their lack of financial and educational resources. As well, they experience a loss of control as their bodies stray from cultural ideals of femininity.

There are primarily three major areas that they discussed in terms of feeling powerless and susceptible to control by others. These include financial resources, knowledge and advice and experiences of their bodies.

FINANCIAL RESOURCES: A PLACE OF ONE'S OWN AND THE MEANS TO SUSTAIN IT

One's environment is an important indicator of one's self. It is a representation of the self and it is a protective shelter for one's body. As a result of their youth, pregnant adolescents are often in a position where they lack control over their environment. For many, the importance of a home, often in the form of an apartment, is paramount to their success as parents.

Financially, these young women are also restricted. As a result of having insufficient resources, they are dependent upon the adults and organizations around them for

shelter, food and support. While attempting to seek independence, they understand that a lack of resources prohibits their progress and they see others as limiting their ability to proceed. Natalie was particularly frustrated by not having enough money to find an apartment for her and the baby.

...the money they're giving is too little bit. They act as if it's their money they're taking out of their own pockets to give you, and they ask like, "Do you really need it?" I really need it. Trust me. I wouldn't be asking. Well, they give you too little bit.

As teenagers, young pregnant women are still in a position of dependence upon adults. Legally, adults are responsible for them and have power over their immediate environment. In many cases, pregnant teenagers still live in their parents' homes or in established residences for teen mothers. The adults in these situations, both parents and residential caregivers, exercise control over many of these young women's life decisions, including basic personal activities such as sleep and eating patterns. In many ways, this dependence results in their own loss of control over their situation and the inability to make independent decisions. For Nadine, the lack of sufficient resources and the inability to get an apartment at her age made her dependent upon the Children's Aid Society to make a decision regarding her baby.

Legally I was allowed to keep the baby. I was allowed to live on my own. But CAS was starting to get involved...I couldn't collect welfare until the baby was born...and it's really a big mess. It's really hard for teenagers under the age of 15...it's really, really hard to get help, to get legal help just to do anything...What's happening is I'm going through a whole bunch of kicking around and, "You can't do this, but you can do this and you can't come here, but you can come here without your parent's consent." My parents aren't behind me at all...my father is absolutely disowning me...What's gonna happen is after the baby is born, it's going to be apprehended by CAS. I'm going to be with it for the night and I'm going to sleep over there...then for 6 weeks after that I'll be living here (at the residence for young mothers), but visiting the baby everyday or every other day or however often they'll let me go see it...it's either that plan or they take the baby right away.

KNOWLEDGE AND INFORMATION

Knowledge and information are a second form of power. Those without this power often lose personal control as they defer to those who have it. Young pregnant women are limited in knowledge and information about their bodies and pregnancies. They are dependent upon experts, doctors, nurses, teachers, counsellors, etc., for guidance and information.

The women I spoke with believe that others know better than they do. They interpret themselves as young, naive and, ultimately, as having less knowledge about themselves and

their pregnancies than do parents, doctors, social workers and other authorities. Karen spoke of this directly as she pointed out to me why she needed the help of the "experts" around her.

I think I'm pretty stupid too, sometimes. I make the wrong decisions...I don't think right. I get in trouble all the time.

They are dependent upon experts for information and they desire a relationship in which they can get the information and care which they need. Their relationships with doctors reflect this quite well. They trust them and rely upon the medical information which they have. The women I spoke with indicated that they did not trust their own knowledge and the signs their bodies were giving them, but waited for the doctor's word to indicate that they were pregnant. For Andrea, this meant taking repeated pregnancy tests until it was finally "confirmed" by the doctor.

I took a pregnancy test at home and it came out positive...and then I went to Birthright and I took one there and it came out positive and then I went to my doctor's and got a blood test...I didn't believe them all, until the doctor's one 'cause that was a blood test.

Further, they trust the doctors with their fears and accept that the doctor will guide them in the right direction. They accept the traditional relationship between doctor and

patient of superior to subordinate. Like other adults, these women generally defer to their doctors and are in a dependent relationship with them. They accepted this relationship while searching for information, guidance and help in understanding themselves. They trust that the doctor will make the best decisions and believe that they cannot question those decisions. Natalie expressed this when talking about episiotomy. Although she greatly disliked the idea, and characterized it as the one thing she really did not want to have, she never spoke to her doctor about it. She accepted her doctor's position as medical authority.

...if I have to be cut, you know, they have to give you...if I have to, they have to, I mean, no use letting me rip or something, that's worse. If I have to be cut, I'd rather be cut than to have...you know...the same with cesarian, you can't really say you don't want a cesarian because...sometimes, there's a situation where they have to do it and if you have to, you have to.

Although adult women may also enter into such relationships of dependence with their doctors and experience the de-valuing of their own body awareness, these women, who are both young and deviant, pay a higher price as the "care" they receive often extends beyond their medical needs. All but one of the women interviewed indicated to me a time when their doctors crossed the line and intruded on their personal

lives. Nadine expressed the tension between needing the doctor, but not wanting her to step over the line.

My first doctor, she was very...I don't know, I liked her, but I didn't. I didn't like her because of my age. She was very particular on my age and very nit picky: "So what are you going to do now? What are you going to be doing?" and she's, "And how old are you?" She'd always be on about my age... Medically...she wasn't even medical. She was sort of more personal and I didn't like it. It was very...like near the end...at first she was very concerned. Near the end, before she left, she was, "So that's a good plan," but what I found was that she wasn't making me feel comfortable, because just the sort of questions she'd ask and she'd be very involved with me and, "you're my medical doctor, you're not my psychiatrist or anything."

Their youth, dependence and lack of identifiable resources also makes them more vulnerable to punitive remarks or unprofessional treatment. Natalie told a story of having a vaginal exam during her early stages of pregnancy.

And the way the doctor used to do it, just push...I don't know. He thinks it's not going to hurt or something. He just pushes it right in. Doesn't take his time. That's why I don't like men doctors. I don't like it at all. No, because they think it doesn't hurt. Because they never had one. I said, "ouch, it hurts." He said, "Well, how did you get pregnant then?" I said "It didn't hurt this much."

While they experience the same paternal relationship with their doctors as do many pregnant women, it is compounded

by their youth and lack of information and experience. Many of the young women I spoke with felt that they received differential treatment because of their age.

Natalie: This is my first baby, you know. And I mean the doctors tend to treat you...with your first child, you know. They think you don't know anything...but they don't treat you when you're older like that. It's because you're a teenager having a baby and they tend to treat you like, "Oh, she's too young."

Their dependence often left them confused. They resisted the doctor's interpretation when it did not take into account their own experiences of their bodies, but they also felt they must defer to medical expertise. As teenagers and as deviants, they felt unable to say anything or change the situation. Rather than change doctors or comment upon their concerns, they tended to suffer in silence.

Informal Aspects: Advice

As teenagers in our society, young pregnant women are also subject to informal control. Wood (1974) in an analysis of strategies used to manage deviant behaviour in society, defines this as "the use of personal power with the intent of influencing the behavior of others" (55). These women, while being dependent upon those around them, are vulnerable to such

control, particularly in the form of unsolicited advice.

These young women were most emphatic about their experiences of others attempting to influence them. They remarked on the advice they received and the pressure they felt from those around them. They frequently talked about how people felt free to tell them what they should do or how they should make their decisions. Although advice and information were often desired, people telling them what they should do or how they should make their decisions was most often viewed as an intrusion. Andrea spoke of the initial stages of pregnancy and the reactions she got from the teachers and counsellors at her school.

...everybody's wanting to talk to you. All the teachers want to talk to you. They're like "I think this..." no they don't tell you what they think, they just say, well, you know, your three options and "we can get you information about that..." and it's just like...I wanted to say just leave me alone for a while and let me make my decision on my own.

Such advice concerned many aspects of the young women's lives. In teenage pregnancy programs they were told what to eat and not to eat, what to wear and how not to dress, to be more active or less active. They told me that they felt restricted in their activities, as caregivers would monitor their actions and comment on their behaviour. All of the

young women in residential care facilities complained of the inability to choose their own hours for eating, sleeping and completing chores. They also mentioned that such rules like curfews, television restrictions and restricted visitors treated them as children. They noted that this was a contradiction, as they were required to act as adults, but were unable to make simple decisions regarding their daily activities.

Guidance and advice were most pronounced in terms of their decisions regarding their pregnancies and their babies. All of the young women I spoke with relayed at least one situation where the people around them pressured them to parent or not parent their babies.

Karen: Everyone...was telling me to do an adoption.

Natalie: ...he (boyfriend) never wanted the confusion between me and the other girl, so he told me...I should have an abortion.

Brenda: ...if she (mom) was here she would have made me keep the baby...she told me that.

Emily: My mom's first reaction was abortion.

This kind of direction and advice increased their confusion and self doubt. They had often already decided to parent their babies, but they needed the support of the people close to them. As these young women experienced this advice,

it was not simply benign, but an intrusion and a direct challenge which actually made things more difficult. Nadine expressed her frustration and fatigue from having to fight against the wishes of others to make the decision she felt was best for her.

I would have given up a long time ago, because of how much pressure has been put on me. It's been incredible. It's just been...I've been depressed most of my pregnancy because of just the power of pressure. I didn't realize how intense it could get and I was depressed. I was always crying for no reason at all. Sometimes I would just sit there and start to cry. It's because they were telling me that I couldn't do it and I wanted to.

More potently, when the young women showed signs of not following the advice, the guidance became mixed with threat or warning. I heard these kinds of stories from all of the young women I spoke with.

Andrea: (My family) just tells me to give it up...They say I'll probably lose it.

Karen: (My sister) say's "I'm going to call the Children's Aid on your baby...you're too immature to have a baby."

Nadine: Either I (agree to their) plan, or they (Children's Aid) take the baby right away.

These young women know that they are faced with complicated and difficult decisions. They know that their decisions will result in difficult outcomes and that the road before them is not easy. Often what they desire is the assurance that they can succeed. What they get is the opposite.

BODY EXPERIENCE

Stigmatization

A third form of social control derives from the stigma associated with being a pregnant teenager in a society which views it as deviant. Pregnant adolescents are a highly visible group who have broken society's norms regarding pre-marital sexuality and family formation. They are watched and monitored throughout their pregnancies and after, as young mothers, by their families, adolescent pregnancy programs, the experts around them (including sociologists) and the public. This became evident as I began looking for volunteers for this study. As I contacted various organizations in the community, I was informed that all young pregnant women were directed toward special programs for pregnant teenagers. No matter where they first surfaced, the school system, doctor's office or social services, they were referred to counselling,

residential and/or prenatal programs and were often required to continue in such programs to receive the assistance, whether monetary, emotional or otherwise, they sought.

Their experience of being monitored also became evident as I spoke with possible volunteers. They understood that they were being closely watched and many of them felt resentment and anger as a result. As I began preliminary work on this project, I was one of three researchers working in one particular agency. There had been two previous studies in this organization in the past year and many of the women I spoke with had taken part in at least one "study" in the past few months. One young woman indicated that she was tired of feeling like a "guinea pig" and another refused to participate, indicating that she had been "studied to death."

This form of control also takes place on a more informal level. Young women who become pregnant are considered deviant in our society. They are a stigmatized group whose protruding bellies and youthful looks advertise their deviant sexual behaviour. Cast into the new role of "pregnant adolescent," their past identities are challenged and they are faced with rethinking their position in the community.

Their interactions with others reflect society's disapproval of their behaviour, their choices and their existence. This first became clear to many of the young women

in their interactions with people close to them. Friends and family told them that they should not have become pregnant and should not be parenting their babies. For example, Natalie said:

(My aunt), she knows about the baby, but she's not...she said I'm too young. She said I'm too young. It's a big responsibility.

Some young women felt they were not welcome any more in their community. In one incident with friends, Emily found out that she was no longer a part of the group she had spent time with before the pregnancy.

There's been a couple of these guys who are like "Oh my gosh, Emily's pregnant." They're just kind of like "holy cow." They're still doing their little things like throwing spit balls in the classroom and everything and I'm going to become a mom and they're kinda like, "whoa." They're sort of too scared to talk to me, 'cause they think that...I'll be different, which I hope that I will be, but they're just kind of like "she doesn't belong in this group any more because she's grown up" or whatever.

For some, realizing they belonged to a deviant group came in the form of a hostile encounter. Nadine had an incident with a person from her school which made this clear.

Yeah...someone came up to me and goes, "You're pregnant?" and I go, "Yeah," and they go, "Oh yeah," and then they kind of turn around and go, "Tramp," and walked away.

What is important here is the participants' experiences of their situation in their community. They think that people are looking at them and judging them. They feel the pressure of being out of place and experience their position negatively. When asked what made her different from someone who is older and pregnant one young woman replied "Just the way people look at me really." Emily, while attempting to find a community to help and support her, instead had an experience which left her feeling even more out of place.

I went to this Catholic church at one time. I was looking for a church. I went to this Catholic church and that was a mistake. As I walked in, everyone just kinda went like this (she turns her head dramatically) and they looked at me and I just, you know, I felt like I wanted to crawl into a hole.

The doctor's office was often a place where the young women felt particularly uncomfortable. Here, their deviance seemed to be highlighted as they felt compared to the other "legitimate" mothers in the room. For Andrea, sitting in the waiting room was often a difficult part of the visit.

There's a lot of older people there, like mothers and their babies...or they're pregnant and they'll stare at me and I feel...like "What are you staring at?"

The negative reactions often contradicted the expectations of these women, who were excited about their situations and the prospect of becoming mothers. Kelly was often surprised by people's shock at her situation.

Just little comments, like, "Oh my God, you're pregnant." They throw you off too, because it's not the reaction you're expecting to hear...you expect them to be happy and not surprised.

Recognizing themselves as deviant members of society, they are concerned about what others think of them. For Sandra, this meant worrying about everyone's opinion of her.

I just felt what other people might think of me. I was fine with it, but I'm that type of person who always cares about what other people think.

The deviant label has the desired effect on these young women. All of the young women hid the pregnancy or masked their bodies at some time or other either with clothing

or by limiting their public appearances. When asked why she would hide it, Emily replied:

What everyone might think of me. Other teenage girls sitting on the bus saying, "Oh my gosh, she's pregnant. Look how young she is." That was the main thing that I was really worried about.

Kelly spoke of trying to avoid the negative comments that strangers or acquaintances might make.

...I think it's a little bit of what people might say...It's always easier to avoid a comment than it is to walk right into it. I think a lot of it is subconscious. I don't think you do it intentionally. You just try and avoid things, you know. You get enough comments at the beginning, as it is.

The realization that society regards young "girls like them" negatively and their fear of this judgement serve to control their activities. They feel limited in what they can and should do and where they can appear. Often, they restrict themselves and remain hidden until the end of their pregnancies. In some cases this meant staying home more frequently than in the past. For others, it was taken to the extreme of leaving their homes, moving to a new community and never leaving the building except for doctor's appointments. This response will be further explored in the next chapter.

Bodily Betrayal: Cultural Definitions of Beauty

The body itself represents a loss of control for the pregnant adolescent. The space they inhabit is a contradiction, providing both positive and negative results, all of which are outside of the control of the inhabitant. This perceived loss of control can result in a real loss of control as the individual feels powerless to attempt change.

Many positive things are associated with the bodily changes experienced during pregnancy. Through the creation of life, the body serves as a thing of wonder and many of the young women I spoke with reflected this awe of their own bodies and what they could accomplish. Kelly reflects on the importance of this experience.

Being able to deliver a baby. Bring a baby into the world. I think that's something that'll always outlast anything else, or outdo anything else that anybody could ever do.

For Emily, her growing belly was a source of great interest and great excitement.

I really like my stomach...there's a life inside there. It never ceases to amaze me. I like when the baby kicks and breathes and I can feel it...I never tire of laying on my back and just letting it kick.

Along with the many positive feelings with regard to the body in pregnancy, many difficulties were also experienced. Body changes were a very large part of the participants' concepts of themselves and of each other. As Young (1990) has suggested, the changing body can lead to a confused experience, where the pregnant woman experiences her body as both herself and not herself. This type of experience was often described in terms of the body somehow betraying the person in the body. This was seen to have happened in several ways.

First, for those who had not intended to become pregnant, the pregnancy itself was regarded as a betrayal by the body. The women I spoke with often described the "accident" of pregnancy as occurring against their will. Sandra and Emily both reflected on how their bodies completely surprised them by being pregnant.

Sandra: ...it (pregnancy) never even crossed my mind, really...I just thought I had food poisoning or something. I thought I was dying actually, 'cause I was so sick. I'd never heard of that before. Like, I knew morning sickness and what not, but this was like, you know, I'd sleep in the morning, so it wasn't the morning, it was just all through the night, all through the day. I thought, "No, this can't be it."

Emily: I was five months pregnant...at the time...and my friends looked at my stomach and said, "Emily, you're gaining a lot of weight on your stomach." They asked me, "Have you been using birth control?" and I said, "Of course I have. I've been using condoms"...and I started getting really defensive...plus I was throwing up a lot in the morning...I just thought it was 'cause I had a flu bug or something. And I lost my period and I talked to the doctor about that and he said it's probably because I lost so much weight...I used a bunch of excuses to just kind of forget about that...I always thought like, Pregnant? No way. There's no way I could get pregnant...There's no way it could happen to me. Then it does. I had no idea. I didn't think I was. I thought my friends were just being stupid. I always just believed what the doctor said, "Well you are really skinny, so that could be doing it." I thought throwing up in the morning was 'cause my medication also...it makes you lose your eating habits and that kind of upsets your stomach sometimes...it makes you sick.

These women developed a list of explanations for the messages the body was sending. They found themselves in a state of denial marked by actively trying to reinterpret the messages of the body. In many ways, this experience was fuelled by their youthful ignorance of their bodies and the fact that they did not always know what the signs meant. The final experience, however, is characterized as the body acting against the desires of its inhabitant.

A second betrayal can be seen in the physical changes which occur with the pregnancy. Many of these changes were

viewed negatively, challenging the ideal body shape of "taut" and "slim." For young women who are in the process of attempting to attain ideal femininity, their size and the obviousness of their position results in a great threat to their perceptions of themselves as feminine. Size, or "fat" was of particular concern to all of the young women I spoke with and all of them made direct reference to this at one time or another during our conversations, most often as a response to the question "How are you feeling?"

Natalie: Like a real slob...maybe because I'm fat.
Karen: I don't like being fat.

Emily: I see fat thighs.

Nadine: I'm absolutely huge. I weigh 198 pounds and I just...I weigh a lot and I understand that...and I'm getting big.

Sandra: Fat and ugly. I hate this. I hate...that's it, that's all I can say is fat.

Andrea: ...and I have like swollen ankles and swollen feet and swollen fingers. I have all swelled up...my knees...I know the swelling will go down after...but everything is just getting bigger and bigger and bigger...

Kelly: ...I was getting bigger and bigger and bigger.

Brenda: Fat. I hate being like this.

The interesting contradiction that developed with regard to body size had to do with their growing stomachs.

The stomach was directly associated with the baby and was a source of great pleasure. It indicated that the pregnancy was progressing well and was therefore not regarded as fat. Rather, it was the swelling in other parts of the body that represented "fat" to these young women, particularly their faces and buttocks.

Other signs of pregnancy were regarded with as much disdain. Skin difficulties, swollen breasts, large nipples, the "brown line", the pushed out navel, and other individual changes often left the young women feeling that their bodies were not their own. Stretch marks were a particularly difficult thing to deal with, especially the possibility of permanent marks or scars. Emily was shocked and distressed by the development of stretch marks.

And then my stretch marks and I'm like,
ugh...now it's like my chest, they look like
stars. My stomach looks like a zebra. Oh,
it's the worst.

Natalie was terrified of the marks.

...all these marks...I just want them to get
off my body, god. I want a clear body, you
know, no marks...I want to just get
everything off my body.

As Young (1990) states, pregnancy is not viewed as

consistent with sexuality in our culture. With the ideal feminine body defined by our culture as slim and firm, the pregnant woman may experience her body as alien and ugly. This may be heightened in the young pregnant woman, who is supposed to be at her peak of beauty in her youth. Only months earlier, she may have represented this ideal, being young and thin. Emily explains:

I get really depressed because there's girls in there that look pretty and they just, you know, they don't have this big belly...it's not really that I'm ashamed of being pregnant...but you don't feel as pretty as you used to.

For some, it is impossible to reconcile their present state with any ideals of beauty. This was very difficult for Sandra, who constantly heard how beautiful she was, but looked in the mirror to see the exact opposite.

You know how they say pregnant women look so beautiful, you know, lovely...whatever. I don't see how they could say that about it. I don't like it...being so fat. It's horrible.

This perspective was often reinforced by the people around them, particularly boyfriends. Nadine's ex-boyfriend was blunt.

He told me I was fat. He said, "You're huge." He did. He told me I was huge looking. He just couldn't believe how huge I was.

Ultimately, many of the changes, both positive and negative, represented a loss of control for these young women. Their bodies, while being life-giving and a source of wonderment, were also "abnormal" or "irregular." Their talk about their bodies conveyed the idea that their body was not their own or, as Young describes it, "myself in the mode of not being myself" (1990: 162). This was accented by the desire to return to the previous, normal condition. Several of the women used the term "normal" to refer to their previous body states.

Sandra: I want to be back to my normal, skinny self instead of this fatness.

Natalie: It better turn back normal...I hate it. I hope it turns back to normal...I don't want my body to stay like this.

The important issue here is the experienced loss of control over one's body. Their bodies were not how they expected them to be. The body itself was at the same time both their own body and not their own body. They also felt that their bodies were betraying them by hurting and being uncomfortable. Emily explained what it was like for her.

Okay, running to the bathroom every 5 minutes, you walk as if you've got a watermelon between your legs, you get so many pains, different pains like pressure pains, like nerves and it's just the worst...awful, it's the worst.

For many, it was unexpected accompanying discomforts which were a complete surprise. Brenda was shocked by the additional changes.

I wasn't expecting it. I was just expecting to be pregnant, have a big belly, and that's it...The pressure pains are really bad...

Karen, too, in spite of being thrilled about the coming baby, was surprised by what was going on with her body.

...I've had a lot of stretching pains. Most people don't, but I've had a lot of stretching pains. Still sometimes I do. Sometimes the baby will move in a certain position it hasn't before and it just kind of stretches and that hurts. My breathing has gotten bad, worse...and my sinuses have just been stuffed to hell. It's very hard to breath. I got sick a lot. I've been very sick a couple of times.

At times, these young women became angry and expressed frustration at being limited by their bodies.

Emily: Sleeping? I can't sleep any more. I wake up about 5 times to go to the bathroom and then I wake sometimes 3 times to take Tums. Then I wake up a couple of more times when I try to roll over and my stomach just feels like a big ball, and it wakes me up. Yeah, I just wake up so many times during the night, I don't sleep at all.

Sandra: I'm never going through this again. I'm never going to do this again, never. Not unless I had a death wish. No way...this has been the worst.

They also felt that their bodies were betraying them by limiting their activities. The fatigue was a surprise to most of them, and all of them commented on the major change from being very active and energetic, to having to slow down and rest often.

Andrea: I get really tired walking and...you just feel dead...you feel like you're like...I don't know. Sometimes I wish I could go to like...like in a wheelchair or something.

Karen: I get tired easily. You don't want to get up out of bed in the morning, which I've felt many, many times.

The pregnancies themselves were not necessarily negative. Most of these young women were thrilled about the coming babies and the wonder of their body's ability to reproduce life. However, they had to reconcile the

transformations of their bodies with this joy. While they may enjoy some of the changes and dislike others, they still lack control over their physical state. The positive and negative changes together lead to a sense of alienation simply because the body is different.

The idea of losing control over their bodies is further illustrated by the fear of labour and delivery and the fact that these women do not know what to expect in terms of pain or their own abilities. Their apprehension is apparent when they talk about labour and delivery and their fear of the unknown.

Nadine: It's really difficult to see myself in labour. I can't see myself in labour. I was talking to the girls outside...and you can't imagine yourself in labour...You can see yourself...going to the park the next day or whatever. You can see yourself doing that, but you just can't imagine yourself in any pain, 'cause you don't know what it's going to be like. It's just strange...I don't think I'm going to have a bad labour. I don't think I will. I hope not anyways, but I don't think I will. I hope I have a nice easy labour. I hope so.

A mixture of positive and negative anticipation was apparent. They were excited about the baby coming, but fearful of the labour and delivery. For Karen, this was extremely difficult to talk about.

I like the baby coming, but, I don't like going through the pain and that...the delivery and that...I don't know. I don't know. I just want it out of me.

Discussion around labour and delivery was often marked by a loss of words; an inability to communicate the unknown. Many of the young women I spoke with groped around for the right terminology and some could never put their fears into words.

Andrea: I don't know, I hope...it goes fast...so there's only pain for a few hours...or more.

Nadine: Pain...I'm afraid of the pain...You know it's really...it's quite...it's quite...quite...different experience...many different experiences...

The fear was particularly marked in situations where the pregnancy was not progressing well. For Sandra, who's baby was breech, labour and delivery seemed even further out of her control.

Not something I am looking forward to at all now. I thought it would be like a day of pain or what not. Like I knew what to expect, like a lot of pain, but now with it all backward and everything, I don't know what to think. I don't know if I'm going to go like (vaginal)...or if I'll have to have a c-section through it or what not...I guess I'll get close to it and find out...you don't know. Half way through something could go wrong and you'd have both done. Nothing I'm looking forward to at all.

These experiences are not limited to young pregnant women. The works of Rothman (1989), Young (1990) and Martin (1987) have shown how these feelings are present in pregnant women of all ages. What is important here is the social positioning of the women experiencing these events. Pregnant teenagers are in a greater position of dependence. With the loss of control in other areas of their lives, this additional sense of losing control compounds their feelings of dependence; of having no power to effect change. Their limited support, access to information and, in some cases, maturity, all contribute to a heightened sense of being out of control.

Many of the experiences of pregnancy at an early age left these young women feeling powerless. Becoming deviant resulted in a new identity that was not socially sanctioned. From this, they became subject to being "studied" and advised by the adults around them and becoming more rather than less dependent upon others. With regard to their pregnant bodies, these young women feel that others have greater knowledge than they do. They are dependent upon authorities for information, guidance and resources and are subject to their control as experts. Finally, the changes associated with pregnancy challenge their previous sense of self and leave them feeling betrayed by the body that is both their own and a foreign one at the same time.

CHAPTER FIVE: REGAINING CONTROL

Women, historically, have employed various means to resist their subordinate position in society and to rebel against patriarchal control. On one level, women have joined with other women and have participated in movements of large scale rebellion and revolutionary activity. Women also resist and demonstrate agency on the private and personal level. As other subordinated groups attempt to maintain control of their situations, women, in various ways, attempt to maintain control of their own bodies and personal lives.

The young women in my sample reacted to the control they perceived in diverse ways. There was a certain amount of resignation and acceptance. On the other hand, they incorporated a number of techniques to regain their control. Sometimes they employed evasive measures to avoid negative situations and/or to protect themselves and their opinions of themselves. At other times, they worked to manipulate the situations and people around them in a struggle to act independently. They also acted in actively resistant ways to assert themselves. Planning for the future was an important

way in which they attempted to become self-sufficient and regain control over their lives.

RESIGNATION

Martin (1987) found that the women she studied responded to external control with acceptance and lament. There was also a certain amount of resignation in my sample. This resignation included both an acceptance that nothing can be done to change a given situation and a certain amount of concentration on the pain or difficulty of that situation.

Although these young women have difficulty with feeling dependent and they dislike some of the treatment that they receive, they often feel powerless to effect change. Their limited knowledge and their subordinate status in society minimize their opportunities to take action in some situations. Their relationships with their doctors are particularly interesting as they accept unprofessional treatment without objection or action. When I asked Karen why she did not do anything about a doctor she did not like, she replied:

I don't like it, but, you know, what can I do?

"What can I do?" was a common phrase used when discussing

their situations. This is a natural result of having limited resources to act and exemplifies the lack of power they have.

Their bodies also brought about this type of reaction as they felt, for the present, unable to do anything to alter their physical states. Changing shapes, unexpected discomfort and fear of delivery often left them resigned that things were completely out of their control. When talking about the stretch marks that had appeared on her legs and stomach, Natalie said:

What can you do? I mean I don't have no choice, you know, they're there.

Sandra felt particularly out of control regarding her weight. When I asked her how she responded to her size, she replied

There's not much. Nothing helps. You still look fat. You know, basically now I don't care what I look like, too much.

EVASION

Martin (1987) saw that women respond with "non-action" to their lack of control over their pregnancies. They chose not to participate in certain activities as these activities were against their interests. The women I spoke with

responded by evading situations which made them uncomfortable.

As stigmatized individuals, pregnant teenagers are often involved in information management to avoid being labelled or stereotyped by strangers. They utilize various strategies to prevent negative interactions and restrict their own behaviour to diminish the effect of their presence. Most commonly, they are involved in "passing" or managing information about their particular failing (Goffman, 1963: 43). Early in the pregnancy, most young women keep their pregnancies secret. They reveal their situation only to a close few and maintain a front of normality to others. The strategy used involves concealing or obliterating "the signs that have become stigma symbols" (Goffman, 1963: 92). This type of concealment was quite common. Sandra explained her reasoning to me.

Sometimes when I go out...when I was in a certain situation...I think it would be better if people didn't know...'Cause you get a lot of looks from people who think you're too young. It makes you feel uncomfortable...when I was in the in-between stage...that's when I think I hid it more; when I didn't look pregnant, but I didn't look not pregnant...and then people would wonder whether I was pregnant or not. I think that's when I hid it the most, because you couldn't tell really, either way. I just looked fat.

As the pregnancy progresses and the symbol of their

stigma, their stomach, becomes impossible to conceal, they shift to disguising their age instead. In the attempt to pass as legitimate pregnant women, they employed clothing, cosmetics and "more adult-like" behaviour in the construction of a new identity. Brenda tried to explain what this meant.

I'm acting more like an adult...more adult-like. I talk more like an adult now. I don't act like a kid that much any more. I act and talk more like an adult.

Nadine also did this. As she was so young, she felt particularly self-conscious about her age. Whenever she encountered strangers, she would "masquerade that (she) was 17." Her embarrassment about her age made her keep her true age a secret until she felt comfortable with the people around her.

Another strategy involved minimizing contact with others who might judge them. For Natalie, this included staying home most of the time.

I don't want nobody to see me now...I don't go down town that much, only if I have to do...shopping, but I make my shopping in one day...so I won't have to go there everyday...I think the less people see of me, I think that's better...'Cause people...think that you're too young...you're just wasting your time down town. You're always down town

hanging out...and that's not me, you know. I don't want people to get that idea of me, so I just...stay here...and that's better. Just keep yourself out of trouble.

For some, this was taken to an even further extreme. Four of the participants left their home towns for the duration of the pregnancy and returned only after they had given their babies for adoption.

Essentially, this evasion is a form of self-restriction. More than simply avoiding certain activities or places, these women actively restrict their own behaviour to avoid any social sanctions. In spite of this, they experience some relief from the social control around them, as they are able to regulate, to some extent, its impact on them.

MANIPULATION

In addition to hiding their pregnancies to avoid negative judgement, they also use the pregnancy actively to achieve their own ends and build their sense of personal power. Many of them withhold information about their pregnancies, activities and future plans from key individuals. Most often, this meant keeping the pregnancy secret from the baby's biological father. Emily actively worked to prevent either of her ex-boyfriends from finding out about the baby.

I decided to keep it secret from both guys.
I just wanted the baby for myself and no one
else. I didn't tell either of them.

In one situation, Nadine and a friend, both in their second trimester, would regularly go to the mall "to pick up guys." In order to continue their dating life, they kept the pregnancies secret as long as possible, laughing at the men who would take them out in the face of this lie.

Using the pregnancy as a means of power over another was not uncommon. This was particularly useful in negotiations with boyfriends or the father of the baby. In Nadine's case, the young man involved was reluctant to accept responsibility and was not lending support to her. In return, she used the fact that his parents were unaware of the pregnancy as a bargaining tool to gain some support from him and his family.

I said, "Well are you going to tell your parents?" And he goes, "Oh, maybe after the baby is born." I go, "Oh yeah? Well, I'll be showing up on your doorstep showing them how beautiful their grandchild is." I was fed up.

Such activities place these young women back in a position of control as they are able to utilize their own personal power to achieve their own ends.

RESISTANCE

Seeking Independence

For these young women, independence equals success and the path to independence is often one of resisting other's control. Like in Martin's (1987) study, resistance includes refusing to accept other's definitions of oneself and refusing to act as expected or required by others.

Womanhood, for the participants, is defined as having control over oneself and making one's decisions independently. When asked what it means to be a woman, the theme of independence came up most often.

Emily: To grow up...I used to think you were a woman if you had sex, but, no...realizing the wrongs and the rights of things is part of being a woman...not depending on your mom and dad any more...doing more things for yourself.

Brenda: Being independent, you know, and making decisions for yourself.

Nadine: When I picture a woman I see very strong headed and strong willed.

They consider independence necessary for survival and for getting things done. Others are viewed as unable to help, wanting to take over, or preventing them from acting the way

they want. The individual must act alone. As they strive for independence, these women set themselves up as individuals in a hostile world.

Natalie: I used to depend on (my boyfriend) a lot when I first got pregnant, but I like to do things for myself. I don't need him no more.

Nadine most clearly stated this concept as she pointed out to me the futility of asking others for assistance; "If you want something done, you have to do it yourself."

This type of self-determination, acting alone, was viewed as an achievement. Perseverance and accomplishing something by oneself was a mark of ability and a show of individual strength.

Nadine: If I say I will, I will. If I say I'm going to do something and I want to do it, then I'll do it.

Natalie: I'll know I did this all by myself without nobody's help.

Brenda: I did this all by myself. I took matters into my own hands.

Self-determination took the form of resisting the pressure of authorities, namely adults. Decisions regarding the pregnancy, the needs of the baby and presentation of their

bodies and sexuality all motivated defiant behaviour.

The pregnancy itself is to some extent a primary act of resistance. It is certainly going against the advice given by the adults around them.

Natalie: I just wanted a baby. You know when you want something and you're not going to stop until you get it? I want a baby and I'm not going to stop until I get it.

Natalie's experience reflects an active decision to become pregnant, despite the pressure of her family and society not to, but all of the young women displayed similar tenacity. Each, at some point in time, had been encouraged by those close to them to have an abortion. Failing this, they had been encouraged to give the baby for adoption. All but one chose to do otherwise. In Brenda's case, the opposite occurred. She was under pressure from family to keep the baby, which was the product of a rape. She stood firm, moved away from home to limit her family's pressure and gave the baby for adoption.

For Nadine, resisting her parents took the form of leaving home and getting legal help to keep her baby.

I've stood firm and the law will protect me. I already called my lawyers and everything to not have an abortion...I was still firm on my answer and I said no way...I'm going to parent this baby no matter how much I have to fight, no matter how I'm going to do it...I'm not going to stop until I get this baby.

Karen also directly challenged the opinions of her family and friends who were pressuring her to give the baby for adoption.

Karen: I didn't want to give it up for adoption. I just said no. I ain't gonna give this kid away. No way. I brought it in to this world. I have to take care of it.

The dependence of the baby signifies the need to take on responsibility and act independently. It provides these young women with an opportunity to do well and increase their self confidence in defending their own position.

Natalie: I just want to give her a home. A good home. I already started on that.

Andrea: You have to grow up. You're gonna have a baby.

The baby also represented a reason or excuse for independence. For Andrea, her baby gave her the confidence to act independently from her boyfriend.

Andrea: That's one good thing about having a baby. There's girls that depend on their boyfriend...They depend too much on their boyfriend and they want them to depend on the girl. But now, you don't need to 'cause you're having a little baby that's always going to depend on you and it's gonna feel a lot better if somebody is depending on you and you can always be there.

She explains the need to feel needed, rather than be the needy one and the sense of strength that comes from this.

The child was often the inspiration necessary to get on with life.

Emily: Now I have someone that's going to depend on me, so I have a reason to live. You know, I have a reason to finish school and a reason to go to college and there's someone that's 100% depending on me and it kind of makes you feel good to know that there's someone else in there. Even now she's depending on me.

Self determination and resisting the pressure of others is apparent in their talk about sexuality. A strong sense of protecting their own bodies is present. In what is often a switch from previous experiences, they feel an increased sense of personal power and feel able to control their sexuality and manage the use of their own bodies. This usually involved restricting sexual relations with boyfriends. Andrea, who had always disliked sex, but had participated to

make her boyfriend happy, now felt the ability to stop participating.

Andrea: I just don't like it (sex). I really don't ever want to have sex again. That's how it is. I hate it...I just don't like it...I don't care. I don't. Honestly, I don't. I don't even want to do it just to make him happy. Just to get it over and done with. No way, 'cause that's how much I hate it.

Emily felt able to challenge the nature of the relationship she had with her boyfriend.

Emily: It's like the only thing we have going in our relationship right now is holding hands and kissing, but that's just pecks. That's all I'll let him do and he gets kind of mad, but I don't want to get into that stuff any more. Now I believe in no sex before marriage and keeping my pride. Not just for the sake of being pregnant, but I've got those morals now. I feel like I want to be like that.

For those who continued to be sexually active, this control was expressed in the terms of sexual relations.

Karen: I sort of protest against that (the pill), 'cause guys are always trying to tell me, because they don't like using condoms, "go on the pill. Go on the pill," and it's like, so annoying to go on it, you know, taking it everyday...and then...like you feel

sick to your stomach, those things you get when you're on it. But guys are telling me to go on, but they don't really care that it's work for you. So I'm just, "No. Use a condom."

This newly found determination also appears in terms of their regard for themselves in the final stages of the pregnancy. In Stigma, Goffman refers to "disclosure," where a stigmatized individual comes to feel that she should be above passing and comes to accept and respect herself (1963: 101). As the pregnancies progressed and the young women came closer to being mothers, they often began to find comfort and pride in their abilities. This gave them a certain confidence and ability to face criticism.

Emily: Well, I just kind of figured that one day I'm not going to be able to hide this stomach any more so why should I bother...and I just started to wear whatever I wanted to wear whether it was showing off my stomach or hiding my stomach and I'd just wear it anyways...I'm proud of my stomach. I am. I walk around just loving it. I'll stick my stomach out as far as I can so people can tell I'm pregnant. It just kind of makes me feel like I'm doing something that some women can't do and some women won't do and I'm just one of those who can.

For some, their pride became an act of defiance in itself. Kelly began to actively flaunt the pregnancy and responded by

confronting those who stared or made comments to her.

Now I think, "If you don't like it, screw yourself."

Through facing adversity and acting to preserve their own needs, these young women increase their sense of personal power and self-esteem. They retrieve feelings of worth and develop the idea that they can in fact be successful.

Planning for the Future

When unable to act immediately, these young women moved toward regaining control and establishing independence through planning for the future. In many ways, they regard themselves as in a state of limbo. The present seems uncontrollable, and is often a period of waiting for the future. The state of their bodies, a place to live and future employment were all of concern.

Bodies

A great deal of planning took place with regard to their physical bodies. First, there was planning around their pregnancies and delivery. Their bodies represented a part of their being that was completely out of control. Much of what

they feared was the betrayal of their bodies and the lack of control they had over their bodies. The pain of labour and delivery and the negative physical state of their bodies both represented this loss of control.

With regard to labour and delivery, the only hope of maintaining some control had to do with planning for the process. Contrary to some findings (Bolton, 1980), these young women were intent on gaining an understanding of the process of labour and developing the coping skills to help them through it.

Brenda: I just have to remember to breath... 'Cause if you don't breath, everything'll go tense. So I just have to remember to breath. I know how to breath and when to breath but I might not remember to, so I'll just tell whoever is there with me to help me to breath and how to breath.

Another means of developing control was through preparation for pain management. Most of the young women I spoke with had consulted their doctors and had made concrete decisions regarding medications and pain control. This demonstrates that in spite of their limited knowledge, these women were prepared to gain information and increase their understanding as their pregnancies progressed. Kelly was particularly well researched and prepared.

My first two medications will be laughing gas and another one. I don't want an epidural and...I really don't want an epidural, but I'm afraid that without it...I'm going to exhaust myself. But I'll just go one step at a time.

Planning also took place with regard to the appearance of their bodies. Having the perfect body was viewed as a requirement for future success. As discussed by Bordo (1989), the ideal body has minimal soft tissue and represents the masculine values of self-control, determination, cool emotional discipline and mastery. These young women respond in the same way that other women and men in our society respond to their bodies. They regard "fat" as a metaphor for loss of control and they view their bodies as manipulable items that need to be brought back under the control of the inhabitant.

Natalie: I want to get my stomach down. Flat stomach. I mean I don't have a big stomach, you know, but there's still flesh there and I don't want no flesh there. I have to get it down.

For these young women, after breaking the rules, they strive even harder to meet the cultural ideals of femininity. Exercise was the answer to this very negative problem. In most cases, this was an extreme change from past behaviour,

but was a necessity.

Brenda: I don't like to exercise to lose weight. I'll be doing it after this, though...maybe jogging around the block...actually, I think I'm just going to jog around the block.

Nadine: I'm gonna, yuck, exercise. I don't like that word, but basically, I'm going to be a little more active than I was...I'll eat a lot healthier.

Sandra: I hate exercising. I won't exercise. I never exercise...I will now though...to get this off.

The idea is that if enough effort and hard work are put out, the body can again be regulated. After breaking the rules and inhabiting a body which reflects her deviance, the pregnant adolescent may strive even harder to meet the cultural norms of femininity. It may be even more important at this time to become "normal" members of our culture, as defined by dominant cultural ideals.

Sandra: Maybe afterwards it will get better. 'Cause I'll be paying more attention to my body...probably after I become finished with my pregnancy and everything, then I'll get back into shape.

Natalie: I'll start feeling good about my body when the baby's out, when I can do things and get, like...do sit ups, like, I know my belly's going down, you know?...I have to get slim and back in shape for next summer.

Some are willing to take this even further.

Natalie: I don't want my body to stay like this. I don't think it will, but I think I'll get my shape back...but I don't think I'll get these marks off...and if my boobs don't go down I'm gonna get a breast reduction. I want them perky again...I want them perky again. I do.

Of course, clothing is an important part of body display. Many of the young women did not have the financial means to buy "nice" clothes during the pregnancy, but all of them looked forward to the time when they could again fit into their old clothes or purchase new clothes.

Natalie: I think after I get settled down and stuff, then I'll be able to do things for myself and spend the money on myself. Take care of myself better, you know? ...Buy new clothes. Buy new clothes. Do my hair...I just want to make myself look good and everything. After I get settled in and stuff...'cause I mean summer's coming and I have to look good for the summer.

The complexity of the issue of control is most evident here. These young women share society's belief that a "good" body reflects a successful life. From this, regaining control over their bodies was a primary goal for the future and, indeed, achieving this goal may be empowering. As these young women work toward a state of "success" through their bodies,

however, they are also accepting the dominant cultural ideals of femininity. Despite such attempts to gain control, and the sense that they are achieving independence, they are not always successful. They remain under the control of external influences and, in fact, aid this by participating in self-regulation.

Housing

An important area for the development of independence is the control of one's environment. The planning for and creation of a safe space for themselves was a recurrent theme in the interviews. For these young women, an apartment or home of one's own was an important symbol or indicator of independence and success which they actively worked to achieve. One's own space indicates a certain amount of freedom. They believed that living on their own would give them more control of their day to day affairs and activities.

Andrea: ...if you're going to be doing something else in your own apartment you can put off the dishes until later or eat later, but here (in the teen residence), it's like there's no way. You can't. You have to do your chores when they (the staff) want, whatever the baby does. It doesn't matter. It's awful.

For most, an apartment was not just a luxury, but a

necessity for taking care of oneself and one's baby.

Nadine: Free advice for everybody who's my age: find a place to go, if welfare will support you or not...because my parents aren't supporting me, aren't going to accept me at home with the baby. I need a place to go.

Goffman suggests that the "setting" is an important part of one's presentation of self; "the scenic parts of expressive equipment" (1959: 23). An apartment indicates more than simply a home, it identifies one's overall success as a person and a parent. The home is a "powerful sign of the self of the inhabitant who dwells within" (Csikszentmihalyi and Rochberg-Halton, 1981: 123). For pregnant teenagers and young mothers, an apartment is a measurement of success, a symbol of adult status. Emily explains:

I don't want to be one of those who drop out. I find...compared to moms who don't drop out of school to the moms who do drop out of school, there's a big difference. Even the way their apartments look. You know. They have cruddy brown furniture and their places are just awful and scribbles on their walls and stuff. And then, you know, the people who got themselves together with nice clean, nice apartments and stuff. I wouldn't want to live like that. I want more options.

In this way, the ability to get an apartment, to

furnish it well and to maintain it to some degree reflect directly on one's ability and level of achievement. For some, it is the finish line, the final mark of achievement.

Natalie: Like, until my house is...I can look around and see I bought everything in here. And I just...like my apartment is nice looking 'cause I have everything I want, you know...then I can say I made an accomplishment, accomplished something.

Establishing a home and filling it with material possessions is a preoccupation for these young mothers. The symbolic character of furniture is important here. "Furniture presupposes a settled life-style" (Csikszentmihalyi and Rochberg-Halton, 1981: 59), indicating the stability and permanence which many pregnant teenagers lack. Working toward this goal through the collection of furnishings and supplies, as well as apartment hunting, were important parts of the way these young women spend their time.

Natalie: The first thing goes to the furniture for the house...then afterward, I have furniture, then...I just need a bedroom set and a living room set and that'll take about...probably five months...'Cause the money I've been getting I've been saving it up and I've been getting stuff for the house. Like this month I'll get my lamps...it's little stuff, but I've got all my kitchen stuff, you know. I just have to get...I have a list.

It may seem like "little stuff," but the process and the items themselves compile to become something much more important. Having one's own space is a display of ability and independence, both to others and self.

Karen: I know I could look after a baby by myself. I can. And I...I mean I have most of the stuff upstairs. I mean the only way I can prove to him that I don't want a...like, I don't depend on him no more is to show him. He doesn't know I've got stuff I've been buying and everything. He's going to be surprised. I'm not waiting on him, 'cause if I wait on him I'll never get nothing.

Education

Having an education also represents success and independence for these women. They understand that their future ability to care for themselves and their child depends upon some education and a job.

Emily: I want to go back to regular school...and if it's too hard then I'll just take a couple of classes by correspondence or whatever. I know it's going to be hard, but I have to go to school. That's one thing, I have to go to school.

For some, the pregnancy itself marked a change in their approach to education and to their futures. It gave them motivation, a reason for succeeding. Kelly explains her

newly found motivation.

I'm independent and I like to be strong. I'm determined...I think I'm more determined now to get my education and finish. More now than ever....Before I didn't have as much will to go to school and really push myself. I had no reason to, really. I didn't like it. I went off and on...but the will was never there to go and do good, but now I have reason to.

Some found new value in what previously had been a chore and re-directed their energy to seeking educational achievement.

Family

The ultimate dream for these young women is to meet the societal standards of family. Although they can be seen as a challenge to the patriarchal definition of family and although they belong to the growing group of female-headed single parent families, they wish for a future family which will consist of father, mother and children.

Emily: ...maybe God's planning on us getting married or something. You never know. Which would be good because then it would be like Mom and Dad and baby, which would be great...

To be married and settled appeared as the answer to immediate problems and concerns.

Sandra: If I was...married and had a house and a husband and a career...it would be way different from now...then I wouldn't have to worry about anything.

These young women are conservative rather than revolutionary in their values. All of them looked to their futures and saw a husband and family that met traditional definitions.

Faced with a loss of control during their teen years, the young women I spoke with were determined to regain control and find independence. This independence was a final goal. For them, standing alone and being able to take care of oneself and one's baby was the mark of success. They employed many strategies to gain independence. Some were evasive measures, aimed at minimizing disapproval. They also resisted the advice of those around them as they attempted to assert their own needs and desires. Most importantly, they attempted to plan for the future. For them, the future represented a time of hope and possibility, a state, far better than the present, when things were under control.

Nadine: Now, I'm looking for a future. You can't dwell on the past. I can't dwell on my past. I have to look to my future. I can't change the past. I can change the future. That's what I'm going to do.

CHAPTER SIX: DISCUSSION

Young women who become pregnant in our society are subject to a loss of personal control. This is the result of being a combination of young, female and pregnant in a patriarchal society. In spite of the limitations placed upon them, these young women make various attempts to resist external control of their lives and act in many ways to regain personal power. Their reactions are restricted, however, due to limits on their access to resources and opportunities for acting within our society. The research findings add to the existing research on adolescent pregnancy and the social control of women. As well, they have important implications for future research and policy development in the area of adolescent pregnancy and parenting.

The loss of control pregnant adolescents experience is a combination of the structural and cultural constraints which exist in a patriarchal society. In fact, they are in triple jeopardy; young, female and pregnant. As a result, they are vulnerable to combined societal restrictions regarding age, sex and pregnancy.

Their youthful position in society results in limited personal control on two levels. They lack resources in the areas of finances and information and they lack legitimacy as pregnant women in our society.

As a result of their youth these women are restricted in their access to financial support. Consequently, they are vulnerable to the control of parents, social service providers and other authority figures who manage these resources. This further limits their decision making abilities regarding such things as housing and education.

They also tend to have limited knowledge and information regarding their own bodies and pregnancy. One result of this is a lack of understanding of and preparation for the transformations involved in pregnancy. For some young women this results in increased feelings of shock and fear in response to physical changes and a heightened sense that their bodies are out of control.

Finally, their youth jeopardizes the legitimacy of their pregnancies and casts them into a deviant position in society. They become stigmatized and lose further control in terms of social legitimacy. Through enrolment in adolescent pregnancy programs which vary from prenatal education to complete residential programs, they are placed in full view of authorities who are in a position to monitor and direct their activities.

Pregnant adolescents experience further limits on personal control as a result of being female in a patriarchal society. In many ways the stigmatization and problematization of adolescent pregnancy exemplifies the social control of women's bodies and sexuality. Pregnant adolescents are stigmatized as a result of their participation in premarital sexual activity and choosing to parent their children. Their existence challenges patriarchal definitions of women's roles, femininity, and most importantly, family as they enter into motherhood outside of marriage and while they are still "children". As a result, they are subject to various forms of control from the society around them. Some of this comes in the form of social sanctions. They are repeatedly reminded of their deviant behaviour in their daily interactions with friends, family, strangers and authorities and are prevented from fully participating in society by being ostracized by their friends and peers.

In addition to the limitations associated with age and sex, these women lose control as a result of being pregnant. They experience the controls of the medical profession and the resulting loss of personal control that is associated with deferring to medical expertise. This, however is further complicated by their youth as they lack the personal power and resources which adult women have to question authority and negotiate with their doctors.

They are further subject to the advice and intervention of authorities regarding eating habits, sleep patterns and appropriate maternal behaviour. Again, the experience is heightened, as these young women are dependent upon these authorities for support and resources in their daily lives.

Finally, they are affected by cultural ideals of beauty. Pregnancy is viewed as a physical anomaly which deviates from cultural definitions of female attractiveness. In our society the pregnant body represents reproduction and eliminates many other aspects of womanhood. Most importantly, sexuality is incongruous with pregnancy. Young women who become pregnant forfeit the part of their identity that is tied up with being sexually desirable. As a result, they lose self-esteem and the personal power which is bestowed upon women who meet cultural standards. This is particularly significant for teenage women as much of their previous power was gained by achieving cultural beauty ideals with slim, young, and unmarked bodies. The loss of this power increases the difficulty in accepting the physical changes associated with pregnancy and may escalate their sense of being out of control.

The reactions which young women may have to the loss of control they experience as pregnant teenagers are also restricted by their social position in a patriarchal society.

The minimal resources that they possess in terms of money, education, knowledge and information restricts their ability to engage in collective action. As a consequence they primarily respond on an individual basis.

One common response of the young women in the study to the loss of control they experience is resignation. They feel that things are outside of their realm of influence and that there is nothing they can do to alter their situations. This reaction is not altogether surprising given the few resources available to these young women, and their feelings of powerlessness.

Resignation is not the only response, however, and the young women in this study often responded in some way to regain personal control. One response was a evasion. In many cases, it was easier for the women I spoke with to avoid interactions than to directly confront possibly negative people.

Another reaction by the young women I spoke with came in the form of manipulation. This is an active attempt to put themselves back into a position of control in certain circumstances. They used the tools available to them, in this case their pregnancies and their own bodies, to gain command over certain situations.

In several cases, the women I spoke with more actively resisted the control of others. One response was acting

directly against the advice of authorities and occasionally using additional resources to enforce their own position. This direct resistance tended to occur in areas of vital importance, specifically with regard to the physical treatment they received and decisions concerning their babies.

An important part of resistance is engaging in future planning. This was the most popular attempt to regain individual control as the young women worked toward achieving their goals by researching and preparing for the future. This makes sense as they have limited immediate recourse, but can plan toward future change, the acquisition of resources and the use of those resources for their own benefit.

The complexity of the issue of resisting control is evident in these findings. While the reactions of these young women can serve to increase their sense of personal power, they may also work against them. There are also limitations to what they can achieve on an individual basis. First, some of their responses do not necessarily increase power, but result in increased self-regulation. Reacting with resignation and evading situations can be seen as increasing their loss of control and encouraging it as they monitor and control their own behaviour. As well, their attempts to get their bodies back to the ideal shape may be experienced by them as empowering. However, as Wolf (1991) points out, cultural standards of beauty control women's behaviour by

restricting their choices and activities. In this way, what they feel is empowering may actually subject them further to cultural definitions of beauty, family and appropriate female behaviour established by others who are in a position to set such standards.

Second, the limitation of resources and possible responses available to these young women can result in the personalization of their problems and prevent them from gathering with others in the same position. These young women felt they had to act alone to handle their problems. One result of this stance is that they set themselves up as individuals and increase the risk of isolating themselves from external support systems which could assist them.

Finally, no matter how these young women attempt to prepare for the future, there are certain structural barriers for which they are relatively unprepared. The difficulties associated with child care, unemployment and limited educational facilities all pose further challenges for the future.

Implications for Future Research

The literature on adolescent pregnancy has approached the issue as a profound social problem. It has compiled data on causal variables, statistical outcomes and potential

prevention strategies and has tended to neglect the experiences of young women during and after pregnancy. The present study hopes to add the pregnant teenager's experience to this information. As well, it hopes to refocus attention to individual experience and de-problematize the issue in terms of sociological research.

This research adds to the available data by increasing our understanding of the limitations placed on young women who parent early. The social restrictions regarding age, sex and pregnancy work together to diminish feelings of personal control and may consequently add to the many challenges which already make succeeding as independent members of the society difficult. Future research might usefully concentrate on the experiences of pregnant and parenting adolescents with the objective of identifying other factors which inhibit full independence. Research needs to begin with this experience and attempt to incorporate it into the vast amount of statistical information already available. This may lead to a better understanding of why young women make the choices they do and what services can best meet their needs. As well, greater research into our society's treatment of adolescent pregnancy needs to occur.

To date, literature on the body has tended to remain in the theoretical realm. In terms of application, the approach has concentrated in areas such as beauty ideals and

the sociology of sport. This research has attempted to bring sociology of the body into the study of everyday experience. It is important to gain an understanding of how the social control of the body functions in relation to other social issues, in this case, adolescent pregnancy.

These findings support the assertions of Bordo (1989) and Bartky (1988) as these young women demonstrate the view of the body as a manipulable item and accept the norms regarding beauty and femininity. It helps our understanding of the subordination of women as it demonstrates the sense of powerlessness which comes from not meeting cultural ideals of feminine beauty.

As noted previously, very little research has been conducted on the social experience of pregnancy. This research adds experiential data to the limited amount of information which exists. It also examines how women in a deviant or subordinate position in society experience pregnancy. These findings demonstrate how the social control of women and the limitations of youth serve to further complicate experiences of pregnancy. Future research in the area of pregnancy might look at how other subordinate groups, such as ethnic minorities and the poor, perceive pregnancy in our society.

Policy Implications and Recommendations

Despite the existence of support programs for pregnant and parenting teenagers, the pregnant adolescent often feels that her needs and concerns have not been adequately addressed. This research may provide some insights into the complexities of their positions. The identification of the different ways in which they experience a loss of control is important to the types of methods utilized to deliver support, assistance and information. It is also important to see the various ways in which these young women attempt to regain control. Some of the strategies, such as evasion and manipulation, may be construed by some service providers as counterproductive behaviour. It is important to provide counsellors, caregivers and other front line workers with information about the motives and interests of these young women.

Programs can develop further by recognizing the complexity of issues involved in supporting pregnant and parenting adolescents. It is important to understand when helping actions may be construed as intrusion and result in diminishing the personal power of young women. It may be useful to recognize when young women are attempting to regain control and understand when the "help" given results in feelings of powerlessness and an increase in counterproductive

resistance. For example, the provision of adequate housing need not take only the form of residential care facilities. New models which provide support to young mothers while fostering independence, such as semi-independent living arrangements, could be investigated. Such approaches may encourage women to make their own decisions regarding their lives and respond by providing support and assistance to promote independence and personal control.

Most importantly, the young women who are the clients of such programs must be involved in the development of program goals and objectives to allow their needs to be the primary focus. Programs and policy makers may improve their services by gaining a stronger understanding of young women's experiences of sexuality and of pregnancy. Increased sensitivity to the multiple issues which result in the choice of early parenting may foster a greater understanding of the needs and desires of young mothers and pregnant teens and result in more effective support strategies.

Conclusion

The phenomenon of adolescent pregnancy needs to be understood within the context of the dominant society's norms and values. In a patriarchal society, pregnant adolescents lose control as a result of being female, young and pregnant.

As long as our society maintains patriarchal definitions of family and restricts women's ability to control their own bodies, adolescent pregnancy will continue to be defined as a major social problem and will be approached with management and interventionist strategies.

The experiences of young pregnant women need to direct both future research and policy activities. It is imperative that we develop a greater understanding of the complexities of this issue at the societal and the individual level. This understanding must encourage a change in approach to the issue as well as the development of support systems which will facilitate young women's ability to support both themselves and their families independently.

Appendix A

INTERVIEW GUIDE

BACKGROUND:

What is your age?

Are you attending school? What grade?

Do you have a job?

What are the occupations of your mother, father or relevant guardian?

Do you presently have any children? If so, what are their ages/sexes?

Who lives in your household/family? Is this the family you grew up in?

Do you have any brothers or sisters? Tell me about them.

Do you have any sisters who were/are pregnant as teenagers?

How would you describe yourself?

RELATIONSHIPS:

What is your relationship with your mother, father, guardian?

How did your parents react to your pregnancy? What kinds of things have they said to you about it?

Do you have a boyfriend?

Does he treat you any differently now?

What kinds of things has he said about your changing body?

Is he the father? Is the father still involved? What is your relationship with him? What does he think of the pregnancy? Who knows you are pregnant (family, friends)? How do they feel about it? Do they treat you any differently now?

ON BEING FEMALE:

When did you begin having your period? How did you feel?
When did you start wearing a bra? Why?

How did you learn about your body (school, mother, friends)?

How much do you know about how your body works? Has this changed?

If you could look any way you wanted, what would you look like?

Have you ever looked like this? Do you think you ever will?

How do you think you look, compared to this ideal? If you could change anything, what would you change?

Have you ever done anything to alter your body (diet, exercise, surgery, etc.)?

How did you look before the pregnancy? Did you like your body?

What do you think it means to be a woman? Do you feel anything like this?

When did you start wearing make-up?

Did/do you ever read fashion magazines? How did/do you use them? (Study, browse through, copy).

How much did you usually spend on clothes, make-up, diets, perfume, personal hygiene products, etc? Has this amount changed since you became pregnant?

CURRENT PREGNANCY:

Did you plan to become pregnant?

Were you using any form of birth control (contraceptive methods)? Have you ever used contraception? Do you plan to use any in the future?

Did you know you could become pregnant (if was not using contraception)? Why did you take this chance?

How did you find out you were pregnant? Did you have a test done? Did you suspect you were pregnant before the test? What made you suspect this (what signs of pregnancy)?

How did you feel when you found out? Why did you feel this way?

What have you done differently during the pregnancy (diet, exercise, sleeping patterns, clothing, make-up, etc.?) Do you dress differently now than before you became pregnant? Do you think you will dress differently in the coming months? How did you choose what you are wearing today?

Do you ever try to hide your pregnancy?

How has your body been feeling? What physical changes have you experienced (belly, nausea, brown line, dark nipples, large breasts, belly button, skin changes, fatigue)? How do you feel about this? Which of these concern you? Which do not?

Have you enjoyed any of these changes?

What do you think your body looks like now? How do you feel about it?

How has the pregnancy affected your activities (work, school, recreation/leisure)?

How has being pregnant changed you?

How have you been feeling emotionally?

What medical prenatal care have you had (checkups, ultrasound, other tests)? How do you feel about this care?

How have others treated you when they realize you are pregnant?

Have you made any plans regarding the labour and delivery? Have you or will you attend prenatal classes?

Looking toward the labour and delivery: how do you feel about it? What thoughts or expectations do you have? How do you think you will handle it?

Are you planning to breastfeed? Why or why not?
What are your plans for the baby?

What are your plans for after the delivery in terms of school,
work, child care/taking care of baby (if relevant)?

PAST PREGNANCIES:

Have you ever been pregnant before? What did you do about it?

How did you feel during earlier pregnancies compared with this
one?

SEXUAL HISTORY:

When did you first become sexually active (age)? Why/how did
you begin having sex?

How many sexual partners have you had?

Have you ever had a sexually transmitted disease? How did you
feel about this? How did you treat it?

Do you enjoy sex? (Getting at reasons for engaging...)

Are you still having sex (with boyfriend, father, others)?
Have you had to make any adjustments? How does your partner
feel about your body now?

Have you ever experienced any form of sexual abuse? (if
possible). Rape, sexual abuse, incest. Age, duration.

GENERAL:

What did you think of the interview?

Was there anything I missed which you would like to talk
about?

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