

Teen Pregnancy: Using Risk and Protective Factors In Prevention Efforts (2022)

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INTRODUCTION

Coinciding with the consolidation of white Evangelicalism around conservative politics in the 1980s, the Pregnant Teen emerged as more than a public health phenomenon, she became a highly gendered and heavily maligned cultural symbol of the perceived disintegration of family structure and patriarchal control (Kobes Du Mez, 2020). With the advent of faith-based but federally funded abstinence-only sex education programs, preventing teen pregnancy took on the characteristics of a “symbolic crusade,” becoming less about the genuine long-term effects of teen pregnancy on teen parents, and more a tool of enforcement for ideas about status, class, and gender (Wright, 2011). With this maligning of the pregnant teen as a symbol of destruction, public figures and policymakers largely abandoned understanding teen pregnancy as a public health issue and treating it as such. When the pregnant teen becomes the pathogen herself, and people are terrified she will infect others, it becomes less urgent to protect her from harm (Pate, 2021). When blame is laid squarely at her feet for the circumstances in which she finds herself, aided by a cultural narrative that says teen pregnancy is exclusively the result of conscious bad choices by girls, a society no longer feels the need to evaluate the forces which drive the issue.

The forces which drive the issue are many, and so are the consequences. The long-term consequences associated with teenage pregnancy include lower parental educational attainment than their non-parent peers, higher occurrence of poverty, poorer nutrition, higher rates of drug and alcohol abuse, and a higher likelihood of parental abuse or neglect (Patel & Sen, 2011). It is important, however, to untangle the degree to which these adverse experiences are the *result* of teenage pregnancy or are heavily associated with its occurrence. What can be understood at the surface level is that teenaged pregnancy is likely to eliminate opportunities for upward mobility that may be available to teens who already face these negative circumstances, and for that reason alone it is worthy of study. Poor teenagers who give birth are unlikely to achieve the educational and social advantages that will help them not be poor as adults.

There is comfort in the trends, however. Following the peak in 1991, rates of teenaged births have fallen drastically throughout the past three decades (CDC, 2019). While evidence shows teenagers in the United States begin sexual activity at similar ages to teenagers in other developed countries such as Sweden and Great Britain, rates of teenage pregnancy and birth are consistently higher in the United States than among its global peers, attributed primarily to lack of contraceptive use (Santelli et al., 2007). While the decline in teenage pregnancy rates in the United States has been consistent since 1991 and has affected all ethnic groups, it has not affected all ethnic groups equally, revealing a tenacious racial risk factor that prevents mitigating

protective factors from protecting all groups of girls equally. There was a 65% decrease in rates of teenaged pregnancy between 1991 and 2015, but birth rates per 1,000 girls remain drastically higher for Hispanic and non-Hispanic Black teens (25.3 and 25.8, respectively) than for white teens (11.4), and American Indian/Alaska Native teens continue to experience the highest birth rates of 29.2 births per 1,000 (CDC, 2019). In the one-year period between 2018-2019, rates fell 5.8% for non-Hispanic white females, but only 5.2% for Hispanic females and 1.9% for non-Hispanic Black females (CDC, 2019). Given that the rates of minority pregnancies are already higher, implying more room for them to fall, it is particularly alarming that the groups which already experience the most risk are benefitting unequally from the population-wide decline in birthrates among teenagers.

This review will examine evidence of risk and protective factors related to teen pregnancy. It will synthesize what is known about the complex relationship between poverty and teen pregnancy in order to make recommendations for prevention measures. With a basis in the belief that teen pregnancy is a public health issue and not a moral one, I will demonstrate that treating the issue from a public health perspective is not only the most compassionate strategy, but also the most effective. Since teen pregnancy is experienced by girls, it is also an issue of gender equality and full participation of women in social and economic life.

EMPIRICAL ANALYSIS – RISK AND PROTECTIVE FACTORS

RISK FACTORS

The most relevant and commonly understood risk factor for teenaged pregnancy is poverty (Berry et al., 2000). Like teenage pregnancy itself, the correlation of poverty to rates of teenage pregnancy is impacted by the racial or ethnic identity of the teenager. Teenagers who give birth are drastically more likely to have been in poverty during their childhood and adolescence than those who do not give birth, with rates most striking among Native American/Alaska Native girls with 47.1% of girls in that group who got pregnant living in poverty, compared with 25.8% of the entirety of girls in that group living in poverty (Berry et al., 2000). If 25.8% of girls within a particular ethnic group seems high, that is because it is extremely high, compared to the population-wide rate of poverty which was 11.6% in 2021 (Creamer et al., 2022). Because of this racial discrepancy, it is appropriate to view the risk factor for teenaged pregnancy associated with poverty as inherently intertwined with risk factors associated with race and ethnicity. Being a racial or ethnic minority makes a girl more likely to live in poverty *and* more likely to give birth as a teenager, but the higher rates of pregnancy are due to the poverty which is associated with the racial identity through structural inequalities, and not due to an inherent quality of the racial minority. This is worth noting because the cultural baggage associated with the archetype of the Pregnant Teen is heavily racialized and rooted in harmful stereotypes about the sexual immorality of non-white groups (Barcelos & Gubrium, 2014).

Associated with both poverty and adolescence is impulsivity, which is a high contributor to teenage pregnancy and unplanned pregnancy in general. Lower socioeconomic status is associated with decisions geared toward short-term, minor- or moderate-reward decisions over long-term, higher reward decisions (Liu et al., 2012). Liu et al. conducted a study in which individuals were given cues of either affluence or poverty before engaging in a gambling-like card game of chance, finding that those receiving poverty cues displayed more impulsivity and less long-term logical thinking than those given affluence cues. When the future is unstable or unpredictable, it may not make sense to plan for it over the possibility of immediate reward. Impulsivity is also overwhelmingly associated with adolescence. Impulsivity is multi-dimensional but is largely understood to be a characteristic of the developing adolescent brain (Ruddy et al., 2018). A 2017 study shows a teen pregnancy rate of 42.6% for girls in the study who had a childhood ADHD diagnosis, compared to 10.6% for girls without the diagnosis (the study drew from a population with other risk factors for teen pregnancy, making the rates higher than in the general population), which indicates a relationship between brain-level impulse control and teenaged pregnancy (Owens & Hinshaw, 2019).

PROTECTIVE FACTORS

Parenting styles have a strong effect on the likelihood of teenaged pregnancy. Lower likelihood of teenage pregnancy is associated with attentive/vigilant parenting styles and parents who have high, clear expectations for educational attainment and abstinence from sexual activity combined with the involvement and monitoring which makes enforcement of these values effective (East et al., 2006). Living with biological parents augments the effects of vigilant parenting in teen pregnancy prevention (Doğan-Ateş & Carrión-Basham, 2007). Girls' own attitudes toward childbearing can also be protective: when girls have a conscious aversion toward childbearing in general, they are less likely to become pregnant. Academic success is also negatively correlated with teenage pregnancy, which may reveal a complicated relationship between academic success and other protective factors against teenaged pregnancy such as vigilant parenting, impulse-control, and higher SES (East et al., 2006). What is consistent in understanding individual and familial protective factors is that no factor exists in a vacuum – poor teens are more likely to live away from their biological parents and less likely to be vigilantly monitored and are less likely to be high academic achievers. Together, these risk factors interact and create a miasma of risk that increases the chances of a teenaged girl becoming pregnant through a number of avenues.

Beyond the family and individual level, extrafamilial or contextual factors can be protective against teenaged pregnancy. High engagement with extracurriculars, including religious organizations and activities, is associated with lower rates of teenaged pregnancy, as is belonging to a peer friend group in which teen pregnancy is not present and is maligned (Doğan-Ateş & Carrión-Basham, 2007). This protective factor is demonstrated in a study by Doğan-Ateş and Carrión-Basham, who conducted surveys with Latina teenage girls, 46 of whom

were pregnant or parenting and 48 of whom were not pregnant or parenting. Access to contraception also, understandably, decreases teenage pregnancy rates (CDC, 2019). Drawing from a population of already sexually active teens, The Contraceptive CHOICE Project offered no-cost contraception to 1,404 teenage girls, 72% of whom chose a long-term option such as an IUD or implant and 28% of whom chose other methods. Among teenagers in the general population who were already sexually active, the birthrate was 94.0 births per 1,000 teen girls, compared with 19.4 births per 1,000 girls enrolled in the program (Secura et al., 2014). It does not stretch credulity to understand that no-cost contraception, particularly long-term options which do not require a teenager to remember to take them every day, decrease pregnancy rates in adolescent girls who are sexually active. This is especially relevant considering the relative parity the United States has with other developed countries regarding sexual activity among teenagers, but much higher teen pregnancy rates (Santelli et al., 2007).

SYNTHESIS

Glaring racial inequalities are evident when examining data on United States teen pregnancy rates (CDC, 2019). While the racial disparity in teen pregnancy is remarkable, it is more useful to see that risk factor as indicative of the more pervasive risk factor of poverty. Reducing the number of people experiencing poverty in the United States is desirable and will lead to a decrease in teen pregnancy, reducing the number of racial minorities is not. Poverty is most glaring as a risk factor for teen pregnancy, and particularly relevant for study because most other risk factors can be understood to be the results of poverty. Poverty is associated with lower access to healthcare (including contraception), lower academic achievement, and lower parental monitoring, all of which are also risk factors for teen pregnancy (Burney & Beilke, 2008).

While the Pregnant Teen is to many a symbol of individual failure, she should instead be understood as a public health consequence of poverty and systemic inequality paired with a culture-wide terror of understanding teens as human beings existing in a complex system of risks and protections. Since teen pregnancy is physically experienced by girls, it is also a gender equality issue. While boys may “step up” and participate in prenatal care and parenting, the social, economic, and health impacts of teenage pregnancy are disproportionately and overwhelmingly endured by girls (Mollborn et al., 2014). Controlling when and if to have children is considered a fundamental benchmark of women’s full participation in society, and teenage girls should be included in this understanding.

RECOMMENDATIONS AND IMPLICATIONS

While the most effective prevention programs for teen pregnancy would be universally available healthcare that includes contraception and an eradication of poverty, neither silver bullet is likely to be in the arsenal of United States public health anytime soon. What is more

achievable is a point-by-point intervention into the risk factors that are most within the control of the environment in which most teenaged girls spend most of their time: the school. Schools have an enormous opportunity to impact the social well-being and health education of teenagers, and in poor environments are often the most consistent provider of health screenings. Effective prevention programs for teenage pregnancy should focus on the school and utilize its existing infrastructure to reach a wide range of teenagers.

The school-based sexual education programs that are most likely to decrease teenaged pregnancy are so-called “abstinence-plus programs,” which equip teens with the knowledge that abstinence from heterosexual intercourse is the only 100% effective method of pregnancy prevention, along with accurate and comprehensive education about other effective forms of contraception, how they work, how and how often they fail, and how teens can realistically access them (Thomas, 2003). Public health programs that provide free and confidential birth control such as Teen Choices in Seminole County, Florida should increase, since cost and the risks associated with parental involvement or notification are primary barriers between teens and contraceptive use (*Teen Choices Health Clinic | Florida Department of Health in Seminole*, 2022). Finally, since involvement with extracurriculars and positive relationships with peers are protective factors against teen pregnancy, schools should invest in robust and engaging extracurricular programs which are available to all students at no cost, and which foster positive peer relationships. At the family level, parenting education programs such as those associated with Head Start and other services aimed at low-income families should emphasize the positive effects of vigilant parenting. Such programs should be sensitive to the barriers to vigilant parenting that are associated with poverty, such as less free-time, more stress on parents, and generational cycles of neglect, and offer appropriate education and support.

Finally, when teens do become pregnant (and some always will), communities, families, institutions, and individuals should fight the impulse to treat the Pregnant Teen as a problem in herself, and instead aim their efforts at protecting her from the harmful outcomes associated with teen pregnancy. The negative outcomes that correlate with adolescent childbearing are not the immutable, inevitable punishment given to sexually active teens by a just universe, they are the result of systems of oppression and inequality. Teens should be given accurate information about abortion, and no-cost, anonymous access to the procedure free from parental notification requirements if they choose it. If they choose to not have an abortion, they should be supported throughout their pregnancies and in their decisions to release custody of the baby to adoption or to become parents. The same systems of support that are meant to mitigate the harmful effects of poverty in general should be available to teen parents, with their particular needs taken into account. The risk and protective factors associated with teen pregnancy in the United States, like most complex social issues, are intricately related to systems of inequality and oppression. Prevention efforts should focus on mitigating these root causes.

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