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Communication, Control, and Time: The Lived Experience of Uncertainty in Adolescent Pregnancy

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I am submitting herewith a dissertation written by Elizabeth Dortch Dalton entitled "Communication, Control, and Time: The Lived Experience of Uncertainty in Adolescent Pregnancy." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Communication and Information.

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Communication, Control, and Time: The Lived Experience of Uncertainty in Adolescent Pregnancy

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DEDICATION

This dissertation is dedicated to my husband Rob, whose patience, encouragement, and love have supported me from the first day of class to the day of my defense. It is also dedicated to our son Will, who has opened my eyes to the wonder of pregnancy and parenting. I hope he will someday understand that everything I do, including this dissertation, is for him.

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ABSTRACT

This study qualitatively examined the lived experience of uncertainty among pregnant adolescents. Utilizing a phenomenological approach, long interviews were conducted with 10 pregnant adolescent women between the ages of 15 and 18. Interviews were transcribed and analyzed using the process of phenomenological explication. Data, emergent themes, memos, and a detailed audit trail were maintained using the qualitative data analysis package Nvivo 10 for Mac (beta version). Findings can be summarized with eight themes that underlie the essence of uncertainty in adolescent pregnancy: suspicion and denial, disclosure and reactions, controlling the flow of information, relational renegotiation, the emerging reality of pregnancy, information behavior, encounters with doctors and other professionals, and the future. From these themes, it is evident that the lived experience of uncertainty is about loss of control. Also of importance is the lack of uncertainty about life after the birth and how this may contribute to cultural and socioeconomic disparities in adolescent pregnancy. In addition, participants' sense of control is both threatened by and surrendered to time; time, therefore, both enhances and mitigates uncertainty. Knowing this allows for recognition of where control can be reestablished to promote better self-efficacy among pregnant adolescents.

This study has implications for uncertainty in health communication and makes the argument for further incorporating pregnancy into the health communication research agenda. In addition, this study compels the extension of research on uncertainty into areas such as mental health, nutrition, exercise, and hygiene, where time may also play an important role. Implications for communication theory, particularly related to privacy management and relational turbulence, as well as home-visitation interventions in the public health sector are discussed.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

A girl, probably about 14 or 15 years old, sits in an upholstered chair in a quiet, tidy room. There is a muted television playing, the station set to an HGTV show where people are searching for beachfront real estate deals. The girl is not watching the television, but is being very still, staring into the distance and occasionally looking down and picking at her nails. She is thin with short blond hair, and is wearing jeans, tennis shoes, and a pink hooded sweatshirt. Next to her sits a woman who looks to be in her 40s, probably the girl's mother. She looks tired and concerned, clutching her purse and resting her chin on her hand. Across from them, a boy who appears to be about 16 or 17 sits slouched in his chair. He has a shaved head, baggy jeans, and a tattoo is visible where his wrist emerges from the sleeve of his sweatshirt. His eyes stay glued to his phone as he either texts, scans Facebook, or plays a game to keep himself occupied until they are called through a nearby door. He begins to rise from his seat, but hesitates, unsure as to whether he should accompany the two women. Neither of them seems to notice his hesitation, and he shuffles in behind them just before the door shuts.

When the trio reemerges from the same door about 20 minutes later, the girl's expression has not changed. While the mother walks over to a nearby counter, the girl, emotionless, sits down and begins to examine a long vertical strip of photo paper. The guy peeks over her shoulder and points to something in one of the photos.

Among this threesome, is hard to determine who the patient is at this doctor's office. It is probably not the guy, because this is an obstetrics and gynecology clinic. Neither the girl nor her mother appears to be pregnant, and surely the girl is too young to be carrying a baby. But doctors' offices do not pass out ultrasound photos to just anyone. As the girl and the boy continue to examine the images, which contain just a tiny speck of a fetus, a nearby patient

waiting for her own appointment draws a sharp breath. As she looks at the young couple, she realizes what she is witnessing. This is adolescent pregnancy.

The scene described above was witness by the researcher while waiting for her own OB/GYN appointment. For an outsider observing such scenes and people, the topic of adolescent pregnancy begs to be understood from the perspectives of those living through the experience. Adolescent pregnancy is a phenomenon that has been framed by research in various fields. In terms of the challenges posed by adolescent pregnancy, the young woman described above will no doubt face numerous difficulties. Pregnant adolescents face greater health risks and chances of complications such as low birth weight and infant death. Between 2003 and 2005, preterm birth rates averaged 14.5 percent for women under age 20 compared to 11.9 percent for women ages 20 to 29 (March of Dimes, 2009). Babies born to teenage mothers, with the highest risk being for those who are under age 15, are more likely to die in the first year of life than babies of women who are in their 20s and 30s (Mathews & MacDorman, 2008). Those who survive are likely to experience poorer overall health than those children born to older mothers (Mollborn & Morningstar, 2009). But the challenges go beyond potential health problems, affecting the mother and child on a social level as well.

For the mothers, roughly 1 in 4 women who give birth under the age of 18 go on to have a second baby within 2 years after the birth of their first (March of Dimes, 2009). Those in high school are far more likely to drop out than their non-pregnant peers, and are at greater risk for low parenting competency (Mollborn & Morningstar, 2009). Often finding themselves without an education or skill set, these mothers tend to face higher rates of under- and unemployment, and are forced to depend on their families and public assistance for support (Mollborn & Morningstar, 2009; Witte, 1997). The children of unwed adolescents face a difficult road as well:

poor coping skills and delayed language development may stem from the maternal stress of adolescent motherhood (Mollborn & Morningstar, 2009). Compared to 7 percent of children born to married, high-school educated women over the age of 20, nearly two-thirds of the children of unwed mothers live in poverty (March of Dimes, 2009). On a societal level, adolescent pregnancy perpetuates an ever-widening gap in both social and health inequalities (Paranjothy, Broughton, Adappa, & Fone, 2009). As the children of adolescent mothers age, they are often at a physical, social, economic, and cognitive disadvantage compared to their peers. Therefore, they may struggle to gain a foothold in society and move toward the same fate as their mothers. Adolescent pregnancy plays a major role in perpetuating social and health inequalities. The cycle of disadvantage continues.

The aforementioned body of research highlights the negative social and health-related consequences of adolescent pregnancy. Constructing this phenomenon as a uniformly negative experience is particularly salient in political and media responses to the issue (Alexander, Duncan, & Edwards, 2010). However, scholarly understandings of adolescent pregnancy do not always frame it as a problem to be solved. Some research challenges the existing discourse that frames young parenthood as an inherently negative experience (e.g., Alexander, Duncan, & Edwards, 2010; Edin & Kefalas, 2011). Adolescent mothers often construct their parenting experiences as positive transformations (Breen & McLean, 2010; Clemmens, 2003; Dalton, 2014); against a backdrop of poverty, low education, and high levels of drug abuse, pregnancy often plays a positive role (Flanagan & Kokotailo, 1999). The baby, it seems, may operate as a stabilizing influence in the life of the young mother. Children provide motivation, meaning, and, especially for women on the bottom rungs of the American social class ladder, "a vicarious second chance at the social mobility that has slipped out of their grasp" (Edin & Kefalas, 2005,

p. 179). In this way, a baby represents opportunity. From this perspective, the baby has a fresh start with better prospects in life than what the mother may have had.

Health, an ideal venue for exploring and refining existing models and theories of communication (Kreps, 1989), provides excellent opportunities to both extend and challenge our current understandings of communication constructs, including uncertainty. But adolescent pregnancy, and even pregnancy in general, has largely been left out of the health communication conversation. Uncertainty affects people's health behaviors, often in unexpected and unpredictable ways; thus, it has real consequences for health outcomes. This review defines relevant concepts and explains why uncertainty in adolescent pregnancy is such an important area of study.

Rationale

Uncertainty has been defined as a feeling of insecurity about one's own state of knowledge (Brashers, 2001). It results from a lack of confidence in one's ability to predict future events or explain past events (Berger & Bradac, 1982; Berger & Calabrese, 1975). The struggle to grasp what is known and not known, to reflect on the past, and to see what might happen in the future is a struggle to interpret. Uncertainty in health, therefore, indicates that a person is struggling to assign meaning to a particular health experience. This is an important area of research because the meaning that both individual people and larger cultural groups assign to health events has the power to shape and alter communication experiences at every level. When individuals deal with a health issue, it creates a unique interpersonal context, altering the boundaries for communication (Duggan, 2006) and providing a wealth of opportunities for examining and extending current theoretical knowledge. Therefore, scholars can look at communication concepts, such as uncertainty, in terms of how people and cultures construct

health events. From there, we can begin to view previous knowledge and definitions in a new light.

Additionally, because of real and immediate benefits to the public, applying communication principles to health issues can help legitimize communication as a field of study (Kreps, 1989). Over the past 25 years since Kreps' article was published, communication has continued to grow into a legitimate and respected field of inquiry; however, scholars need to continue applying communication knowledge in a way that alleviates pressing social issues such as adolescent pregnancy. This study builds upon previous research about adolescent pregnancy to better understand the lived experience of uncertainty in this context. The focus for this study further explores the communication mechanisms surrounding uncertainty and how adolescents use them to make sense of their pregnancy experiences.

Illuminating the phenomenon of uncertainty in adolescent pregnancy from the participants' worldviews potentially helps improve the quality of life for young pregnant women. The communication behaviors surrounding uncertainty have been studied within health communication; however, the focus has largely been relegated to the illness experience. Pregnancy is not a typical or everyday circumstance, nor is it a time of illness (Matthias, 2009). But the symptoms of even the most normal pregnancy can mimic those of illness, which may lead to bewilderment and uncertainty. Also fairly common is the threat of concurrent illness during pregnancy, which can compound feelings of uncertainty and distress (Handley, 2002). The gestation period and childbirth are usually dealt with by a physician in a doctor's office or hospital, a place generally reserved for the sick. Pregnancy, therefore, is a condition that straddles the worlds of health and illness, making it a unique social and health condition that stands to add dimension to our current understanding of uncertainty. Focusing on adolescent

mothers-to-be adds the unique cognitive and behavioral characteristics of adolescence, lending increased depth to this topic. This transition to adulthood is typically a time of increased risk-taking behavior, such as the unsafe sexual practices that can lead to pregnancy. These are the types of behavior from which uncertainty tends to naturally follow (Arnett, 1999; Laugesen, Dugas, & Bukowski, 2003).

Statement of Problem

Adolescent pregnancy can have serious repercussions for mothers, their children, their families, their communities, and society. Uncertainty, as part of the lived experience of adolescent pregnancy, may both exacerbate and mitigate the challenges associated with this experience. Additionally, the contribution this study makes to our understanding of uncertainty and of health communication in general makes it a topic worthy of academic attention. Therefore, this study provides the opportunity to improve health outcomes of pregnant adolescent women, to aid in reducing the social burden of adolescent pregnancy, and to advance our understanding of an important communication construct. Addressing this topic may also potentially lead to the development of further guidelines for preventing adolescent pregnancy.

Aims & Objectives

This study contributes to the current body of health communication research by incorporating pregnancy, adolescent pregnancy specifically, as an important context in which to understand communication processes. Overall, this type of research has important implications for health behaviors and outcomes, patient-provider communication, close relationship communication, as well as the specific construct of uncertainty. The specific objective is to describe uncertainty as it emerges through symbolic communicative processes. As a

phenomenological study, the following two research questions are addressed to understand the lived experience of uncertainty in adolescent pregnancy:

RQ1: How do pregnant adolescents experience uncertainty during their pregnancies?

RQ2: How do pregnant adolescents ascribe meaning to uncertainty within their pregnancy experiences?

Uncertainty may occur on a variety of different levels. Previous research suggests that theories of uncertainty should focus on the multiple, inter-related types of uncertainty surrounding health experiences rather than on any single kind of uncertainty (Hines, 2001). Because of this, this study is open to understanding the different layers of uncertainty that may emerge, rather than a singular focus on, for instance, uncertainty and information seeking or relational uncertainty. A review of this construct as it has been examined across a variety of fields reveals the need for this particular study to fill in gaps in current scholarly knowledge.

Review of Related Concepts, Theories, and Literature

Uncertainty is a result of people being unsure about their environment and lacking confidence in their ability to predict future events or explain past events (Berger & Bradac, 1982; Berger & Calabrese, 1975). More broadly, Mishel characterizes uncertainty as "indicating the absence of meaning" (1988, p. 225). The experience of uncertainty can pertain to ambiguity, probability, complexity, insufficient or conflicting information, and the unknown or unknowable (Babrow, Kasch, & Ford, 1998). It is purely a self-perception about one's own state of knowledge or ability to derive meaning rather than an indication of how much knowledge a person actually has. The uncertain person, in other words, may feel insecure about his or her own state of knowledge (Brashers, 2001). Uncertainty can also result from a person's assessment of the probability of an event. According to Babrow (1992), there is a curvilinear relationship

between beliefs about probability and uncertainty. Those who are certain are confident about the probability that an event will occur (or will not occur); however, people are most uncertain when they believe the probability of an event occurring (or not occurring) to be about 50 percent. With a potential outcome having an equal chance of occurring or not occurring, people may struggle to predict future events. Uncertainty, in other words, arises from the quantity of possible outcomes and the probability that each outcome will occur (Shannon & Weaver, 1949).

Uncertainty and Adolescents

A prominent feature of adolescents' minds is that they lack the skill to plan for future events if those events are not immediately eminent (Freeman & Rickles, 1993; Jorgensen, 1981). For example, pregnancy may or may not result from having unprotected sex. Pregnancy, therefore, is not an immediate enough threat to necessarily cause an adolescent to plan for its occurrence. Another defining characteristic of adolescence is the increased likelihood to engage in risk-taking behavior, setting them apart from younger children and adults (Arnett, 1999). This is important to note because of the natural increase in potentially threatening consequences that arise from risky behaviors (such as unprotected sex). Outcomes of risky behavior, therefore, are largely uncertain (Laugesen, Dugas, & Bukowski, 2003) due to the multitude of possible outcomes to different risky behaviors, of which the adolescent may or may not be aware. Uncertainty arises from the adolescent's perceived probability that each possible outcome of risky behavior, whether positive, neutral, or negative, will occur. The proclivity to engage in risk-taking behavior, therefore, because of the uncertainty it can generate, is what makes adolescents such an interesting and important population in which to examine uncertainty.

Uncertainty and Health

The idea of uncertainty is especially applicable, and has been particularly influential, in examining people's health experiences. As human beings, the different processes that both sustain and threaten our bodies are often a mystery to us. Uncertainty, therefore, plays a complicated role in how people understand and manage their health. Questions arise pertaining to how much certainty people need and want, as well as how much uncertainty is tolerable or preferable. Historically, a theoretical focus on *reducing* uncertainty has dominated communication research. During the 1990s, scholars began to challenge the notion that people are always seeking to reduce uncertainty. What resulted was an ideological shift toward the alternative concept of *managing* uncertainty (Afifi, 2010). This shift can be traced by the expansion of theory surrounding the concept.

Theories. Three theories have been used within the field of communication to understand uncertainty in health: theory of uncertainty in illness (Mishel, 1988, 1990), problematic integration theory (Babrow, 2001), and uncertainty management theory (Brashers, 2001). Each represents a departure from earlier social scientific conceptualizations of uncertainty, such as that proposed by Berger & Calabrese (1975) in their uncertainty reduction theory. Uncertainty reduction theory explores initial interactions between strangers and assumes uncertainty causes anxiety that the bearer takes steps to reduce. But the theory of uncertainty in illness, problematic integration theory, and uncertainty management theory all move away from the idea that uncertainty is necessarily anxiety-producing and that people always seek to reduce it through communication. When examining uncertainty in health situations, a certain level of uncertainty is often acceptable and sometimes even desirable. All three of the aforementioned theories contain valuable principles that have been used to understand the pregnancy experience. Therefore, each

of these theories is briefly examined to situate the current study and its unique approach to adolescent pregnancy.

Mishel (1988) posits that uncertainty occurs when a decision-maker has difficulty assigning a value to an event or circumstance, when sufficient cues are lacking, and when outcomes cannot be predicted. This theory of uncertainty in illness postulates that the antecedents of credible authority, social support, and education can all influence how a person perceives uncertainty. When revisiting and reconceptualizing the theory (1990), Mishel introduced the idea of managing the uncertainty surrounding the illness experience. As sick people experience uncertainty during acute phases or chronic illness situations, their perception of that experience may evolve over time. Uncertainty, therefore, may be appraised as a natural part of life. As a result, a tolerance for ambiguity and unpredictability emerges.

Babrow and Matthias (2009) call for a more discriminating analysis of the uncertainty construct within the communication field. As a lens through which to examine the relationship between communication and uncertainty, they suggest problematic integration theory (PI) for its meaning-oriented perspective on the human health experience. People assign meaning to their experiences in the form of probablilistic and evaluative orientations (Babrow, 2001). Probabilitstic orientations are the associations by which people come to understand their world. These include the beliefs, definitions, expectations, and perceived similarities or metaphors that people use to make meaning. Evaluative orientations, on the other hand, address questions of whether an object, event, outcome, or characteristic is positive or negative. Often, integrating probabilistic and evaluative orientations results in uncertainty. In short, the theory is useful as "a kind of cognitive heuristic for understanding problematic cognitive-affective states," (Bradac, 2001, p. 467). Not only is communication central to the experience of problematic integration,

but also it is one of the only ways in which uncertainty in pregnancy has been studied within the communication field (see Matthias, 2009; Matthias & Babrow, 2007).

As an explanatory structure, uncertainty management theory shares many of problematic integration's assumptions, but is narrower in focus (Bradac, 2001). Consistent with problematic integration theory, uncertainty management theory backs away from the idea that uncertainty is necessarily anxiety-producing. Therefore, uncertainty may or may not lead to attempts to reduce that uncertainty (Brashers, 2001). As Mishel found when reconceptualizing uncertainty in illness, *management* becomes a more appropriate term as a range of emotional and behavioral responses to the uncertainty experience exist. Communicative behaviors that accompany uncertainty management play out in three different categories: information acquisition, information handling, and information use (Hogan & Brashers, 2 009). To make decisions, plans, or predictions about other people's behaviors, people often seek to reduce the complexities and ambiguities of daily life (Brashers, 2001). At other times, uncertainty allows people to maintain hope or optimism when added information might take that away. Despite its applicability to understanding communication in health experiences, uncertainty management theory has yet to be applied to pregnancy, or specifically adolescent pregnancy.

Relationships, health, and uncertainty. Acute health experiences can introduce new levels of uncertainty into interpersonal relationships. Relational uncertainty has been defined as the questions that people have about involvement within close relationships (Knobloch & Solomon, 1999). Specifically, relational uncertainty occurs when questions about the *nature* of a close relationship arise. Questions about the self, one's partner, and the relationship as a whole are three primary sources of relational uncertainty (Knobloch, 2010) that may exist for those experiencing adolescent pregnancy. For instance these types of questions concern the role and

identity of the self in the relationship, as well as the partner's feelings and level of involvement in the relationship.

Coping with health events is often examined on an individual basis, ignoring how stressors can affect the other people in one's life (Goldsmith, 2009). For example, when a partner experiences long-term or chronic illness, this can have a major impact not only on the individual, but also on the relationship. As Goldsmith (2009) points out, there are many different layers of uncertainty within the illness experience: uncertainty about the illness, uncertainty about identity, and uncertainty about the relationship. These layers have been examined in the context of HIV/AIDS, with special attention given to the relational complexities of managing social support and uncertainty. Complexities include added relational uncertainty, the dilemmas that can result from a lack of coordination between partners in managing uncertainty, and the burden of managing others' uncertainty about the illness (Brashers, Neidig, & Goldsmith, 2004). Also, seeking and receiving social support can often *create* uncertainty, as questions about stigma and impression management, obligations for reciprocation, and dependence on others may arise (Brashers, Neidig, & Goldsmith, 2004). Overall, this dyadic, multilayered approach to understanding the relational experience of illness may be useful for understanding the impact of adolescent pregnancy on close relationships as well.

For pregnant adolescents, it is possible that the pregnancy gives rise to uncertainties about relationships with sexual partners, friends, siblings, parents, grandparents, teachers, and others. These uncertainties surrounding health experiences are not always necessarily negative (Goldsmith, 2009). For instance, within intact families, unplanned teenage pregnancy can have positive relational results, such as increased cohesion and improved family functioning (Cervera, 1994), perhaps suggesting reduced relational uncertainty. But, situations involving broken

families, physical or emotional abuse, and poor conflict resolution skills can all lead to relational turmoil for pregnant adolescents (Hanna, 2001) and increase uncertainty by harming the young woman's sense of security. Relational uncertainty can also result during the transition from pregnancy to motherhood. Adolescents, for instance, may struggle to reconcile their expectations of their support system with the actual amount of support they receive once the baby arrives (Quinlivan, Luehr, & Evans, 2004).

Health information behavior. Managing uncertainty in health situations leads to questions of how people interact with health information. Seeking health information is, in fact, a noted response to illness-related uncertainty. For instance, during an illness episode, people may seek out information about possible treatments, symptoms, or prognoses to help them make decisions. Much of the research surrounding cancer patients and information seeking shows the psychological and emotional importance of having information needs met to possibly improve a patient's quality of life (Jefford, et al., 2005; Johnson, 1997; Ransom, Jacobsen, Schmidt, & Andrykowski, 2005). Sources of health information may include health-care providers, peers, friends and family, health services organizations, and the media. Channels for exchanging health information include face-to-face and mediated communication (Brashers, Goldsmith, & Hsieh, 2002). Having established that meaning-making in health is not always about reducing uncertainty, it follows that information *management* (Brashers, 2001) takes into account that people interact with information in different ways to help them manage uncertainty.

Information management can include such behaviors as seeking, avoiding, providing, appraising, and interpreting environmental stimuli. In a given health situation, if uncertainty is distressing, information can be used to decrease that uncertainty. But information can also *increase* stress-producing certainty or uncertainty. In some cases, uncertainty may be appraised

as an opportunity to preserve hope or optimism, resulting in information avoidance or seeking information that helps to maintain uncertainty (Hogan & Brashers, 2009). Therefore, it may be preferable to avoid information to maintain one's current state of knowledge. When it comes to avoiding information, uncertainty management has been examined in the contexts of cancer (Thompson & O'Hair, 2008), Alzheimer's disease (Stone & Jones, 2008), organ transplantation (Stone, Carnett, Scott, & Brashers, 2008), and diabetes (Vevea & Miller, 2010). But a closer examination of how pregnant adolescents interact with information is warranted. This has potential implications for both interpersonal communication and health outcomes as well as adds to our understanding of how pregnant adolescents construct meaning from their experiences.

Uncertainty and Pregnancy

The experience of pregnancy is fraught with uncertainty (Matthias, 2009). The first trimester of pregnancy is a particularly uncertain time in terms of the viability of the pregnancy (Patterson, Freese, & Goldenberg, 1986) and the uncertainty surrounding symptoms can be very destabilizing. Experiences with different doctors, nurses, midwives, and ultrasound technicians can be conflictual and confusing, especially for a young woman who may not be a strong advocate for herself within the health system. Information from these practitioners, friends, the Internet, and the father of the child can also be contradictory, further compounding uncertainty by increasing the number of possible outcomes. Uncertainty may also result from a lack of exposure to health resources and an overall lack of knowledge surrounding the pregnancy and childbirth experience. If the patient feels insecure in her level of knowledge surrounding her condition, she may struggle to derive meaning from the pregnancy experience.

Pregnancy is a time in a woman's life when the wellbeing of both herself and her child are so important that any uncertainty related to health is naturally intensified (Matthias, 2009).

The experience of problematic integration gives rise to a struggle for meaning within health experiences. This struggle is particularly salient in pregnancy because of the enormous values at stake when the health of the baby and mother are uncertain (Matthias & Babrow, 2007). Matthias & Babrow (2007) discovered the indispensable role that the midwife plays in helping the pregnant woman cope with uncertainty. Later, Matthias (2009) examined the differences between how expectant mothers handle problematic integration with midwives and obstetricians. The obstetricians facilitated coping with uncertainty by addressing the mothers' probabilistic orientations (beliefs, expectations, and uncertainties), while the midwives addressed both probabilistic and evaluative orientations (values, desires, hopes, and fears). The latter was found to provide a more complete coping mechanism for the mothers (Matthias, 2009).

Uncertainty in pregnancy has also been examined through the lens of Mishel's theory of uncertainty in illness. Handley (2002) found that uncertainty in pregnancy was negatively related to age, education level, and income. The inverse relationship between education and uncertainty has been found within other studies as well (Dean & Degner, 1998; Mishel, Hostetter, King, & Graham, 1984). The relationships between age, educational level, and uncertainty support the decision within the current study to examine uncertainty in adolescents: there is a good chance that, in some form, uncertainty is a factor for pregnant adolescents who are younger and may have less education than adult women who become pregnant. Handley's study also found that uncertainty was significantly higher for pregnant women from rural areas than those living in urban counties. The relationships between income and uncertainty, as well as the significantly higher uncertainty among rural pregnant women, support the decision to examine adolescent pregnancy in the specific geographic area of Central and South Central Appalachia.

Given the background information about uncertainty and adolescents, uncertainty and health, and uncertainty and pregnancy, a gap in the body of health communication knowledge when it comes to understanding this construct emerges. Adolescent pregnancy is potentially a rich context for an in-depth exploration of health-related uncertainty. The richness comes from both the complex nature of the pregnancy experience and the unique characteristics of the adolescent status. Knowledge of the theoretical background on uncertainty serves to sensitize the researcher to emergent themes without forcing a predetermined frame on the data.

CHAPTER 2: METHODOLOGY

Qualitative research is about understanding the richly textured human experience by focusing on the participants' constructions of their experiences. Researchers, therefore, are charged with eliciting those constructions from the participants and then engaging in a process of interpretation (Jackson, Drummond, & Camara, 2007) to capture symbol usage and communication as the subjects understand and intend them (Chesebro & Borisoff, 2007). Qualitative researchers must frame the study within the defining assumptions and characteristics: an evolving design, the presentation of multiple realities, the role of the researcher as the instrument of data collection, and a participant-centered focus (Creswell, 2013).

Meta-theoretical Framework: Phenomenology

The researcher's epistemiological position defines one's theory on the nature of knowing and the relationship between the knower and the known (Guba, 1990). Pertaining to the current study, the researcher takes the position that data are to be found in the ways that pregnant adolescents construct their experiences. Therefore, engagement with the participants in collecting data is critical (Groenewald, 2004). Additionally, the researcher believes it is impossible to separate the knower from what is known. These factors are in line with the philosophy of phenomenology, which asserts that the researcher cannot detach herself from her own presuppositions (Hammersley, 2000). Phenomenology therefore serves as the meta-theoretical framework guiding this study.

Phenomenology is based on the philosophy of Edmund Husserl who rejected the idea that objects of the world can exist separately from human consciousness. Objects of consciousness, therefore, are what constitute the external world and are the only things about which humans can be certain (Groenewald, 2004). As an approach to research that seeks to understand human

beings, consciousness is the universal and sole medium of access. The researcher should not consider the objects of the external world from the viewpoint of a detached, impartial observer; instead, the researcher should attempt to access what those objects mean to the subjects involved (Gurwitsch, 1974). The researcher is charged with describing the phenomenon of interest as accurately as possible without any kind of predetermined framework, staying true to the facts as presented by the subject. It is about accessing the lived experiences of the people who are involved, or have been involved, with the phenomenon of interest (Groenewald, 2004). Fully embracing phenomenology as a meta-theoretical framework has implications for sampling, question development, the interview process, and data explication.

Participants

The participants in this study include adolescent women who are currently experiencing pregnancy. According to the American Psychological Association (APA) (2002), the term *adolescent* can be defined in several ways. Chronological age is one way to set these parameters, but physical, social, and cognitive development must also be considered. One way of defining adolescence is "the period of time from the onset of puberty until an individual achieves economic independence" (APA, 2002, p. 5). There is widespread acceptance that those in the age range of 10 – 18 years old should be considered adolescents. This study, therefore, uses the same parameters. Those who are under 18 years of age are required to obtain parental/guardian consent (see Appendix C) prior to the interview.

Recruitment took place in areas commonly labeled Central and South Central Appalachia. These areas include eastern Tennessee, eastern Kentucky, western North Carolina, and parts of Virginia and West Virginia; they were chosen not only because of proximity to the researcher, but also because of existing health and social inequalities that make the issue of

adolescent pregnancy so salient in these areas. Although Appalachia has long been emerging from the Civil War era characterization of isolation and poverty (Keefe, 1988), the Appalachian Regional Commission acknowledges that the region's income, employment, health, and educational disparities continue to exist (ARC, n.d.). Poverty and low education, which are known antecedents to adolescent pregnancy (Bickel, Weaver, Williams, & Lange, 1997), characterize much of the Central and South Central Appalachian area (Behringer & Friedell, 2006). Inequalities even exist within individual states. Data from within the state of Kentucky, for example, show significantly higher teen birthrates in the state's Appalachian counties than the non-Appalachian counties (Kentucky Cabinet for Health and Family Services, 2012).

In addition, this region of the United States is an opportune area in which to examine uncertainty. As previously stated, uncertainty is compounded by risk-taking behavior (Laugesen, Dugas, & Bukowski, 2003) and Appalachian populations are known to engage in a disproportionate amount of health risk behaviors when compared to the rest of the United States. For example, tobacco use (Behringer & Friedell, 2006), obesity, physical inactivity (Halverson & Bischak, 2004), risky sexual behavior (Wewers, Katz, Fickle, & Paskett, 2006), and prescription drug abuse (Zhang, Infante, Meit, & English, 2008) occur at higher rates in Appalachia. Income and education level, which again tend to be lower in this region (ARC, n.d.), have also been found to have a negative relationship with uncertainty during pregnancy (Handley, 2002). It is therefore reasonable to expect that the young women of this region grapple with uncertainty in some capacity through their construction of the pregnancy experience.

Guba (1981) proposes *credibility* as a standard by which to establish trustworthiness in qualitative work. This can in part be accomplished by developing a familiarity with the culture of the research population early in the research process. Additionally, by choosing from a specific

cultural population of young women, this study presents a picture of adolescent pregnancy that, while not generalizable or global in meaning, is potentially transferable to other populations that may share similar characteristics. *Transferability* is a criterion of qualitative research that allows the findings to extend to other contexts or settings (Guba, 1981; Shenton, 2004). This is also considered a strategy for ensuring trustworthiness in qualitative research, and requires that the researcher convey to the reader clear boundaries around inclusion criteria. The current study, therefore, focuses on young women from the Central and South Central regions of Appalachia. Both the demographic and cultural characteristics of this region make it an interesting and important place to examine the phenomenon of uncertainty in adolescent pregnancy.

Data Collection

One way that qualitative researchers collect data is through interviewing. An open-ended, symbolic-interactionist approach to interviewing allows for greater flexibility and responsiveness in the interaction between researcher and participant, and is the approach that is most philosophically aligned with phenomenology. The process of phenomenological research is centered on capturing rich descriptions of the phenomena of interest, so the researcher must take care to allow data to emerge through the interview process (Groenewald, 2004). The major assumption behind symbolic interactionism as an approach to interviewing is that "meaning is constructed through interaction with others and with self" (Taylor, Haley, Wells, & Pardun, 2000, p. 223).

Interviewing and Health

When it comes to collecting qualitative health data, interviews are a uniquely interactive way to elicit information from participants through conversational partnership. Interviews, typically an exchange between one interviewer and one participant, are the most commonly used

method for collecting qualitative health data (Green & Thorogood, 2009, p. 93). In qualitative health research, these exchanges should not be a mechanical reading of standardized questions as this defeats the purpose of interpretive research. Collecting in-depth, information-rich data, therefore, requires a great deal of mental agility and sensitivity (Ulin, Robinson, & Tolley, 2005). Instead of standardized questions, unstructured interviews use interview schedules that consist only of topics and broad questions. Typically, few specific questions and no fixed questions are included. To get at more precise information that may be of interest, a semi-structured format with more specific open-ended questions can be used (Bowling, 2009). Either way, it is the job of the qualitative interviewer to encourage the participant to take an active role in determining the flow of the conversation and embrace a participant-centered approach that allows for the development of emergent themes (Creswell, 2013).

Qualitative interviews typically follow a pattern that consists of three different types of questions: main questions, follow-up questions, and probes (Ulin, Robinson, & Tolley, 2005, p. 82). The main questions should be derived from the themes and subthemes of the research problem. These types of questions introduce the topics to be discussed and are phrased in the form of questions. This phrasing should allow for and encourage spontaneity from the participant, and also keep the dialogue reasonably focused on the topic at hand. McCracken (1988) refers to these as *grand tour* questions, which both guide the interview and provide a springboard from which rich information can flow. Mimicking the flow of natural conversation, main questions should begin with the easiest and least-threatening questions and move to more complex and potentially sensitive issues as the interview progresses (Ulin, Robinson, & Tolley, 2005).

Follow-up questions are intended to generate greater detail on a specific topic and take the conversation to a deeper level. As data collection progresses, certain topics or thematic patterns may be of particular interest to the researcher. Follow-up questions can allow the interview to flow down a particular path to gain certain insight on that topic. Probes are specific types of follow-up questions that ask the participant for even deeper elaboration on a particular topic or comment. They may be phrased as, for example, "Tell me what you mean by that," "Then what happened?" or "Can you explain what that means?" Care should be taken when using probes to elicit deeper understanding of a topic: aggressive probing may be perceived as intrusive, while insufficient probing may be seen as boredom on the part of the researcher (Rubin & Rubin, 1995). With practice, sensitivity, and careful listening, a balance that leads to effective probing can be achieved (Ulin, Robinson, & Tolley, 2005).

Finally, Rubin & Rubin (1995) suggest that in-depth interviews follow a series of seven stages compatible with the flexibility of unstructured and semi-structured interview formats. These stages, which are compatible with the underpinnings of phenomenological research, guide this study's interview process. First, *creating natural involvement* can be done with informal chat and sharing personal experiences related to the interview topic—for this study, the process of introducing both the researcher and the purpose of the study. Next, *encouraging conversational competence* means taking steps to establish the researcher as a partner instead of an interrogator. This involves a great deal of genuine interest, compassion, and empathy with the participant through active listening. It may boost the participant's confidence to begin with the easiest, least-threatening questions, and move to more sensitive topics as the interview progresses.

Throughout the interview process, *showing understanding* becomes increasingly important. Certain acts on the part of the researcher suggest acceptance of the participant:

sympathetic tone, responsive facial expressions, murmurs, and gestures all help to establish rapport and comfort. From there, once the partnership is established, the interviewer can begin *getting facts and basic descriptions.* This is the heart of the interview, focusing on descriptive material. But the emotional peak of the interview occurs at the stage of *asking the really difficult questions.* It is not uncommon in health communication research to discuss topics that are outside of normal discourse with strangers. This is certainly true of the current study, which deals with such topics as sexual behavior and pregnancy. In these cases, it is often helpful to repeat difficult questions later in the interview so that the participant has time to think about them in more depth. Also, reminding participants of the confidential nature of the interview and acknowledging the sensitive nature of these topics may help soften the impact of the questions.

Often, after opening up about potentially sensitive or embarrassing subjects, the participant may feel exposed, vulnerable, and uncomfortable. It is now the job of the researcher to *tone down the emotional level.* There are several ways in which this can be done. The interviewer can turn the interview around and ask the participant if she has questions or answers to other questions. If the participant has become upset, the interviewer can always change the topic, or, alternately, allow the participant to express her feelings until she has reached a calmer state. This is often a delicate deflation of emotion that requires skill and sensitivity on the researcher's part. At the end of the interview, the interviewer must *close while maintaining contact.* This involves thanking the participant for what she has shared and reminding her of the confidential nature of the exchange. It is wise to ask permission to contact the participant after the interview has concluded in case clarification of interview material is needed in the future. The participant should also feel free to contact the researcher at any point after the interview closes.

Interviewing adolescents. "Adolescence is an in-between age, neither childhood nor adulthood, and effective interviewing strategies require particular attention to interpersonal communication skills" (Coupey, 1997, p. 1349). For researchers, an initial step in interviewing children and adolescents is recognizing the power dynamics between young people and adults. Some researchers argue that one way of addressing this power dynamic is by interviewing children in groups rather than on an individual basis (Eder & Fingerson, 2009), thus making focus groups a preferable alternative to one-on-one interviews. Reciprocity is another means of overcoming this inherent imbalance. Reciprocity can be implemented at several different levels, whether through directly empowering individuals or by using research to empower and improve the lives of young participants. In the current study, reciprocity enactment happens as the researcher attempts to maintain a participant-centered focus. In addition, the researcher is beginning each interview by stressing the importance of each participant's role in advancing scholarly understanding of the adolescent pregnancy experience.

In the clinical setting, physicians and other practitioners are faced with some of the same challenges as researchers when eliciting information from youth. Therefore, there is useful information about interviewing adolescents that can be drawn from pediatric medical literature. The "functional approach" to the medical interview embraces a patient-centered, flexible approach to interviewing (Coupey, 2007), not unlike the participant-centered, unstructured or semi-structured approach to collecting qualitative data. At the beginning and throughout the interview, it is important to clarify the confidential nature of the exchange. This can be reinforced by conducting the interview in a space that conveys privacy: for example, having a door that shuts and that is far enough removed from other areas that the conversation cannot be overheard (Sacks & Westwood, 2003).

Similar to suggestions above by Rubin & Rubin (1995), the most effective approach to interviewing adolescents begins the exchange with the least threatening, most open-ended and nonjudgmental questions and then progresses toward more sensitive topics such as sexuality (Sacks & Westwood, 2003). Coupey (2007) stresses the importance of prompts and active listening to facilitate openness and greater depth of information from the patient/participant. It may also be necessary to include clarifying comments if the participant pauses or seems confused by a question. In addition, the interviewer "should respond to nonverbal cues whenever they occur . . . . Acknowledging such nonverbal cues as tone of voice, facial expression, or body movements with a nonjudgmental observation often prompts disclosure of additional information relevant to the problem at hand" (Coupey, 2007, p. 1353). Acknowledgment of nonverbal cues, such as "You seem sad when you talk about your mother" can convey to the participant that the interviewer is actively listening. This, in turn, can facilitate trust between the two parties.

Procedures

Inclusion criteria for participation in this study requires that she is between the ages of 10 and 18, currently pregnant, and lives in the Central or South Central regions of Appalachia. This does not have to be her first pregnancy. To recruit participants, this study employs two different kinds of sampling: purposive and snowball sampling. Purposive or judgmental sampling entails choosing participants based on knowledge about a population and the purpose of the study (Babbie, 2012). Purposive sampling is appropriate because, in line with the phenomenological framework, the goal of this study is to access the lived experiences of the people who are involved (Groenewald, 2004) with adolescent pregnancy. Snowball sampling involves collecting data on a few members of the target population who can be reached initially, then asking those participants to help recruit other members of the population from their social network. This is

appropriate when members of the target population are hard to reach or difficult to locate (Babbie, 2012), as these participants have proven to be. Sampling was terminated at the point of redundancy when no new information was forthcoming from participants (Lincoln & Guba, 1985).

Participants were identified with the help of community contacts including social workers, public health departments, and various outreach and intervention programs that serve young women in these regions. Once contact was established with individual recruits, a mutually convenient time and place was determined for the interview to take place. Interviews were conducted and recorded by the researcher, who employed note-taking and the use of a digital voice recorder during the interview. These field notes served as an important part of the memoing process, whereby the researcher recorded what was seen, heard, and experienced through the course of data collection and reflection on that process. Groenewald (2004) describes and uses four types of field notes, all of which were employed in the current study: Observational notes describe 'what happened' based on the use of all senses; theoretical notes attempt to derive meaning as the researcher reflects; methodological notes are critiques, instructions, or reminders to oneself about the research process; and analytical memos summarize a day in the field or review progress. This type of preliminary engagement with the data served as a step toward explication and was maintained through the use of a detailed audit trail within the qualitative data analysis package Nvivo 10 for Mac.

Prior to beginning each face-to-face interview, the researcher obtained informed consent from either the participant herself (Appendix B) or, if she was under 18, from a parent or legal guardian (Appendix C). The researcher also explained her personal background and the purpose of the study to establish rapport and enhance the comfort of the participant. The participant was

informed of and given a $30 Visa gift card incentive along with the researcher's contact information.

The interviews began with a set of demographic questions including age, education, marital status, description of family, etc. Once these short, "easy" questions were covered, the researcher launched into more open-ended questions to delve into topics of interest (see Appendix A). As described above, the symbolic interactionist approach assumes that meaning can be found in interactions with others and with the self that the participant describes (Taylor, Haley, Wells, & Pardun, 2000). Therefore, topics and possible subtopics were used to elicit information that revealed such interaction; for example, "times when someone discussed the phenomenon with others, evaluated their [sic] own thoughts about the phenomenon" (p. 225). The interview schedule is a combination unstructured/semi-structured format (Bowling, 2009) to ensure that while the interviews are participant-led and in-depth, any emergent themes from previous interviews can potentially be explored. Previous research conducted with the same population determined that the interview often requires some structure because adolescents sometimes have difficulty thinking broadly and discussing personal topics without having specific questions to address (Dalton, 2014).

As suggested by the aforementioned methodological literature, the questions mimicked the flow of natural conversation, beginning with the easiest and least threatening questions and moving to more complex and potentially sensitive issues as the interviews progressed. At the conclusion of each interview, the researcher thanked the participant and asked her if there were any further questions, comments, or concerns. The researcher checked to be sure that the participant knew how to contact her and asked permission to contact the participant in the future if needed. Recordings were then reviewed and transcribed by the researcher.

Digital recordings, informed/parental consent forms, field notes, memos, and hard and soft copies of transcripts have all been stored properly to ensure organization and the protection of participants' identities. Digital files were immediately transferred to the password-protected laptop of the researcher, which is stored in her private residence. All hard copies of transcripts, consent forms, notes, and memos have also been stored at the researcher's private residence and locked in a filing cabinet. Copies have been stored in the office of her academic advisor, where they will remain for three years per IRB requirements, after which they will be destroyed. She and her academic advisor are the only people who have access to both the digital and hard copies of materials.

Explication of the Data

The term "explication" is substituted for "analysis" because according to Hycner (1999), the term analysis does not entirely fit with the goals of phenomenology. The term analysis is usually indicative of breaking the data into parts, which risks losing the whole phenomenon. Explication, on the other hand, allows for an examination of the elements of a phenomenon while keeping the context intact. To explicate the data, the current study adopts Groenewald's (2004) five-step simplified version of Hycner's (1999) explication process.

The first step is *bracketing and phenomenological reduction.* Here, the researcher opens herself up to the phenomenon with neither presupposition nor the intrusion of the researcher's own theoretical concepts or interpretations into the world of the participant. The researcher brackets out her own personal views and submerges herself in the data by listening repeatedly to the recordings of each interview. This allows her to familiarize herself with the territory of the participant's world, and become familiar with the words and language spoken within that world. The next step is *delineating units of meaning.* During this critically important phase, the

researcher extracts the statements that illuminate the researched phenomenon. This involves a great deal of judgment on the part of the researcher, who at the same time must continue to bracket out her own theories and presuppositions.

The third phase is *clustering units of meaning to form themes.* The researcher must now rigorously examine the units of meaning, and group them together based on significant topics (although there may be overlap among clusters). Deriving appropriate meaning may involve returning to the original recorded interviews to gain a sense of what Hycner (1999) calls the 'gestalt' or overall holistic meaning. By examining meaning within these clusters, central themes emerge to express the essence of those clusters. During the fourth phase, the researcher *summarizes each interview, validates, and modifies.* The summary is a holistic gathering of emergent themes, which the researcher then validates by returning to the participant to ensure that the essence of the interview has been captured correctly. Modification may be necessary after validation has occurred. The fifth and final phase of explication is *general and unique themes for all the interviews and composite summary.* Here the researcher looks for the most common patterns among the emergent themes, taking care to note any negative cases or individual variations among participants. Finally, the researcher writes a composite summary that reflects the context from which the major themes emerged. At this point, everyday experiences become theoretical discourse.

The methodological processes outlined above are tried and tested approaches to conducting qualitative health research, thus creating a sound foundation upon which to conduct the current study. Basing research on well-established methodological approaches is an important way to establish credibility (or validity) within a study (Guba, 1981). The importance of developing an early familiarity with the culture of interest has already been described, but

there are other steps taken in the current study to ensure credibility. These, as suggested by Guba (1981) and outlined by Shenton (2004) include iterative questioning to promote honesty from the participant, negative case analysis, frequent debriefing sessions between the researcher and her superiors, peer scrutiny of the project, keeping reflective commentary in the form of memos, having previous experience and legitimate qualification to conduct research, providing thick description of the phenomenon of interest, and a thorough examination of previous research findings to assess the degree to which the current findings are congruent with those of previous studies.

Transferability allows the reader to draw conclusions about other situations to which the results and conclusions may be applicable. This demands detailed description of the setting and inclusion criteria, both of which are provided in the current study. *Dependability* is another criterion that ensures the ability to replicate the study (Guba, 1981; Shenton, 2004). Steps taken to ensure dependability include providing a detailed description of the research design and implementation as well as an honest reflective appraisal of the methodological aspects of the project. *Confirmability* ensures that the findings of the study are the direct result of the experiences and ideas of the participants (Guba, 1981; Shenton, 2004). In the current study, this is supported by a detailed "audit trail" created in Nvivo 10 for Mac (beta version) that outlines how data were gathered and processed, as well as the theoretical aspects of emergent concepts related to the research question. Overall, the collection and explication of interview data are based on well-developed phenomenological principles that guide the entire research process.

CHAPTER 3: FINDINGS

The findings of this study indicate that pregnant adolescents struggle to assign meaning to their pregnancies when they encounter people, situations, and events they cannot control. Therefore, the essence of uncertainty in adolescent pregnancy is a lack of control. Given the very specific and relatively short duration of pregnancy, time is a particularly salient factor in determining how participants handle uncertainty—whether they attempt to avoid, manage, or accept it. At various points along the pregnancy trajectory, adolescents encounter different circumstances that challenge their sense of control; at the same time, there are also circumstances they believe they can control, and attempt to do so, with varying results. These may be classified as acts of uncertainty management.

Interviews with 10 pregnant adolescents from economically disadvantaged backgrounds reveal that uncertainty can be traced along the temporal trajectory of pregnancy, from conception to birth and beyond. Findings, therefore, are organized according to events and encounters that follow a rough chronological order. Because of the important role that time plays in moderating pregnancy-related uncertainty, this was the most logical way to present findings. The order in which findings are presented is not meant to reflect the exact chronological experience of each participant; in fact, some themes are fluid in that they may surface more than once or at differing times during the participants' pregnancies. Overall, the pattern captures the essence of uncertainty as it is constructed by the participants.

Description of Participants

Because of the nuances that make each participant unique, and in an effort to highlight negative cases that emerge in the findings, this section provides a brief profile of each participant prior to explication of the themes. Participants are presented in the order in which they were

interviewed. All participants came from economically disadvantaged backgrounds, were either African American or White, and were between the ages of 15-18. All planned to give birth to and raise their child.

Amanda is 15 years old, White, and a home-bound sophomore in high school. She is approximately six months pregnant, and resides in a rural area with her mother, step-father, a younger brother and an older sister. **Molly** is 18 years old, White, and resides with her mother and step-father. She is a high-school graduate, and is approximately eight months pregnant. **Aria** is 17, African American, and has moved in with her aunt within the last six months. They live in a small urban/suburban area. Her mother is incarcerated and her father is deceased, so she has spent her childhood in and out of foster care. She is approximately seven months pregnant, and is a home-bound senior in high school. **Heidi**, at four months pregnant, is at the earliest stage of pregnancy of all the participants. She is 16, White, and resides in her great-grandfather's basement with her mother, younger brother, and her mother's boyfriend. She continues to attend high school and is a junior in a small urban/suburban area. **Jade** is the only participant who had experienced a stillbirth prior to her current pregnancy. Within three months of her full-term loss, she became pregnant again and is now in her sixth month. She is currently 17, African American, and resides in a small urban/suburban area with her mother and three younger sisters. She still attends high school as a sophomore and works at a fast-food restaurant.

Rachel is the only participant who admitted to intentionally getting pregnant. She explains that it had originally been her boyfriend's idea, and that they conceived within four months of actively trying. They began this process when she was 16; at the time of the interview she has just turned 18 and is about eight and a half months pregnant. She is White, resides with her boyfriend in a rural area, and is completing her senior year of high school on home-bound.

Isabelle is an 18-year old senior in high school. She resides in a small urban area and is African American. She is the only participant whose biological parents are still married to each other. She is also the only one who seriously considered abortion. She is currently about eight and a half months pregnant.

Maria is 17, African American, and a junior in high school. She resides with her mother in a small urban area. She is about nine months pregnant. **Christina** still attends high school as a sophomore. She, too, is African American, and lives with her mother, her mother's boyfriend, and two sisters in a small urban area. She is 15 years old and about nine months pregnant. **Alisha** is the only participant with other living children. She is 16 and currently pregnant with her third child. She is raising her first, who is three years old, and gave the second one up for a closed adoption. She is African American, a sophomore in high school, and lives in a small urban area with her mother, step-father, younger brother, two younger sisters, and her son.

Themes

There are eight primary themes that capture the lived experience of uncertainty in adolescent pregnancy. *Suspicion and denial* occur prior to and around the time that the pregnancy is discovered. *Disclosure and reactions* describe the processes of telling selected others about the pregnancy, and the ensuing reactions to that disclosure. *Controlling the flow of information* describes events surrounding the spread of the news. From there, *renegotiating relationships* involves the guilt, conflict, forging of bonds and severing of ties that result from adolescent pregnancy. *The emerging reality of pregnancy* happens at various points along the pregnancy trajectory, and is characterized by confirmation of viability, finding out the sex of the baby, the changing pregnant body, behavior change decisions, and fears for the baby's health. *Information behavior* also happens at different times during the pregnancy and involves the

importance of interpersonal sources and social media use. *Encounters with doctors and other professionals* are characterized by inexperience with the medical system and healthcare personnel as well as ideas about the incompetence of such professionals. Finally, descriptions of *the future* include birth, motherhood, responsible parenting, the role of the "baby daddy," and professional aspirations.

Suspicion and Denial

To begin, participants were asked to describe the first time they suspected they might be pregnant. Prior to and sometimes after a positive HPT (home pregnancy test) or blood test, participants describe both the suspicion and denial surrounding the possibility of pregnancy. Suspicion and denial occur both within participants' own minds, and within their interpersonal relationships as the possibility of pregnancy surfaces. Although they often occur within the same thought process or interpersonal communication event, suspicion and denial are discussed separately because they are unique constructs.

Suspicion. Suspicion can be defined as the inclination to adopt some belief (White, 1993). That inclination has to do with being ready or willing to believe that something is true. Suspicion has a spectrum of degrees, as one can be more or less suspicious of something; pregnancy, however, does not. The experience of suspecting pregnancy provides an interesting picture of suspicion when there are only two possible alternatives: pregnant or not pregnant. The participants in this study also experience interpersonal communicative suspicion, in which a person is making a truth/lie judgment about what someone else is saying (Levine & McCornack, 1991). Some people express suspicion that the participants are pregnant before the truth has been revealed. Others express both suspicion and denial after pregnancy has been confirmed. The authors point out that there is a difference between the enduring trait of generalized

communicative suspicion and situationally aroused suspicion. Both the possibility and confirmation of pregnancy create situationally aroused suspicion and lead to uncertainty within interpersonal interactions in this study.

Most of the participants indicate feeling suspicious that they might have been pregnant before it was confirmed. In other words, they expressed varying levels of willingness to believe that they were pregnant. Indicators of possible pregnancy included missed periods, morning sickness, and, as Heidi (age 16) describes, just a feeling: "Oh…it's really I had a feelin'. Like, you know, just a feelin.' And I was just like, 'Whoa…I really think I am.'" Attempts to make sense of pregnancy indicators show how the participants grappled with this sense of uncertainty. Maria (age 17), for example, says:

> And then I started feeling sick, but I don't think, I mean, I thought it was just like- Okay, I've been late before, so that's what really kinda caught my attention. But I was extra late. So…then I was like, Okaaaayyyy, huh…maybe I need to, ya know, tell my mom about this. But I was nervous to let her know though, it took me a minute. Cause, then I had started missing more than one period, I missed a few.

Unusual and disruptive physical symptoms initially aroused suspicion, and caused the participants to speculate as to possible causes of these symptoms. With pregnancy in the backs of their minds, some attributed symptoms to stress or stomach viruses. Varying amounts of time and effort were dedicated to rationalizing these signs, attributing symptoms to anything but pregnancy. Eventually, however, they were brought face-to-face with the possibility of pregnancy. About half of the participants claimed that they had used contraception; the other half did not. Interestingly, the lack of contraception was not mentioned as a reason for suspecting pregnancy. They seem to have an awareness of contraception, but do not understand the

likelihood of conception in the absence of some sort of protection. For example, when asked if they had used any kind of birth control, Christina explains, "No, we tried to at first, but then…yeah." This demonstrates how remote the possibility of pregnancy was in their minds, and how much adolescents tend to struggle with thinking ahead about the consequences of their actions.

There was one negative case within this theme; Rachel (age 18) and her boyfriend had been trying to conceive for approximately four months before she became pregnant. Instead of suspicion, she explains that she felt hope: "I was hopin' every month. I was hopin' and prayin' every month. Cause I was hopin'- one of these months it'll just, it'll happen." She says that she felt no different, and saw no suspicion-arousing signs of pregnancy the month she conceived. This is probably because her anticipation led her to take a pregnancy test as soon as she was able to, which is prior to when any symptoms of pregnancy typically occur (such as a missed period).

It is not only the participants who experienced suspicion; the uncertainty aroused by suspicion, then, often becomes a shared experience. Parents, siblings, friends, and sexual partners were usually privy to the girl's missed period(s) and other symptoms, either because of astute observation or through disclosure on the part of the participant. Molly (age 18) describes how her suspicious mother convinced her to take an HPT:

> It was the day after Mother's Day. And I woke up…well, the day before, on Mother's Day, my mom had did this big fish fry. And I walked in the house, and just the smell of it made me really sick. And I walked outside, and it was just BAD! Well the next morning I woke up and my mom said, had a pregnancy test on the table, and said, "Take it. I really think you're pregnant." Well I took it, and within 15 seconds it shot up: Hey, you're pregnant.

Christina's (age 15) boyfriend suspected that she was pregnant:

> I really, I didn't have to tell, like he, I did tell him, but he knew—but he thought he knew, well apparently he did know before I did… he was like, "You're pregnant. You've missed this many periods, blah blah." So when I finally told him, he was like, "I knew it!" [laughs] Like he already knew. I was like, Wow, okay!"

As evidenced by Christina's boyfriend, when the person harboring the suspicion is proven right, he or she is described as reveling, if not in the pregnancy itself, in his or her correctness. Heidi herself seemed excited to be proven correct at the doctor: "And I went to the doctor and he was like, 'Well you're pregnant,' and I was like, 'I knew it!' And I was like, 'Don't have to tell me, I took a test so I KNOW [laughs].'"

Suspicion also arises in the interpersonal context as a reaction to perceived dishonesty. These are the situationally aroused experiences of suspicion (Levine & McCornack, 1991). This occurs both when the girl is trying to hide her pregnancy and when she reveals the news to an unbelieving sexual partner. Isabelle (age 18) was trying to hide her pregnancy from her family. Her sister, however, suspected her pregnancy and confronted her:

> I didn't want my sisters to find out either, cause I knew they would tell on me. But my sister noticed. She, you know, she was like, ok- you, she like, she came in the bathroom one day, she was like, "You're acting really distant. Like you don't wanna be around us, you go in your room, shut the door." She was like, "Are you pregnant?" And I was like, "NO! What are you talking about?" And she was just, like, "Okaaaay…"

Her sister's suspicion makes Isabelle uncertain about her ability to continue hiding her pregnancy.

Heidi, who lived with her mother, brother, and mother's boyfriend in her great-grandfather's basement, initially did not want her great-grandfather to find out about the pregnancy. However, because of their close living quarters, which afforded her "NO privacy at all," the delicate dance to maintain secrecy became too much to manage and she told him the truth. Furthermore, it is possible that the intrusion of an outsider's observations can make one speculate as to what else that outsider notices or suspects. Heidi's cramped living situation is an example of this, and may lead to a kind of chronic uncertainty.

Denial. Denial occurs in tandem with suspicion. For the participant, it occurs internally when she does not want to face her suspicions or the confirmation of pregnancy, as well as when she is trying to hide her pregnancy (like Isabelle). She may also deny the possibility of pregnancy when confronted by loved ones about their suspicions. In addition, denial occurs among those who do not want her pregnancy to be true: this includes both those who notice her unusual symptoms or behaviors and those who do not believe her upon disclosure of the pregnancy.

Internal experiences of denial prior to confirmation of the pregnancy emerged as a way to cognitively manage the uncertainty surrounding the idea of being pregnant. In these cases, denial is tempered by a lingering suspicion that pregnancy may be a possibility. For example, Jade (age 17) had experienced a full-term stillbirth at 16 and was pregnant again within a few months. She explains, "I was three months, and…I kinda felt like I was [pregnant] but I didn't wanna like, think I was. And I was kinda scared, surprised." The nightmare of her first pregnancy had left her feeling extremely vulnerable and uncertain. The prospect of facing another pregnancy and possible loss was frightening for her deal with, so she tried for a time to buffer herself from signs

that pointed to pregnancy. Telling herself that it was "just a missed period," she says that "In the end, I threw up, and took a test and it said positive. So…it's kinda…scary."

Some participants expressed strong denial along with very low levels of suspicion, having reasons to believe that pregnancy was not a possible explanation for symptoms they were experiencing. Amanda, age 15, was confronted by a family member who believed that she was pregnant. But Amanda relied on false physical indicators to convince herself that this was not a possibility:

> But it was just, it was a big shock. But my sister, she had said it about a week before, she was like "I think you're pregnant." And I was like, "I just had my period like a week ago, no I'm not! It's like, there is no way!" She was like, "I think you are." And I was like "NO, I'm NOT!"

She later learned that she had experienced implantation bleeding, instead of what she thought was a very light menstrual cycle. Isabelle had been told by a doctor several years prior that she would be unable to conceive. Therefore, she and her boyfriend had never used birth control. Her doctor's assertion, as well as three years of pregnancy-free unprotected sexual intercourse, led her to deny the possibility of pregnancy:

> B: So when you missed your period, was that in the back of your head, like…hmm-
>
> I: Yeah, but I was just like, "I'm not pregnant," because I was—what grade was I in?—I was in eighth grade trying out for cheerleading, and I had went in to get a physical, and they told me something was wrong. And I went to the doctor, and they were telling me I couldn't have kids, and you know, stuff like that. So you know, I never thought it could happen! So, then it just happened, and I was just like, "Wow! That's why when I missed my period," I was like, "Ok, well maybe I'm just like, stressed out or something."

Similarly, Christina's boyfriend had told her that he was infertile. She was unsure as to whether he, who claimed that his "sperm cord" did not work, had been mistaken or dishonest with her.

For many of the participants, denying that they might be pregnant was a way to suspend the pregnancy and delay the inevitable reality that was creeping into their minds. Molly explains:

> And then her…my baby's daddy would look at me and say, "You're pregnant." And I was like, "No, I'm fine." And I was, he…was like, "something's wrong." And he knew, but I was like, "no, I'm fine. I'm not having no baby." Cause I didn't want a baby at the time.

This tactic emerges as a means of holding on to control of one's life for as long as possible, and to continue the pre-pregnancy life that is a better fit with what she claims to want for herself. Molly goes onto explain that her denial was a way of managing her fear. After her positive HPT:

> M: And I called my best friend and I told her to come get me, cause I'm pregnant! We need to make sure I'm pregnant cause I was just…I was in denial at that point. Cause I was thinking, ya know, it's a Dollar Store test, it's probably not true. But it was—very true.
>
> B: So [the health department] did a blood test on you and…?
>
> M: Um, everywhere I went except for my doctor did a blood test. Well they did a urine test, then my doctor did a blood test to make sure. Cause I was like, ya know, urine tests can be bad! We're gonna, I just need a blood test done too cause I don't believe [laughing], I wasn't thinking. I was just scared.

She continued to seek out more and more alternatives to the multiple definitive indicators of her pregnancy. With each test – "I…got two more pregnancy tests, I went to a pregnancy resource center, I went to the health department, went to the doctor…" – her fear increased. She explained

that she was panicking, and, like all of the other participants, including Rachel (who had planned her pregnancy), asked herself: "Okay…so what do I do now?"

Molly's experience is an example of how denial can continue even after a positive HPT or blood test. Christina, too, questioned her positive HPT. After taking a First Response brand HPT, which she acknowledges are "supposed to be pretty accurate," she says, "But I was still like, Mmmm, I still don't know." This is a way of delaying having to "deal" with the pregnancy, and all of the uncertainties that accompany this change. As Isabelle explains, "Cause at first, I was just trying not to deal with it. Like, I just wasn't pregnant! I was just ignoring it. But, can't ignore it anymore really [laughing]." No longer are they uncertain about whether they are pregnant; instead, they are uncertain about everything else they are about to face.

Denial is also enacted within the participants' close relationships. Denial in these situations plays out as part of expressed situational communicative suspicion. This includes parents and sexual partners, who often demand physical proof of the pregnancy. The term "baby daddy" is a common in vivo term used by participants, so it will be used to describe the fathers of the participants' babies. Isabelle, who tried to hide her pregnancy from her parents for as long as possible, believed that they knew she was pregnant but were "in denial." Rachel felt that her mother was shocked that she would conceive intentionally. Even with the proof of a positive HPT, her mother attempted to deny what was right in front of her eyes:

> She was just like, "This ain't two lines! This is one line!" I was like, "Mom, there's a faint line there." I was like, "That one says pregnant," she was like, "No it doesn't," I was like, "Yeah it does," it was pretty funny. She didn't wanna…I don't know, she couldn't believe that I was trying to [get pregnant].

Heidi, Jade, Maria, and Alisha (age 16) were all confronted with denial when they told their baby daddies that they were pregnant. Maria explains why it was so difficult at the time to tell the baby's father about the pregnancy, and why he denied it was his: "So, but…I think he was just really trying to deny it, because he had a girlfriend at the time, so…" Alisha, too, had difficulty dealing with denial on the part of her baby daddy:

> Then he didn't believe me at first, then I took another one and was like, "You see?" Then I went to the doctor and got ultrasounds and everything and showed him and was like, "This is proof, I'm showing you like, this is really happening…" I felt really sad and hurted…And he just, that's when he finally came to his senses, and he was like, "Oh my gosh, I'm really about to be a father!"

Denial of these positive signs of pregnancy indicates that uncertainty is a preferable, more comfortable alternative to the truth of being pregnant. The participants and their relational partners know that, at this point, they cannot control whether the participant is truly pregnant; however, they can delay acceptance of this fact by residing in a state of willful avoidance for as long as is cognitively possible.

Suspicion and denial are intricately linked with uncertainty. When we talk about suspecting pregnancy, there is only positive or negative; in other words, it cannot be partially true, or a truth that is open to interpretation. Because there are only two possibilities, it may seem that this leads to a limited level of uncertainty. But the results indicate that a great deal of uncertainty surrounded the discovery of participants' pregnancies. As demonstrated in the themes that follow, uncertainty is augmented by the many variables that accompany the nine months of adolescent pregnancy.

The two possibilities—pregnant or not pregnant—cause uncertainty because they exist as two competing beliefs within the participants' minds. When suspecting and denying the possibility of pregnancy, a certain discomfort arises from the friction between what participants want to be true and what they suspect is actually true. Only one of the participants had intentionally become pregnant at that time, and the rest claimed that their pregnancies had been accidental. Therefore, the possibility of being pregnant was at odds with what they wanted for themselves at that moment. Although all (except Isabelle) had quickly come to embrace the idea of pregnancy, their earliest suspicions produced cognitive dissonance. Cognitive dissonance can result from inconsistency between a person's behaviors and beliefs, or between two beliefs that are at odds with one another (Festinger, 1957). It seems that in the current study, uncertainty is a product of cognitive dissonance, as participants are suspended between two possibilities: pregnant or not pregnant. Denial, for both participants and their relational partners, is enabled by selective exposure (Festinger, 1957). Ignoring signs that indicated pregnancy allowed participants to avoid information that is likely to increase suspicion and agitate cognitive dissonance. This discomfort ultimately gave way to whatever emotions—fear, surprise, excitement, sadness—accompanied confirmation of the pregnancy.

Disclosure and Reactions

Disclosure of pregnancy. Once pregnancy has been discovered and confirmed, participants had to make decisions surrounding disclosure. Interview questions that addressed disclosure decisions included whom she told first, next, and so on, as well as why and how she told them. These decisions included whether to disclose, when to disclose, to whom they should disclose, and how to disclose. In doing so, participants create informational boundaries, structures that describe who is and is not allowed to access private information (Petronio, 1991,

2000). Communicative acts of suspicion and denial are often part of telling other people about the pregnancy. As described above, suspicion can result in both voluntary and forced disclosure; denial on the part of her relational partners is often a reaction to disclosure of the pregnancy. These experiences can have a major impact on the meaning she assigns to her relationships, pregnancy, and identity. But the uncertainty surrounding disclosure also stems from decisions about how, when, and to whom disclosure should occur.

Disclosure is the process of revealing personal or intimate information to someone else (Rotenberg, 1995). It is a form of telling, one that reveals some aspect of the self (Charmaz, (1991a). All of the participants had specific people from whom they wanted to keep the pregnancy secret for as long as possible. Sometimes this included particular individuals and sometimes it was groups such as their peers at school and the general public. The boundary between acts of disclosure and secrecy revelation is somewhat foggy. Secrets, information individuals purposely conceal from others (Bok, 1983), are most often framed as a type of disclosure. Revealing secrets is distinct from most other forms of self-disclosure, and there is a unique pattern of reasoning behind people's decisions to reveal secrets (Caughlin & Vangelisti, 2009).

Pregnancy that is unplanned, as with all but one of these participants, is considered to be among the most highly personal topics of disclosure (Matthews, Derlega, & Morrow, 2006). Two different forms of disclosure are protective disclosure, which is planned and carefully controlled with the intention of preventing or reducing shock in the receiver, and spontaneous disclosure, which is more sudden, not planned or controlled, and often involves the spilling out of raw emotions (Charmaz, 1991a). These participants overwhelmingly describe protective disclosure with few exceptions.

Strategic disclosure decisions. Strategies surrounding disclosure of the pregnancy involved decisions about whether and whom to tell, when to tell them, and how to do it. Specific protective disclosure strategies included keeping the pregnancy secret for as long as possible, telling her mother or parents, telling the "easiest" people first, enlisting the help of others in the disclosure process, and managing the emotional reactions of others.

When asked what advice participants would give another pregnant teen if she were to disclose her pregnancy to them, Amanda, Heidi, and Jade indicated that they would advise her to keep the pregnancy secret for as long as possible: "Don't tell anybody! Keep it to yourself for AS LONG AS POSSIBLE, until you are comfortable telling" (Amanda). Inherent in this suggestion is that she would be managing this information within herself, alone, for a while.

Molly, Aria (age 17), Rachel, Maria, and Alisha, when asked what advice they would give another pregnant teen, said that they would tell her to go to her parents or mother. Alisha says:

> I would tell her…I would say the best thing for you to do is to go talk to your momma. Just sit her down and try to talk to her…And tell her that you, that you really is sorry. But you wanna keep your baby, and you don't want a abortion if they try to get you one.

Even Alisha, who is already a mother herself, is still dependent on her own mother, and therefore feels she must answer to her. The suggestion to go to one's parents is made both out of a sense of obligation and the importance of support during pregnancy. The participants view parents, especially mothers, as an important resource. For instance, they can help set up doctors' appointments or offer advice. For at least six of the participants, this motherly advice comes from the experience of having been teen mothers themselves.

The suggestion to disclose to one's parents also taps into the inevitability of eventual disclosure of the pregnancy, particularly when the girl is still living under her mother's or parents' roof. Aria describes the advice she gave another young woman who came to her and expressed that she thought she might be pregnant:

> At the end of the day, your parents, if they really care about you and stuff, which most of them do—like I said, most of 'em say stuff like that to scare you so that you won't get pregnant—and I was just like, "You just gotta tell em. You have to tell em cause they're gonna find out sooner or later."

Although not a strategy for disclosure, the idea that the pregnancy inevitably becomes too difficult to hide is a motivation for disclosing the pregnancy; in fact, the idea that the circumstances would reveal the truth anyway is among the recognized motivations for secret-telling (Vangelisti, Caughlin, & Timmerman, 2001).

For many of the participants, early disclosures were based on who would be "easiest" to tell. Rachel, upon telling her boyfriend that they had successfully conceived, next went to her sister:

> Uh, we decided like, who would be the easiest to tell and who would be like, like the easiest to like, I don't know, explain—like, I don't know, like, not have a huge reaction about it. I knew my mom would freak out. My mamaw would have freaked out. My Papaw was living with us at the time, he would've freaked out. So it kinda just went down a little line.

Similarly, Molly went to her step-sister because she had suspected the pregnancy even before Molly herself did. Therefore, she would not be shocked by the news: "…and she would talk to me about it, and I was like, you know, she told—I just, I needed someone to talk to." This

strategy of telling people who would be "easy" to tell seems to serve as a means of acquiring allies. These allies can provide positive support for difficulties that may lie ahead, including disclosing to people who will be less supportive and more upset.

Enlisting the help of others in the disclosure process, the next strategy participants describe, grows out of creating allies. For instance, Amanda worried about telling both her step-father and her "verrrrrrry religious" grandmother. She pled jokingly with her mother to "let dad drink tonight," so that he, a former alcoholic, would be relaxed when Amanda told him. Instead, her mother advised her to tell him in a direct manner: "because if I'd have like beat around the bush he would have been mad." After more pleading, she convinced her mother to tell her grandmother for her while Amanda listened on speakerphone. In doing so, the burden of telling was lifted but allowed Amanda to be privy to the conversation.

Aria knew that her cousin, the daughter of Aria's aunt and custodian, would be sympathetic to her situation. Therefore, she asked for her cousin's help in planning how she would disclose the news to her aunt:

> A: I was just like, "I don't know how to tell her," I was like, "I'm scared." She was like, "Well you gotta tell her."
>
> B: Tell your aunt?
>
> A: Yeah. She was like, "I know how"—you know, it's her mom, so she knows how—And my cousin told me, she said, "Write a letter. Put it in a letter." So what I did was put it in a letter, and waited on my aunt to get home. She finally came home at like, 11 or 12 at night. We was all in the living room. I gave her the letter, and it was just like that.

Revealing to "easy" friends and family members first often served as a means of bringing them on board to serve as a buffer for more difficult disclosures.

Finally, participants describe strategic attempts to control the emotional reactions of others. These attempts to mitigate uncertainty, as the participants armed themselves against potentially strong negative reactions from loved ones and outsiders. A popular sentiment among the participants is that when it comes to getting pregnant, "what's done is done." Only one participant, Isabelle, had even considered abortion; therefore, the fact that there was going to be a baby was not perceived as something that could be undone. By pointing this out, participants framed anger, judgment, and stress as futile reactions to disclosure of pregnancy. Heidi, for example, describes how she responded to her boyfriend Aaron's mother's anger: "There's no reason goin' off on [Aaron] now, it's too late!...Sorry, there's gonna be a baby." When asked what the worst part about being pregnant is, she explained: "I think the way people just like, stereotype bein' a pregnant teenager. Like sayin' it's…it's bad. And you know that's not, 'You shouldn't a been doin' that.' Well maybe I shouldn't've but you know, it's too late now, I'm havin' a baby." At the point of pregnancy, in other words, judgment and anger are pointless. Similarly, Amanda told her stepfather "yeah, you kinda can't be [angry] cause there's nothin' we can do about it." This strategy was an attempt to diffuse heightened emotional reactions, and reduce the uncertainty that comes along with dreaded encounters—an attempt to wield control over a potentially volatile situation.

Reactions of others. On the other side of the disclosure act is the reaction that comes from the person to whom disclosure had occurred. This includes sexual partners, parents, grandparents, siblings, friends, and the public. As described above, participants attempted to control the reactions of others by pointing out the futility of negative emotions; however, reactions of others can never be completely controlled, and often become confusing encounters

that create lingering uncertainty. Some reactions are unexpectedly positive. Even so, they may bring to the surface questions about relationships and identity.

One way that disclosure leads to uncertainty is via the inherent risk with which it is associated. Within health communication, this has been examined in the context of chronic illness. A person who is chronically ill may hesitate to disclose his or her condition because of immediate risks including stigmatization, inability to handle the receiver's reaction, and inability to effectively communicate about the condition. Ultimate, long-term risks include loss of autonomy and loss of identity (Charmaz, 1991a). Although very little concern was expressed about stigmatization, participants did worry about how people would react to the news and how they would communicate the news to others. What seems to differentiate adolescent pregnancy in this study, however, is the perceived inherent risk of being called a liar.

Many participants were aware of this specific risk, and given the number of girls whose relational partners did not believe them upon disclosure, their concerns were legitimate. Heidi explains:

> Uh…Since me and him weren't talkin', I was wondering if he was gonna believe me, ya know, cause we kinda got into it when we broke up. And I was wantin' like, cause some people, he's had girls do this, they'll call and be like, "I'm pregnant," just to get him to come back to 'em. And he kinda thought I was doin' that.

She went on to describe various examples of peers faking pregnancy. She said it happens "all the time, all the time. In order to keep your boyfriend." Alisha's boyfriend also thought that she was faking the pregnancy by bringing him someone else's positive HPT. Once she took an HPT in his presence, he not only accepted but actually became excited about the pregnancy.

Other participants' sexual partners did not necessarily deny the pregnancy, but initially questioned their paternity. Molly, for example, says of her boyfriend: "Ya know, he started second-guessing the baby and saying, 'Oh well I don't know if it's mine.' And, I was like, 'You know, there's no other possibility, it's not anybody else's.'" Maria's baby daddy was in a committed relationship with another young woman at the time of conception. She says, "And he didn't really believe me, so that was hard." These accusations of dishonesty led the participants to wonder whether they would have a partner in their pregnancies. Eventually, however, each participant's baby daddy accepted a role in the pregnancy. At the time of the interviews, all but Jade seemed sure that the baby daddies were going to "be there" in some capacity for the baby after the birth.

There was, of course, a great deal of apprehension surrounding expected reactions from baby daddies, parents, and other people to whom the participant would disclose her pregnancy. Participants tended to prepare for the worst when it came to the reactions they would face. But many of them were pleasantly surprised by the responses to their disclosures, particularly from baby daddies. In fact, 7 of the 10 participants directly described the baby daddies as being excited and happy about the pregnancy—even those who had initially denied paternity. Aria says of her boyfriend, who was incarcerated when he found out, "He was happy. He wanted a baby, yeah. So…he wanted a baby." Although Amanda's boyfriend was upset by the news of the pregnancy, his reaction was not the angry outburst she expected:

> I was expecting the reaction that, "I can't believe you did this to me, and nuh nuh nuh nuh." But I got a completely different reaction. Like, "Oh, okay." I was like, "So, how are you feeling?" He was like, "Can I call you back?" And I was like, yeah, then we hung

up and he called me back about ten minutes later, and he was like, "I've never cried so much in my life."

His reaction was one of complete shock and fear. Instead of having to defend herself against his anger, she described feeling guilty and sorry for upsetting him.

Isabelle described her boyfriend's reaction as being more positive than her own:

Like he was just like, Oh my god—like, he didn't know what to say. But like, after like 10 minutes, he was just…happy! And I was just like, "Why are you happy right now? This is not okay!"

She found the interaction confusing when his feelings did not match her own disappointment. Isabelle has begun to emerge as a negative case in several respects: She has married biological parents, strongly considered abortion, continues to struggle with the thought of having a baby, and mourns for her lost future. Further descriptions of her uniquely future-oriented perspective set her apart from the rest of the participants to an even greater degree.

Both Alisha and Rachel expected harsh reactions from their grandparents. But Alisha's grandmother surprised her by not being upset by her third pregnancy in as many years. She reasoned, "If I have one, I can take care of two." Rachel describes her concern about her grandparents' reactions:

R: And I didn't really wanna tell them either, cause they're like, real Christian, and where we're not married or whatever, or I'm so young, they would just…I don't know.

B: But you eventually told them?

R: Yeah.

B: And what happened?

R: I mean they was…it wasn't like anything I expected! They was like, all kinds of excited, like all kinds of stuff! Like asking what we needed and stuff like that. So it wasn't really that bad. Maybe I was exaggerating a little!

Molly's preacher also had a more positive reaction than she expected:

That's not something you get, ya know, you're thinking, usually you're thinking preacher you're thinkin' "Okay, well I don't wanna tell them cause they're gonna judge," ya know, cause a lot of people do. And I'm thinking, "Ya know, here I am not married, goin' up tellin' a preacher 'Hey I'm pregnant,'" and I'm expecting her to be like, "You shouldn'ta done that!" But she just, she got the biggest smile on her face and was like, "Okay! We're havin' a baby."

Unexpected reactions were disorienting in some situations, and a relief in others. New emotions and feelings arose, such as guilt, and often led to more questions than answers. In other situations, participants were relieved to have support from loved ones and boyfriends that they did not expect. Expectancy violations theory states that when another person's communication violates our expectations, we first try to interpret what the violation means, then figure out whether, in our interpretation, the valence of that violation is positive or negative (Burgoon, 1978). Perhaps, then, uncertainty occurs when participants either struggle to make sense of the violation, struggle to determine how they feel about the violation, or both. This also depends upon characteristics the participant perceives in the communicator. The communicator reward valence (Burgoon, 1978) has to do with how the participant feels about her grandparents, boyfriend, or preacher, and what future rewards she may be able to gain from those people. If she has positive feelings toward this person, and if she senses he or she will be able to somehow

reward the participant in the future, the violation is likely to be construed more positively. For these participants, a major potential reward may be social support.

A final type of reaction that emerged can be characterized as self-oriented. This occurred when the reactions of others were centered on their own perceived role in the pregnancy and the life of the baby. As Heidi's mom exclaimed, "We're havin' a baby!" using the first person pronoun "we" rather than "you." Heidi had taken the HPT at the grocery store with her mother present:

> H: I started crying as I was walkin' through Food City, cryin' while we was like, grocery shopping [laughing]. And everyone was just like, "Is she okay?" And my mom was like, "I'm havin' a grandbaby!"
>
> B: So you were with your mom, you were at Food City, then you kept shopping?
>
> H: Yep, we kept shopping, I was just like, this is crazy [laughing]!

Both Amanda's brother and Rachel's sister had the immediate reaction of claiming their uncle and aunt status. According to Rachel, "So when we told her, she was just like, 'Oh my gosh I'm gonna be an aunt!' She was like, 'I'm gonna be the Godmom and everything!' I was like, Oh my gosh…she's crazy." Rachel's two best friends had a similar reaction: "They was like, 'Oh my gosh!' They was like, 'I'm gonna buy all kinds of stuff, and I'm gonna play and all kinds of stuff.'" When asked about the downsides of pregnancy, Christina described strangers who took a sudden interest in her life. She claimed that mere acquaintances would ask if they could be the child's Godmother. She was also bothered by the passing comments of peers: "Like, 'My momma would beat me if I got pregnant.' Just little stuff, like…Yeah, 'I couldn't be pregnant at this age,' and uh…'I can't see myself doing that.'" The participants characterized this type of self-oriented reaction as "crazy" and sometimes irritating. They also began to perceive the larger

sphere of influence their pregnancies would have, bringing in new people and situations that could amplify feelings of uncertainty.

Controlling the Flow of Information

Given that participants had to decide if, when, how, and to whom they would disclose the fact that they were pregnant, grappling with the reactions of others can lead to questions, assumptions, and revelations about interpersonal relationships. However, each participant experienced a point where she lost control over the flow of that information. No matter how pregnancy is constructed within their social worlds, whether common or shocking, the news of pregnancy is always gossip-worthy. Therefore, the "telling" of pregnancy was never completely on the participants' terms. Communication privacy management theory [CPM] posits that people choose what kind of private information they share and with whom they will share it. In doing so, they are constructing boundaries that signal ownership of information (Petronio, 1991, 2000). In this section, the young women reveal what happens when the privacy boundaries break down, and the uncertainty that results when their sense of control over information boundaries is lost. CPM will be revisited and expanded as it applies to these findings.

Amanda had set privacy boundaries by telling only close family, and none of her friends, that she was pregnant. When asked why she didn't tell anyone outside of immediate family, she explains:

> Because I knew what would happen, and it did…It was, I went to WIC [Women-Infants-Children], and I guess whoever took my papers and whatever was the mom of one of the girls at my school. And she told her daughter that I was pregnant. And so of course then EVERYBODY knew the next day.

The opportunity to disclose on her terms was taken from her, and she was bombarded by the curiosity of her classmates. At the heart of her difficulty was the loss of efficacy at maintaining privacy boundaries: "Cause if I, I think it would have been, if I had been able to tell people myself, it would have been easier than everybody finding out, cause then it's all on top of you at once." Unable to deal with the constant questioning of her peers, she retreated from school to finish the year at home.

The shared rules of privacy Molly had negotiated with her parents and baby daddy were quickly breached. Her father told his sister, who told her children: "Then the people I went with to school with from his side of the family would tell people at school, and they'd come up to me going, 'Are you pregnant?' And I'm like, okay well, time to tell everybody." Her boyfriend, too, had not respected her wishes to keep the news private: "He was like, 'Yeah, she's pregnant.' And I was like, 'Um, can you please keep that quiet?' And he, he was telling all his friends too. And that kind of, I mean that really irritated me." Although she wanted to choose the "right" time to reveal her pregnancy, privacy rules were breached and the choice was no longer hers. Christina's boyfriend also failed to respect her wishes to keep the news private. She explains that "he didn't tell a lot of people. But you know how like you tell that one person who just tells everybody? So like, yeah, that's how it got around."

Having disclosed to that one "wrong" person was a common pattern. Participants were able to pinpoint one person, one leak to whom they could attribute the spread of the news and the violation of their privacy. Maria, whose baby daddy had another girlfriend at the time, suspects that a trusted friend of his told that girlfriend:

M: I really didn't want my school to find out YET. I wanted to you know, keep it all secret for a minute. But then once, uh, his girlfriend at the time, once she had found out, then-

B: How did she find out? Do you know?

M: I really don't. I still don't know. I think somebody had told her, um, one of HIS friends had told her I think, and then once she found out, she felt like she had to tell everybody so that messed me up, and I was just like, ugh…

Jade had created information boundaries with a close friend, the only person to whom she had disclosed the pregnancy. But that friend violated her trust to such a degree that it was difficult for Jade to discuss:

J: But then…I told her not to tell nobody, and she did.

B: How did that make you feel?

J: [Long pause] Mad.

Isabelle had difficulty negotiating privacy rules within her own immediate family. She had been forced to disclose by one sister who had guessed that she was pregnant, then felt pressure to tell her other sister. She attributes this pressure to being younger than her sisters. She begged the second sister to keep the pregnancy secret because she had a plan for how to disclose to her parents:

I: I planned on bringing my boyfriend over, and my grandmother. Then my grandmother found out, because my sister told my grandmother. So she said she would come over and help sit down and talk to them. And my sister knew that I was gonna sit down and talk to them about it, but she got mad, and she went and she told them, like as soon as, as soon as we had the conversation.

B: So, I mean, how did that make you feel?

I: I was just like- how could you do that to me? Like…I was, just felt betrayed.

Alisha blamed a teacher for announcing the pregnancy to one of her classes:

> Cause that was my whole point, cause at Northside, one of the teachers told the whole class that I was pregnant. And I felt like it wasn't her place to tell that. And I just felt like they was gonna talk about me. But I, now I just feel like I don't care what nobody else say. So I just let 'em know, I was like, "Yeah I'm pregnant. I'm proud to be a mother of two kids, or three, but I'm proud to be a mom."

Her description taps into a pattern of response to losing control of private information. Once the news was out, participants felt that it was futile to deny the pregnancy. This was in part due to a perceived inevitability of eventual disclosure.

Because of the physical manifestations of pregnancy, there is a perception that people were bound to find out about it eventually. Therefore, though they may have been upset initially, participants' ultimate responses to these breaches were somewhat passive. When asked how she felt about her boyfriend telling others about the pregnancy, Christina says, "I didn't even really, I wasn't, I didn't really have a problem with it. Cause eventually, everybody was gonna know I guess, because it was gonna become obvious." Molly, Aria, and Heidi all made similar statements that hinted at their inefficacy for keeping the pregnancy secret long-term. Molly and Aria, for instance, talked about the importance of telling your parent or parents about the pregnancy because "they're gonna find out sooner or later," (Aria).

As described earlier, some people will only reveal a secret if the circumstances would reveal the secret anyway, implying that the person does not particularly want to reveal the secret (Vangelisti, Caughlin, & Timmerman, 2001). This seems to be the case in the current study, and

helps explain their sense of inefficacy at maintaining privacy boundaries. Some, like Rachel and Alisha, willingly face their family and peers as the news spreads, while others, like Amanda, become overwhelmed and retreat from the public eye. Either way, participants acknowledged that, given the nature of pregnancy, they were at the mercy of time, and therefore had little control over the flow of information about their pregnancies.

The disclosure of pregnancy can be examined through the lens of CPM (Petronio, 2002), which has a system of core principles that are applicable to adolescent pregnancy. Among these principles is that people use personal boundary rules to control private information. This has to do with how decisions to reveal private information are made. These "rules" can be broken down into different factors that motivate how, why, when, and to whom we share private information with others. Applying the personal boundary rules (Dindia & Allen, 1992; Kenny & McEachern, 2000; Petronio, Flores, & Hecht, 1997; Petronio, Reeder, Hecht, & Mon't Ros-Mendoza, 1996) to the current study can help explain the decisions and of actions these participants.

First, decisions to disclose are driven by culture, which can vary in terms of how much value is given to openness and disclosure. Second, the factor of gender suggests that people, both men and women, will reveal more readily to a woman than to a man. This can explain why many participants first went to their mothers and other female relatives rather than their baby daddies. Third, there are differences in motivation that can loosen privacy boundaries. On an interpersonal level, both attraction and liking can cause someone to reveal private information that they would otherwise keep to themselves. Trusted friends, especially those who had been through the experience of adolescent pregnancy, were often among the first to whom participants revealed the pregnancy. Finally, the risk/benefit ratio is taken into consideration when determining disclosure. Some of the benefits of disclosure include gaining social support, a relief

from stress, and becoming closer to the person we tell. In the current study, some participants refer to the people from whom they have gained support as a result of revealing the pregnancy to them. Typical risks include embarrassment, rejection, diminished power, and everyone finding out the secret. Some participants were also rejected by loved ones, and eventually, in every case their secret was leaked to the masses. In addition, the risk of not being believed has emerged from these findings.

The news of the pregnancy spread as a result of breached privacy rules. When disclosing the news of the pregnancy to others, participants have either failed to negotiate mutually agreed upon privacy rules about the flow of information, or these rules were breached. Most participants are able to point out a specific confidant to whom they can assign blame for leaking the news of the pregnancy. Negotiating privacy rules can be as simple as saying "Um, can you please keep that quiet?" (Molly). But in the case of pregnancy, questions of boundary ownership can become quite complicated. Whose news is it to conceal or reveal, the participant or her baby daddy? These are two people who have come together and created another human life. Boundary ownership is a question of who has the greater stake in how the information is handled (Petronio, 2002). Biologically speaking, each has an equal genetic stake in the baby. But participants clearly carry the burden of pregnancy differently than the fathers. It is they who become pregnant, which often means enduring difficult physical symptoms, questions from others, and having to leave school. Many participants complained of baby daddies who were too eager to reveal the news to others. But in the end, they rationalize that pregnancy inevitably reveals itself anyway. Their control over the spread of the news was only ever temporary.

Renegotiating Relationships

As each participant disclosed her pregnancy to family, the baby's father, and friends, she encountered a fundamental shift in her relationships with those people. This is in part related to her new identity as a pregnant person, but identity shifts are not discussed by the participants because they don't yet seem able to recognize that shift. They cannot fully conceptualize a new pregnancy identity, and therefore cannot assign meaning to it. Instead, their shifting identity becomes manifest to them in pieces, chunks that surface through encounters within close relationships. The relational shift may happen immediately, or it may be something that takes place gradually over time as the pregnancy progresses. Participants describe episodes of relational turbulence—"tumultuous experiences that might occur within relationships in response to a transition" (Solomon, Weber, & Steuber, 2010, p. 117)—that vary in magnitude. These episodes produce guilt, conflicts, and the forging and cutting of relational bonds.

Guilt. Many participants described the guilt they felt upon telling others that they were pregnant. Guilt occurs when people feel that they have injured, unjustly hurt, or failed to help another person (Guerrero & La Valley, 2013). Participants encountered disappointment, shock, and sadness in the reactions of those to whom they disclosed the pregnancy. Not all participants indicated that they felt any guilt about becoming pregnant; for instance, neither Rachel, who had conceived intentionally, nor Heidi mentioned any feelings of remorse or regret. But for those who did, feeling guilty further complicated their emotional states and relationships with those whom they felt they had "let down."

Amanda, Molly, and Alisha directly apologized to relational partners and family members for becoming pregnant. Amanda described her apology to her boyfriend, who was shocked into tears by her revelation: "I was like, 'Oh god. Like, I'm sorry.' He was like, 'It's

not…I mean obviously you can't do it by yourself, so it's not your fault.'" He was one of the few baby daddies not described as being excited or happy about the pregnancy. Amanda's guilt seems to stems from the realization that others' lives will be directly affected by this pregnancy, and not necessarily in a positive way. Molly felt guilty for hiding her pregnancy from her grandfather, whom she knew would be disappointed. Sensing his suspicion, she says,

> He asked me about it, and I was like, well ya know—I told him, I said, "Well I'm pregnant. I'm not gonna sugar coat it or say anything else about it." I said, "I'm pregnant, and I'm sorry, I didn't know, ya know…" And he just kind of…he called me some very mean words, and left.

She felt that he was not only angry at her pregnancy, but at the fact that she had tried to hide it from him. Alisha's mother knew how much this third baby would complicate her life and that it would threaten her ability to keep her children and stay in school: "She was like, 'You already going through stuff with school,' I was like, 'I know I'm sorry, like, it wasn't supposed to happen this way, like I didn't want to get pregnant. It wasn't supposed to happen like 'at.'" When experiencing guilt, a fundamentally relational experience, making amends by apologizing can help set dyads on the path to reconciliation, and help individuals restore self-esteem (Guerrero & La Valley, 2013).

Among the primary causes of guilt is the feeling that one has failed to live up to an interpersonal obligation (Baumeister, Stillwell, & Heatherton, 1994). The idea of disappointing or "letting down" family members forced the girls to face the expectations that other people had for them and made them feel that they had not met these expectations. This was an uncomfortable feeling and may even have been the first time they had encountered what other people wanted for them in life. Christina, who was among the youngest participants at 15, "felt

bad" that she had made her mom cry. She knew that she had also disappointed her aunt, but had trouble making sense of why exactly she was disappointed:

> She was just…telling me how she was disappointed and stuff…Yeah, she was like, well, almost like…I don't know if she was like, calling the child a mistake, I really hope not! But she made it seem like, she said, I remember her saying something about something being a mistake. But I dunno, you could just tell she was mad.

Maria, on the other hand, was acutely aware of the expectations that others had for her. She felt that everyone who knew her was shocked that she had gotten pregnant, because she was "more of a busy type":

> M: And like, I've just felt like everybody was gonna be disappointed in me. Like, I really did. I thought, ya know, my mom was gonna be mad at me, and my family, I just felt like they were gonna be so disappointed. Like, because, I felt like they didn't expect that from me.
>
> B: Why did you think that? I mean…
>
> M: It was just how I was, I was—I was more of a busy type. So like, it was like, I never really had time to really do much. I was a cheerleader, I was a dancer, and then, you know, I…it just all went downhill. I don't…so I felt like they probably didn't really expect it. So…

Coming face to face with others' emotions forced participants to realize that this pregnancy is larger than them. It has a continuing ripple effect that they can only begin to see, and they cannot stop or control it. In health communication research, coping with health events is often examined on an individual basis, leaving out the impact that health events can have on the other people in one's life (Goldsmith, 2009). What is striking about these participants is that the data shows the

exact moments when they first begin to realize that this acute stressor has an impact on others. For a moment, they are forced to see beyond the egocentrism that characterizes the typical adolescent worldview (Jorgensen, 1981), which they very uncomfortable. Feeling at least partial responsibility for other people's negative emotions can cause a great deal of uncertainty about the relationship, as questions about the future direction of that specific relationship may leave them wondering about the amount of support they will have during this transition.

Conflict. With pregnancy comes change, and with change comes transition. Transition can be understood as an adaptive response to change characterized by varying degrees of instability (Marineau, 2005; Walker, 2001). Within families, periods of transition occur when members enter into and depart from the system (Wood & Talmon, 1983). Adolescent pregnancy introduces a new human life, with all of its inherent demands and complexities, to the system. Solomon, Weber, and Steuber (2010) explain that transitions often involve the reorganization of roles and relationships, requiring a shift in the way people define themselves within relationships. In the context of adolescent pregnancy, relationships shift as the pregnancy moves people from the known to the unknown. Previous research has examined this shift in the context of dating relationships, as couples move from casual to more serious dating, and labeled such shifts as times of turbulence. Relational turbulence, closely analogous to airplane turbulence, is the "tumultuous experiences that might occur within relationships in response to a transition," (Solomon, Weber, & Steuber, 2010, p. 117). Both open conflict and relational uncertainty tend to spike during times of relational turbulence, which can be attributed to increased interdependence between partners (Solomon, Weber, & Steuber, 2010). Perhaps with unplanned (and planned) pregnancy, there is a very sudden and forced interdependence as two people have created a new person.

It is not surprising then, that adolescent pregnancy produces interpersonal conflict and uncertainty. In the current study, it does so by raising questions about boundaries within relationships. Transitions within relational systems (such as families) demand a reorganization of boundaries. The term "boundary" was originally coined in reference to family subsystem rules that determine who participates when and how (Minuchin, 1967, 1974). Families (and presumably other social systems) vary in terms of how permeable these boundaries are (Wood & Talmon, 1983). Thus closeness, privacy, and autonomy are all thrown into question with the role confusion produced by nebulous boundaries during times of transition. In the current study, conflict is produced by questions about where boundaries lie, setting new boundaries in the pregnancy, and boundary violation.

Molly, Heidi, and Isabelle worried a great deal about telling paternal figures in their lives about their pregnancies. The conflict situations that their pregnancies stirred raised questions about whether these men would continue to be a presence in their lives, and point out unspoken boundary rules about what are acceptable and non-acceptable behaviors in the eyes of these paternal figures. Molly's grandfather had essentially cut off contact with her:

> M: I told him about 3 weeks after finding out I was pregnant, and he has not talked to me. He won't have nothing to do with me. It's hard. It's really hard. But he, ya know…
>
> B: So why? Why does he have that attitude toward you?
>
> M: I, I have no clue…he had a kid for 44 years he did not know about. And he…the only reason he married my grandmother was because she was pregnant. So I don't know why he won't talk to me, I don't have any clue. He just, since…I ain't talked to him since…May. And I've called him, tried to have something to do with him, but…he won't return my phone calls.

Heidi lives in her great-grandfather's basement, along with her mother, brother, and her mother's boyfriend. Her great-grandfather financially supports all of them. When he found out about the pregnancy, "He was like, 'Oh you're getting' out, and I'm kickin' you out!' and all this and that…" But unlike Molly's grandfather, he had come to accept the pregnancy by the time of the interview. Isabelle, who was the only participant growing up in a traditional nuclear family, explained that she had a close relationship with her father, but not with her mother. Therefore, the period of relational turbulence that ensued upon disclosure of the pregnancy led to uncertainty and hurt as she lost her only ally in the house:

> And for a long time when he found out, for about a month he didn't talk to me, didn't say anything to me, and it hurt me because he was the only person that I really had, you know, so…but he got over it, so we're back to normal.

Like Heidi's great-grandfather, his emotional reaction eventually cooled. These resolutions came as a relief to the young women, who relied upon these paternal figures for instrumental support. It is likely that unspoken expectations about sexual conduct and procreation had been violated between the participants and the paternal figures who considered themselves to be "in charge" of the adolescents, thus producing a kind of familial relational turbulence.

Interpersonal conflict also resulted from the participants' attempts to create new boundaries around both the pregnancy and the future baby. Amanda and Heidi, for example, both ran into difficulty with their baby daddies' mothers. Amanda was concerned about Jacob's mother's drug addiction, and how it might affect her interactions with the baby. So she attempted to set ground rules:

> His mom started with heroin. And then, now I think it's Xanax, or I don't know, some kind of pill. But when I told her if she wasn't clean, or at least not on the drug while she

was around him, that I wouldn't want her around him at all, and if she came to the hospital and was messed up, or anything like that, I would ask her to leave. And she took it really offensively.

To protect her child, Amanda was not afraid to confront Jacob's mother; however, she did worry that this and other conflicts with her would come between her and Jacob. She explains that she was pleasantly surprised when he took her side and agreed to the boundaries she had set even thought it had upset his mother. Heidi explains of Aaron's mother, "She don't like me." She was forced to defend Aaron against his mother, who was angry about the pregnancy. This turned into an argument about how his mother would treat the future baby, and the boundaries that Heidi set:

> But I'm fine, she can hate me all she wants. Yeah, that's the way I feel. As long as you're good to the kid, and if I ever see her like, like, you know- I don't believe in spakin', I don't like that stuff. So if somebody tried to whoop my kid I'd probably be whoopin' them! [laughs]. That's the way I am, like "Lay your hand on my kid- see what happens!"

Heidi also made a point of setting boundaries with other sexual partners from her recent past. For example, when she found out she was pregnant with Aaron's baby, she explains that she "was actually talkin' to someone else at the time" named Justin. To refocus on her relationship with Aaron, "I told [Justin] I wanted to get back with the baby's dad and all that, and he was fine with that. But he's super jealous, so I don't talk to him no more." Because Justin could not handle her relationship with the father of her baby, she cut off contact with him.

Conflict also arose when people committed transgressions that the participant saw as overstepping her personal boundaries. Amanda, Heidi, and Alisha were appalled by suggestions that they get an abortion. Amanda's grandmother immediately asked if she would be getting an abortion or would consider adoption. Amanda explains that she was very hurt by her

grandmother's comments, categorizing them as "rude" and uncalled for. But she attributes her grandmother's reaction to shock:

> I think she was just shocked, and didn't know that what she was saying was rude when she did say it. Then when she came down to visit us, she apologized and she was like, "I didn't mean to hurt your feelings." And I was like, "It's fine."

In the heat of an argument, Aaron told Heidi she should get an abortion. She grew very angry, and quickly pointed out to him that it was her choice, not his: "And I was like, 'Well I'm having it, and I honestly don't care if you're there or not.'" His suggestion led her to draw a hard line, creating, or perhaps pointing out, a boundary within their relationship. Her comment illustrates that his control over the situation only extends so far, and that suggesting abortion oversteps her personal boundaries. For Alisha, her father's pressure on her to get an abortion was a violation of not only her personal agency, but of his role as a pastor:

> I said "Daddy, you know I don't believe in abortion," said, "I don't like it, I believe every child have the right to live." And I, and he, I was like—he's a pastor! And that's what really made me mad, cause you're a pastor, and telling me to get an abortion. You're a man of God. So…but, then when he, he sent my momma the money to get one, and I couldn't do it.

While participants felt that abortion was a matter of personal choice, the pressure from outsiders to consider abortion caused uncertainty about how much interpersonal support they will have as mothers-to-be. In addition, uncertainty arises as people become aware of multiple discrepant views (Roloff & Chiles, 2011). This uncertainty may lead to questions about whose solution—in this case, the participant or those suggesting abortion—is best. Though the participant may want

to keep the baby, they are disturbed by the realization that others may not want the same thing, and she may start to question her own decision.

Violations of privacy boundaries are also a source of relational conflict. Heidi's uncle, for instance, pried into the nature of her relationship with Aaron by suggestion that it was, in fact, incestuous:

> But he thinks like, Aaron's in our family and he's not. Yeah, so I was like, he is a friend of the family, I talked to his mom about this, and all that. And he thinks it's incest and all this stuff. And I was like, he's not in the family! I was like, it's not incest! But he was just like, "That's nasty, and if you can't find someone better than your own family, then…" somethin'. He's just trashy anyway, gets on my nerves.

She then cut off contact with her uncle, feeling enough discomfort with his suggestion of incest that she decided to double-check with Aaron's mother to be sure that it was not true (it was not). For Isabelle, who tried to hide her pregnancy from her family for as long as possible, the news of her pregnancy raised questions about her relationship with her sister, Ciara. Ciara had guessed that Isabelle was pregnant and confronted her about it. When she admitted the truth, Ciara was more upset about her dishonesty than about the pregnancy itself: "So she was just, she was *mad*. She was like, 'I can't believe you didn't tell me!' And I was just like, 'I didn't feel close enough to you to tell you,' or whatever." When Ciara violated Isabelle's privacy and forced her to disclose, Isabelle turned the fault of her dishonesty back on to Ciara. Now questions about the trust and openness within their relationship continue to hang between them.

Finally, the participants themselves admit to being guilty of occasionally "crossing the line" in their relationships. They recognized that they, too, were often the initiator of interpersonal conflict. However, they consistently blame their behaviors on hormones. In this

way, although they take responsibility for these moments of escalated tension, they still make an external attribution by ultimately blaming the physiological disruptions of pregnancy. Amanda explains:

> I guess with pregnancy I couldn't even stand to look at him. I wanted to strangle him every time I seen him, but it was kind of just like, anything he'd say I'm just like, "Will you stop talking?" And there would be times we he's just like, sitting on the couch, and he'd be saying something, and I'm just like "Stop breathing! Don't talk, nothing! Just be quiet!" So we broke up for like 2 or 3 weeks.

Rachel complains of her hormonal anger:

> And I get really mad easy, still. I don't even know why. I just get mad, easy. And it ain't like I mean to! One minute I'll be sitting here, and then the next minute I'm like, "Get off me! Go sit over there [laughs]."

Maria complained of emotional turmoil that resulted in a great deal of "drama" in her life. She would feel happy one moment, and be crying or angry the next. But she felt that this was simply part of pregnancy, as confirmed by her mother: "She was like, 'Well, welcome to being pregnant!'"

Forging bonds and severing ties. Not every relational shift is connected to conflict. In addition to guilt and conflict, participants experienced relational changes by both gaining and losing relationships. In some instances, new bonds were forged and existing ones strengthened; in other cases, participants were abandoned by or chose to cut out people in their lives. Both gaining and losing people created uncertainty for the participants. The conscious choices they describe about whom to include and whom to exclude from their lives can be classified as acts of uncertainty management.

Many participants describe the various types of interpersonal intimacy that have resulted from the pregnancy. As the pregnancy progresses, a renewed closeness with some family members emerges. Previous research has found that with teenage pregnancy, families can become more cohesive and have improved functioning (Cervera, 1994); however, in the current study, the suddenness of the intimacy often leads to questions and uncertainty. Molly, for instance, describes the initial hesitation she had with the reemergence of her father as a paternal figure in her life:

> I mean, I see my dad, but it wasn't like, ya know, I seen my dad maybe 3 times a year. Twice a year. And now it's like he wants to come around more, I'm kinda like, "whoa, hold on. You weren't really around before," but I understand why he's doing it. He has a grandchild on the way, and he wants to be there for his grandkid.

She explained that he called "all the time now"; during the interview, in fact, her called to make dinner plans for that evening.

The way Amanda and Heidi described the increased communication with their mothers is positive yet hesitant, mainly because it is such a shift from the previous state of their relationships. According to Amanda, prior to becoming pregnant, "I was never home." Her mother was always questioning her about her whereabouts, exhibiting mistrust and annoyance at her absence. Now, she is seeing a completely new side of her mother:

> It's a LOT different, cause I don't know, I wasn't really around much, so I wasn't like seeing how she was and all that…and now it's like, I see how she's feeling and all that and it's a lot different. And it's changed us a lot. Cause it's a bigger change than like everything else, it's like, WHOA! My mom's like that?

She goes on to describe how their relationship has improved as a result of Amanda being home most of the time. There is less tension between them, and therefore less conflict. For Heidi, she describes her mother's sudden curiosity about Aaron, and how she wants to "talk a lot more now."

Participants also describe the loss of connection with certain people in their lives. Their descriptions portray a damaged sense of trust, uncertainty about the future of their relationships, and little efficacy about mending these ties. According to Jade, "Umm…I would say the people that I thought was really there are not gonna be, and that I don't need 'em. Um…it's made me think about stuff." As described previously, Molly was also confused and hurt by her grandfather's sudden stonewalling. When asked what the hardest part about pregnancy is, Molly explains:

> I think losing family that was close to me. Cause my, my grandfather wasn't the only family that I lost, you know. I mean, I lost a lot of respect from one of my uncles. And I lost a lot of, I lost a lot of the older people in my family that were very close to me did not approve of me being pregnant and not married.

Christina's cousin, with whom she had been close, threatened that if Christina ever became pregnant, she would be angry:

> C: And then like, one of my cousins, she when I told her I had had sex for the first time, she was like, "well, if you ever become pregnant I'm gonna be pissed." And since then I haven't heard from her. So I'm assuming that she's…
>
> B: Pissed?

C: Yeah, cause she's…well I have heard from her, when my mom told her about it. And I talked to her a little bit about it, but ever since then I haven't heard from her. So I'm assuming she's pissed.

Christina clearly does not know where she stands with her cousin, nor whether or when they will resume contact. She also seems to feel powerless about repairing their relationship at this point. One of Isabelle's sisters, upon discovery of the pregnancy, had revealed the news to their parents without Isabelle's permission. This betrayal damaged her trust in her sister to the point where they were no longer speaking: "So me and my sister are no longer talking, we don't have…we don't talk to each other at all, like…I kinda just told her about herself."

At other times, participants describe the choices they made to consciously include and exclude certain people from their lives. These choices emerge as a way to manage uncertainty by limiting exposure to those who do not understand the situation. For instance, participants describe the increased amount of time they spent with other pregnant adolescents or peers who had children. Maria explained that her cousin, who was her age, had just had a baby. She assured Maria that pregnancy would not ruin her life, which Maria found comforting. She explains that being with her cousin "made me feel like, okay, well this is not AS bad as it should seem." Amanda compares her friend Corinne, a teenage mother, to the rest of her friends:

And then, I think hanging out with my friend Corrine, it's a lot…it's a lot better hanging out with her. Cause she has a baby so she knows what I'm going through, what I'm gonna be going through…So it's like, hanging out with her, she's like, "So, how are you feeling? Have you felt this yet? Are you feeling this? I felt this..." Just like, kind of comparing our two pregnancies…All my other friends – well not all of them – certain ones still are friends with me, it's like they are like, "Oh we're here for you." But they

don't know anything. They don't understand, none of it. They were like, "Well we're here to listen." But I want feedback! I want answers back. And with Corrine, I get that.

When asked who had had a positive reaction to her pregnancy, Alisha describes her best friend, who is also pregnant. Their babies will be cousins, because the fathers are brothers. She is one of the only people Alisha ever spends time with: "I don't, I don' even—I basically have one friend I be with. And that's the one that, we're pregnant together. That's the only one I ever will be with."

When describing her social circle, Molly explained: "Um, most of my friends have a ba- all my friends pretty much have a child already. The only one of my friends that are still pregnant is Lindsay, yeah she's the only one who's still pregnant." Yet both she and her baby daddy, Mark, decided that certain friends were not a good influence, and cut them out of their lives. Molly characterizes these changes in her social circle as losses, showing that their decisions are somewhat tainted with regret:

> And I lost some friends, because they wanted to be…they wanted to go out, they wanted to party, and they wanted to do all that, and I was like, ya know…I gotta kid, I—I got a kid on the way, I don't care to drive y'all out there, but I'm not stayin'. And they were like, "Well you're no fun no more!" And I was like, well, bye. I don't need you! I think makin' the decision of, do I need to hang out with this person, cause they do this? Or hang out with this person? I mean, I've lost a lot of friends. Because I've realized, hey, they're not really the best people to be around, I don't want my kid around them when she's born.

Mark, once "wild" and "crazy," made similar choices for the same reasons: "And when I got pregnant, Mark just ditched all his friends. He moved, he changed his number, everything, and don't talk to nobody no more."

Actively choosing whom to include and not include in their lives emerges as an attempt to manage pregnancy-related uncertainty. Friends who have not experienced adolescent pregnancy are not as relatable anymore, and serve as a reminder of life before and without pregnancy. Imagining life without pregnancy leads to uncertainty about their own feelings toward the pregnancy. Isabelle, for instance, complains that when spending time with non-pregnant peers, she is constantly reminded of what could have been: "When it comes to like certain things that remind me like, if I'm sitting at school, and like my friends start talking about prom, I'm kinda just like, 'Awww…that sucks!' It's just…a lot of changes." But by choosing to spend time with other pregnant adolescents and adolescent mothers, participants can better control the cognitive and emotional influences that operate on their self-perceptions.

Emerging Reality of Pregnancy

As the pregnancy progresses, there are moments for each participant where the reality of the pregnancy takes root. These moments are characterized by feelings of joy, anticipation, fear, excitement, and uncertainty about the transition that is taking place. The ability to assign meaning to the pregnancy vacillates as different events related to viability, physical changes, the sex of the baby, behavior changes, and fears about the health of the baby occur. The invisible and unknowable aspects of pregnancy make it a complicated phenomenon, and uncertainty about the meaning of their pregnancies is in constant flux.

Confirmation of viability. Participants express both joy and fear when describing events that confirmed viability of the pregnancy. The term "baby" will be used instead of fetus, as

"baby" is the in vivo term participants used to talk about the fetus. Feeling and seeing the baby during ultrasounds were events that were characterized as emotional turning points, producing a range of feelings as participants came to see their babies as living beings. Amanda, Molly, Aria, and Rachel describe the happiness and excitement that these events produced. When asked what has made her happiest about being pregnant, Amanda describes, "The first time I felt him move, I…aw man, I started crying. Well, the first time I heard his heart beat, THAT was kind of a big thing and I started crying. And when I first felt him move." Molly describes how feeling her baby kick made the pregnancy real for her: "And…I, I love to feel her kick. Cause it's just like well okay, I got a baby." Aria had similar feelings:

> B: So, have you had, I guess you've had a couple of ultrasounds? Gotten to see her?
>
> A: Yes.
>
> B: How does that feel?
>
> A: That's, that's the best. I think, and I wanna say that's probably what was bringing me closer to it was the actual like, Oh yeah, you really do have something in you [laughing], like you have something growing in you. And that…that's probably what captured my attention and stuff. You know, you gotta get, you're a mom now! So…yeah, I could say that's, the ultrasound, that's the best [laughing].

Aria's description taps into the salience of fetal movement and scans as moving her toward a "mom" role. Prior to the scans and kicking, the reality of pregnancy had not been fully realized. These events led to a turning point in the depth of awareness. Rachel, too, identifies confirmations of viability as the best part of pregnancy: "Uh, the fact that I got something growing in me. It feels cool, feeling her move around and stuff. And knowing that she's actually in there." Their descriptions also capture the idea of producing, and doing so successfully. As

adolescents from economically disadvantaged backgrounds, they have not yet had many opportunities to create or produce anything that they deemed noteworthy. At the point of conception, none even had a high school diploma. Though a few were involved in sports and other extracurricular activities, successfully growing a baby was constructed as a higher level of accomplishment.

Ultrasounds have been found to be an important factor in reducing anxiety (Crowther, et al., 1999; Dykes & Stjernqvist, 2001) and enhancing reassurance (Clement, Wilson, & Sikorski, 1998; Stephens, Montefalcon, & Lane, 2000), security (Larsen, Nguyen, Munk, Svendsen, & Teisner, 2000), and overall awareness (Caverzasi, Lastrico, & Bagnasco, 1991; Dykes & Stjernqvist, 2001) about the pregnancy. Fetal movement has also been linked to feelings of increased attachment to the pregnancy (Heidrich & Cranley, 1989). In the current study, these moments were also powerful turning points toward a reality that was both scary and wonderful. As Isabelle states, "And start, when I start feeling him move and stuff like that. I was just like, alright! Gettin' a little scared! [laughs]." Molly points out that without these moments of confirmation, uncertainty can take over as she questions what she cannot see: "Yeah! That's why…it just kinda scares me cause I'm like, what's going on in there?" When the invisible becomes visible, it is a powerful moment in both increasing and decreasing uncertainty.

Finding out the sex. Perhaps the most salient of these turning points is when participants find out the sex of the baby. It was described as a momentous event, one that nobody skipped in favor of a delivery-room surprise. Heidi's child development class even had a baby shower planned for the following Friday after she found out the sex of the baby. Both Molly and Isabelle characterize this as a time when their feelings about the pregnancy changed. According to Molly, "And I, it didn't really hit me, I didn't really start getting excited and happy about being pregnant

till the ultrasound and I found out what she was." When asked to describe a turning point in her pregnancy, Isabelle identified the 20-week ultrasound:

> Um, I would say about when I found out what, if like, what the gender was. I was just kinda like, "Okay, this is really happening." Like sometimes I just, I just forget about what's really about to happen. Sometimes I just would like, "Oh god- I'm really about to have a baby! I really have to sit back and think about that." So I would say, yeah, it was about 5 months when that happened—I started realizing what was really going on. It's happening.

Finding out the sex allowed them to think of the pregnancy and the baby in more concrete terms. It also helped them begin to assign identity and meaning to the baby growing within them. Christina speculated about what it would be like to *not* find out the sex ahead of the delivery. She explained that she had been "very anxious" to find out, and that for parents who choose to wait, "You'd have to have like, unisex outfits and stuff."

Purchasing clothing and other products for the baby was both a way to celebrate and manage disappointment over the sex of the baby. Rachel and Maria were excited to learn that they were having a girl and a boy, respectively. As Rachel describes:

> I couldn't wait! Like, I need to know. Cause at first we thought probably it was gonna be a boy, since we wanted a girl so bad. We both wanted a girl really bad, and oh my gosh, we thought we jinxed ourselves. But then we found out it was a girl, it was like, "Oh my gosh! It's exactly what we wanted!"…Right afterwards we went to this like, thrift store, and bought like, all kinds of clothes and this little bouncer. We went crazy, and then we went out to eat to celebrate.

When asked why she and her boyfriend had wanted a little girl, she had difficulty articulating her reasons: "I don't know. I just like…those, and being…a little girl." Maria explains her excitement: "And I was just like, 'Awwww!' I mean I was happy, I was cheesin'… but I wanted, I really wanted a boy cause I just think they're the cutest little things ever…My mom said they're the easiest." Finding out the sex was also a turning point for both Maria's and Alisha's baby daddies, who were ambivalent about the pregnancies until that point. Maria's baby daddy "lost his mind, like—he just jumped up and it was like…he had won a football game! Like, he was so excited!" Alisha describes her boyfriend: "Now he's really happy, talkin' bout how he can't wait for her to get here…He say he can't wait for her to get here."

In contrast, Molly, Isabelle, and Christina had to come to terms with ambivalence over their feelings about the sexes of their babies. They engaged in rationalization efforts to ease their disappointment and convince themselves that it will all turn out for the best. For Molly, seeing all of the "cute" female commercial baby products helped her become excited about having a girl:

> When they said a girl, ya know, I was really wantin' a boy. But I took whatever I got, but I wouldn't, I was really wantin' a boy. But then, I kinda went and walked around the stores for a little while and seen all these girl clothes, I was like, "Okay, well, they're really cute, so I'm just gonna—okay, I'm happy."

Christina was surprised to be having a girl, and had conflicted feelings about it: "Yeah, I, I wasn't…I mean, I guess I was excited. I just thought I was gonna have a boy for some reason. And I ended up having a girl. I'm…I mean I'm glad I'm having a little girl though, now. Yeah." She seemed, at the time of the interview, to still be grappling with convincing herself that she was happy with a girl. Despite her initial displeasure, Isabelle rationalizes that because she is

having a boy, she will not have to worry about her daughter ever becoming pregnant as a teenager like she did. It is future-oriented observations such as this that have made Isabelle stand out as an emergent negative case.

Choosing to find out the sex of the baby emerges as an act of uncertainty management. It reduces the number of variables that must be thought about and dealt with as the pregnancy progresses. It also helps participants assign meaning to the pregnancy, namely by helping them link the pregnancy to an actual baby.

The changing pregnant body. Many participants describe uncertainty related to physical changes that happen as the pregnancy progresses. For others, the absence of change or growth is more disconcerting. Rapid weight gain, for instance, was a common complaint. Aria, Rachel, and Amanda, when asked what the worst part about pregnancy is, all immediately describe the misery associated with rapid weight gain. The biggest downside to pregnancy, Aria says, is "Not wanting to be fat! [laughing] Not wanting to be fat." For Rachel, it was a side effect of weight gain: "The worst part is um…like, stretch marks. I hate stretch marks." Amanda describes her self as being "tiny" pre-pregnancy, and had difficulty accepting her changing body:

> Um…when I first started gaining weight, like, rapidly. Cause in the beginning, the first trimester I gained nothing. I was like the same, I had like a little bump, it wasn't really noticeable. And then second trimester, I started like, sticking out, and then started gaining weight, and it was just like, nothing, none of my clothes fit. Cause I was in a 00, and I'm starting to put on my sister's 3s and 4s and I'm like, "Noooo!" And I only fit in those. So now I'm like wearing stretchy pants, and I'm like, this is…I cried like once or twice, I was like, "This is terrible!"

Only being able to wear someone else's clothes seemed to shake her sense of identity. Clothes that were hers could no longer fit on her body, a change that happened within a matter of weeks. Though her mother assured her that she would lose the weight, Amanda still felt despair. Because of their youth, these participants have only just become "women" in the physical sense. Suddenly a new change is happening, one that threatens their appearance and is thrusting them forward into a new body that they are not entirely sure how to navigate.

Other discomforts such as swelling, exhaustion, nausea, and frequent urination are common complaints among the participants. Though they were aware that these symptoms were part of pregnancy, they still struggled to reconcile these discomforts with how their former bodies used to feel. When Amanda's friends ask her to go walk around downtown, something she used to do frequently, she struggles with wanting to join them and knowing the consequences: "But now it's like, if I'm standing for more than 2 hours, my ankles…I come home and I'm like, 'I'm gonna die!'" Alisha, who was on her third pregnancy, did not experience such unpleasant symptoms with her first two. Early in this pregnancy, she says, "all I did was sleep, and my body wasn't like, how I used to be. Cause I used to be, I'm an active girl. I stay runnin', I'm always hype and I wasn't nothing like that. Just was down." Rachel, once an energized high-school athlete, finds the exhaustion associated with pregnancy disconcerting:

> And I felt awful almost all day. And constant like, exhaustion. I don't like that. I get exhausted so easily. I'd walk from the kitchen that was right there, and I felt like I needed a two-hour nap. I get so exhausted. I don't know if it's just where I'm itty bitty, er…I don't know.

She and Alisha also complain of not being able to eat the specific fast-food selections they used to enjoy. Says Alisha, "Just like this morning when I had my McDonald's, it came up…I guess I

can't eat what I always get." Heidi describes the fear she feels with extreme nausea, and not knowing why it is such a severe experience for her:

> And when I get sick, when I get sick, I um, I get to where I'm bout to pass out. I don't know like, why I get lightheaded, and then my ears ring, and then I get sick, and then I start losin' my vision, then I pass out. So when I get sick it's scary.

For Molly, sensations associated with frequent urination are confusing:

> And I'm wonderin', cause there's, there's sometimes that it's like, I don't, I don't…it's like I go to pee? But I don't KNOW that I have…it's like my body don't tell me? And I get to the bathroom and it's like, "Okay, where did this come from?"

She tells stories of other women thinking they are urinating and not recognizing that their water has broken. She explains that she worries this will happen to her, and is concerned with every visit to the bathroom.

With the onset of unpleasant physical symptoms, uncertainty emerges in several ways. First, uncertainty surfaces through comparisons to the former physical self. They are losing, for a time, the parts of themselves that were able to cook tacos (Heidi), dance (Maria), and walk around theme parks (Amanda). Second, participants struggle with the actual experience of pregnancy symptoms, and the unexpected severity with which they affect daily activities such as walking and eating. But in other instances, uncertainty arises when expected physical changes are not occurring.

Aria knew that she should eventually begin to feel the baby move inside her. At a certain point, she grew concerned when this was not happening:

> And the funny thing about this is that I wasn't feeling her, and I was actually into it with my boyfriend at the time, so I was scared. I was like, "Maybe I'm stressing her out. Like,

she's not moving at all and stuff." So me and him ended up going to the ER the next morning and we heard the little heartbeat, so we felt better.

Heidi, who was four months pregnant at the time of the interview, was concerned about not seeing any changes in her size:

> But what scares me is like, my stomach, it ain't big at all. And that kinda freaked me out- that's like, something…cause I, I expect to have a belly by now especially. So I was like, "Why am I so little still?" They keep sayin' that it's okay and healthy, so I'm just sayin' "Maybe I'm little!" [laughs], I don't know. But that kinda freaked me out. Cause at first I was like, "Well I'm gonna be little for a little bit." Then as it started to keep going, I was just like, "I should have a belly." But then I just got that little pooch thing going on. I was like, "Uh, I want my baby bump!" But I ain't got it.

Rachel, too, had had these concerns early in her pregnancy: "It was weird at first, because, like, nothing was really changing. Cause like, I have a high metabolism, so I wasn't like gaining any weight." But eventually, "when the bump started coming up," she felt a great deal of relief. The absence of a "baby bump" early in pregnancy is a source of uncertainty. As the pregnancy progresses, its presence serves as a strong indicator that the pregnancy is real and healthy. For Molly, comparison to the changes in other pregnant women made her question the health of her pregnancy:

> Um, I've been, I would compare myself, cause I have a couple of girls that I know that are due around the same time as me. Well, I have one girl that is kinda, she's my friend and she's 26 weeks and she's 10 times bigger than I am. I started looking at myself - and we were the same size when we got pregnant - I started looking at myself, and started looking at her and I said something's not right.

Concerned that she was not growing as fast as her friend, she went to her doctor to see if something was wrong. They tested her for intrauterine growth restriction (IUGR), but at the time of the interview, she was "not sure exactly what's going on."

In all societies, there are certain expectations, and perhaps even myths, surrounding the idea of pregnancy. The descriptions provided by these participants demonstrate that they participate in the social construction of pregnancy and hold fast to preconceived notions about what symptoms and changes to expect. When physical manifestations belie participants' expectations, or don't fit socially constructed ideas about what the pregnancy should be, uncertainty arises.

Behavior change decisions. The physical changes that accompany pregnancy are often mystifying for participants, and restrict their abilities to perform behaviors that were once routine. But participants also made choices to enact behavioral change, and reflect on the types of behaviors that are unacceptable during pregnancy. These behaviors include going out with friends, drugs, and violence.

Many of the young women describe their busy social lives prior to becoming pregnant. For Maria, becoming pregnant meant scaling back her social life and the extracurricular activities she cherished. Describing herself as once very "busy" and "active," now she says, "I…I'm not saying I don't have fun now, but I had more fun then!" Molly believes that waiting out this period of stifled socializing will ultimately be worthwhile:

> There's a lot of stuff that I'm gonna miss out on because, you know…I gotta kid comin', ya know. Before I got pregnant, I was thinking I'm going out with my friends on Friday night, having fun! Now I'm like, no…I don't, I don't know what to do because there is a

lot of stuff I'm gonna miss out on, but there's gonna be a lot of…but it's gonna be worth it.

According to Isabelle, "I was like a go-out-with-friends, and like, go bowling or go skating or go to the movies, and now I kinda…I just, sit at my boyfriend's house on the weekends, like, that's really all I really do." Alisha explains, "I, I have made a big change in my life." With this, her third pregnancy, she has decided to focus on caring for her first son and preparing for the new baby:

> I don't do this like, before I was pregnant, I used to always stay out the house. I used to always go to parties, and hang with friends and do all of that. But now it's like, no, I don't do none of that.

Aria reflects that she "can't really do the teenage life, like going out and partying and stuff. But, that's something I chose to give up. I chose to do what I did, and also keep my baby, so." She also experienced a turning point when she discovered what her marijuana smoking could do to her baby during pregnancy, so she decided to quit. Both Heidi and Christina explained that they felt obligated to control their impulses toward violent reactions. Heidi describes many instances of "gettin' into it" with others, including physical confrontations with males. She describes one male classmate punching her in the stomach at school, "Cause he was tryin' to talk to me." Instead of fighting him herself, she chose to outsource her retaliation to a male friend: "I got 'em back. One of my guy friends got 'em back, beat him up." Christina, too, has had to rein in her propensity toward violent reactions:

> But there, sometimes people do- they test me! And it's very, and I used to be like, ready to like, you know, be violent [laughs], but now it's like, people, I don't know why, they still…it hasn't been a lot, maybe like, 2 or 3 people who decide they wanted to say

> something like, smart. And I couldn't like pop off like I wanted to. So it's changed me, it's made me more calm cause I'm not willing to risk my child's life for some childish person.

Whether big or small changes, participants indicated feeling somewhat hemmed in by the behavioral changes pregnancy demands. Even diet must be taken into consideration: "And um, I have to take care of my body in a different way, and eat certain foods. Kinda different" (Maria). But by framing behavioral changes as a personal choice, they hold on to some sense of efficacy about the health of their pregnancies. Doing what is "best" and making good choices during pregnancy can be classified as uncertainty management as it reduces the number of perceived possible negative outcomes for the pregnancy. Previous research into adolescent pregnancy has labeled these changes as "desistance from antisocial behavior" (Breen & McLean, 2010, p. 15), which play a crucial role in enacting resilience in the face of challenges, an idea that will be explored further.

Fears about baby's health. A final aspect of the reality of pregnancy is fear about the health of the baby. This was yet another source of uncertainty among participants, who expressed both abstract fears about a potentially unhealthy baby and fears based on events that had actually occurred. Christina, for instance, acknowledged her apprehension about having a healthy baby. She explained that as she neared the due date, those worries had begun to diminish: "Actually, like not too long ago…I was really like nervous about like, 'What if something's wrong with her? What if, what if…?'" Amanda, who was concerned about being "so little" and "so young," thought that those factors might affect the health of her pregnancy. When asked if she wanted to do second trimester screening, she managed her uncertainty by avoiding information that might indicate a problem with the baby:

> And I got asked if I wanted to do the testing thing, to see if there's something wrong, and I was like, "No." Cause I didn't wanna…like if they had said yes, there's something wrong, I wouldn't wanna worry the whole time, and then cause stress and everything else, and then *cause* something. And I was just like, if it comes out and there's something wrong, then there's something wrong, that's the end of it. There is no giving him up because of something, there is no changing my mind because he has something wrong. It's like, in the end, it's still my baby, and still him. I was like, "He's the same baby he's been this whole time, so…"

For others, including Molly, Aria, and Jade, fears about the health of the pregnancy and baby were based on actual events. As described previously, Molly had been screened for IUGR, but did not yet know the results.

> But you know, I was talking to my mom yesterday – I actually broke down on my mom yesterday – and I was like, ya know, if something's wrong, I just wanna know what it is. Cause when you get pregnant, you expect, "Hey, I'm gonna have a healthy pregnancy and I'm gonna have a healthy baby," and then it's just like, whoa, whoa.

Her attitude toward testing and screening differed from Amanda's, perhaps because she had reason to believe that something was wrong. In the face of potential threat – in this case, the idea that something might be wrong with the baby – those who seek out information can be classified as "monitors," while those who avoid information can be classified as "blunters" (Miller, 1987). Differences in Amanda's and Molly's approaches to screening in healthcare, therefore, can be attributed to differences in coping style. Molly goes on to explain that it is difficult to remain calm about "every little bump or anything," and to refrain from immediately calling her doctor: "Ok, it's really scary! Cause you're goin', 'What's goin' on?'"

Aria was also concerned about the health of her baby, due to her previously described marijuana smoking and her inability to feel the baby moving. Jade, however, stood out among the participants as being completely overcome with fear. She spoke very little during the interview, eventually becoming too emotional to continue. As she describes, "First son I had passed away. And second one…kind of scared of this happening again." She was later prompted to elaborate on her feelings when she found out she was pregnant again:

B: Did you feel surprised?

J: Yeah. And scared.

B: Yeah…why were, what were you scared about?

J: Making it, going all the way through and then it's gonna pass away again.

She seemed to have disassociated herself from the pregnancy, feeling extremely uncertain about whether this baby will survive. She even referred to him as "it," despite knowing that it was another boy.

The reality of the pregnancy begins to solidify at different points along the participants' pregnancies. This is an extremely nuanced pattern of experiences. Whereas the previous theme of relational renegotiation captures the pregnancy-related uncertainty that is outside of the participant, the reality of the pregnancy is the struggle to assign meaning to pregnancy experiences occurring within themselves. The ebb and flow of uncertainty in their descriptions points to the importance of understanding experiences such as ultrasounds, weight gain, and pregnancy loss among pregnant adolescents. Moments where the viability of the pregnancy is confirmed can reduce uncertainty, as can the participants' behavior changes giving them a sense of agency over their bodies. Finding out the sex of the baby may increase or decrease uncertainty, depending on whether the desired sex matches the actual sex. Physical changes, too,

can go either way, decreasing uncertainty if the changes match expectations and increasing uncertainty when they are more severe than expected or are not happening at all. Fears about the health of the baby, which can happen at various points along the pregnancy trajectory, increase uncertainty along with the number of possible adverse outcomes. These instances of finding out information, making choices, and being swept along with change are fundamentally about control: gaining control, losing control, and accepting what cannot be controlled in pregnancy.

Information Behavior

Each participant was asked to imagine a hypothetical situation where another pregnant teenager asked her for advice, and about where and how to get information about pregnancy and parenting. These questions were intended to elicit how participants interact with information and what types of sources they deem valuable. In the context of illness episodes, people seek out information to help them make decisions. Health information can be exchanged through face-to-face or mediated channels, with sources varying from healthcare providers, family, friends, peers, the media, and healthcare organizations (Brashers, Goldsmith, & Hsieh, 2002). To manage uncertainty, people interact with information in different ways, engaging in behaviors that include seeking, avoiding, providing, appraising, and interpreting environmental stimuli (Brashers, 2001). In the current study, participants provide evidence of heavy reliance on interpersonal face-to-face channels when managing information. They also provide some evidence that they view their future selves as useful information sources, which points to the perceived value of personal experience in generating knowledge.

Reliance on interpersonal sources. The interpersonal information sources described by participants include healthcare providers, social services personnel, family members, and the participants themselves. Participants believe that healthcare providers, including doctors, nurses,

and counselors, have at least some of the answers that pregnant adolescent may be seeking. Maria, for instance, suggests using providers who work in the school:

> Um, I actually feel like…well if we're still in school, I feel like she should go see like, a counselor. Cause I feel like they'll give you more information, because um, they can tell you really exactly where to go.

A school counselor may not be able to provide treatment, but she can help direct the participant on the path to proper medical care. Heidi reported that her OB/GYN had given her pamphlets and a book that she would gladly pass along to another pregnant teenager in need of information: "Like they got one called *Prenatal Pregnancy* or something like that, it's just a little book. Probably give her that." However useful healthcare providers may be, participants acknowledge that they themselves might be hesitant to ask questions. Christina, for instance, suggests that asking questions at appointments is a good way to get information:

> C: When she starts to go in for her appointments to just ask her nurse. Like, when they ask if you have any questions, which they normally do, they should, just ask all the questions you have! And…yeah, that's the way I think.
>
> B: Yeah…is that what you did?
>
> C: Mmm, sometimes I be scared…I don't know why! [laughs] But sometimes I just…I'm not gonna ask a whole bunch of questions even though I probably should.

Although she recognizes that doctors and nurses often prompt patients to ask questions, she is fearful about doing so and does not know why. Rachel, too, admits that although touring the hospital with a nurse was a great time to ask questions, she did not:

And he's telling us other things, like we was asking questions as we went along. I was trying to remember what they was telling us when we asked questions. Other people asked questions, but I didn't.

Several participants had been, and still were, recipients of social services, including home-health educators, pregnancy resource centers, and teen pregnancy programs through their schools. Overall, participants described their experiences with these programs as being very valuable. Alisha, for example, immediately named two women she knew through an after-school program as the best place to go for information. Amanda was very enthusiastic about her involvement with a home-health education program:

B: Where should she go like, get information to help her deal with this? Like, what would you tell her in terms of resources for her?

A: [Name of program]. I have that, and oh my gosh it's amazing. She comes and I mean, some of the stuff she talks to me about, I'm like, I would have NEVER thought of that. If it wasn't for her, I would be clueless on a lot of things. She helped me out so much with so many things. Like, deciding on circumcision was a big thing.

Molly describes how the comprehensive support she has gotten through her program has been helpful:

And I went to the health department, and they gave me Jennifer, which is my home nurse through [Name of program] and they have really helped me! Throughout my whole pregnancy now, tellin' me what I can do, what I, what's out there, what can I, what to expect. They've gave me pamphlets, they gave me books, they gave me everything that I needed to know for this child. Because I had no clue at all what to do.

Isabelle had visited a pregnancy resource center early in her pregnancy and been set on a helpful and informative path while trying to keep her pregnancy secret from her family:

> I: Um…I would say go to the [Name] Center. Because that's where I went when I first, when I first found out. That's where I got my first ultrasound, and they helped me out on what I wanted to do. And they gave me like these papers that told you everything, basically. Like a whole bunch of pamphlets, like it was like, a big envelope full of stuff. So, I would say go to the [Name] Center. I think they're really helpful with stuff like that.
>
> B: So they had a lot of reading material for you, stuff like that?
>
> I: Yeah, and they talk to you if you have any questions, and they help you out- they get you set up with a doctor, what hospital you wanna go to and stuff like that. Like, they're, they're helpful.

Though participants do talk about reading material, it is not material that they have sought out on their own. Their approach to reading material is passive: they do not mention actively seeking out materials online, in a library, in a bookstore, or anywhere else. These materials are given to them by interpersonal sources; therefore, these people are important tools of information dissemination. It is not uncommon for health information to be acquired passively (Case, Andrews, Johnson & Allard, 2005). People often stumble across health information while reading newspapers, watching television, or listening to the radio (Carlsson, 2000; Longo, 2005). These "unplanned" searches for information may be termed passive information seeking (Kelly, Eldredge, Dalton, & Miller, 2014), a useful categorization to apply to the information behaviors of participants in this study.

Only Amanda and Rachel discuss family as an important interpersonal resource for pregnancy and parenting information. The rest of the participants either take for granted that they

will receive guidance from parental figures, or do not view them as important sources of information when it comes to pregnancy and parenting. But Amanda spoke a great deal about her Aunt Nancy, a midwife, who talked to Amanda a great deal about birthing options. Conversations with Nancy had convinced Amanda that she wanted a natural water birth, delayed umbilical cord cutting, and placenta encapsulation so she could ingest it postpartum. She also helped her choose a new doctor. Rachel planned to rely on family when it came to information seeking. When asked where a pregnant teenager should go for information, she explained that they offer classes at the hospitals, although she had not used them herself:

> And just tell her that, just, take them classes if you don't feel like you can do it, but I mean, I didn't take them classes because I mean, I have my mom, his mom…he has all kinds of people that just had babies. So I mean like, if I had any questions, I'd like call one of them up or go over there, so.

Finally, participants indicated that they themselves could be useful sources of information because they see past experience as very valuable, similar to their reasons for relying on family members. Aria explains that experience has been her teacher:

> B: What kind of advice would you give her about sort of, where to get information about how to do this?
>
> A: I would tell her…just…see with me, I didn't necessarily need that. Cause like I said I grew up pretty much raisin' my little sisters and stuff, so I knew a lot. But I would just tell 'em like, you know, there's classes out there.

Maria says that for the hypothetical pregnant teen in need of information, "So…or ya know, I'd let her know, ya know if you ever need me, I'm, you know I'm here. And I can give you what I

know off of my experience of pregnancy." Alisha indicates that, in addition to taking advantage of social-service opportunities, she would also offer her own advice and help:

> Or I would sit and talk to her and tell her, and just like get a fake baby or a newborn baby and show her the things to do. And like, how much to put in the bottle, and stuff like that, and how when they wet, try to change 'em and stuff.

Social Media Use. The aforementioned results are interesting, given the heavy reliance on the Internet by women across the world seeking pregnancy-related information. For most women, the Internet plays a significant role not only in information seeking, but decision-making and social support during pregnancy (Lagan, Sinclair, & Kernohan, 2010; Madge & O'Connor, 2006). Women actively seek information about such topics as fetal development and maternal nutrition (Gao, Larsson, & Luo, 2013), particularly in the early stages of their pregnancies (Larsson, 2009). Women largely regard the ability to sift through health information online as common sense. They are motivated to seek pregnancy information online by a desire for reassurance, the need for a second opinion to challenge other information, for greater understanding to supplement other information, and perceived inability to access this information elsewhere (Powell, Inglis, Ronnie, & Large, 2011). But in the current study, only Heidi, almost as an afterthought says, "I don't know really. All these smart phones, Google it!"

This raises questions about access, efficacy, and the general relationship that underprivileged pregnant adolescents have with the Internet. It is important, therefore, to summarize instances of social media use, which were mentioned by Amanda, Aria, Heidi, and Alisha. Though they were not directly asked about social media use, their descriptions provide evidence that, for these participants, the Internet is where reality is created—created by themselves, close friends, and peers. It is a source of *personal* information, as disseminated

through social networking sites like Facebook and Twitter, but not necessarily for health information from valid sources. Amanda and Heidi both describe the harassment they experienced via Facebook as news about their pregnancies spread. Amanda explains:

> So when I left school, of course then it was on my Facebook. I mean everybody, they're like, "Why aren't you at school? Where you at? How are you, how's the baby? Duh duh duh…" Cause I didn't, like I don't have it all over my Facebook yet.

As described previously, she left school to avoid the uninvited questions and comments about her pregnancy. But the harassment follows her, as there seems to be no privacy boundaries regarding questions and curiosity. Heidi was being bothered by a classmate on Facebook, "because I wouldn't talk to him" after word got out that she was pregnant. The reality of other people's thoughts and perceived involvement with the pregnancy are made real through communication on social media, where personal drama is on public display.

Aria uses social media to post updates about her pregnancy, tweeting freely about her feelings and experiences: "I tweet about my little girl, like, 'Oh she's moving,' and just stuff like that, and so people know I'm pregnant." As she reports about her pregnancy to her followers, she is creating information about herself. It is possible that this is a way to keep control over "news" surrounding her pregnancy, creating her own reality through social media messages. For Alisha, too, social media is partially responsible for circulating news of her pregnancy:

> It got out, cause…Facebook. Friends screenshotted me, cause I told her it was a girl, she screenshotted me, and then every status I made about me being sick they was like, "That's that pregnancy system [symptom?]," and that's just how it got out. Then I'm like, I really don't care no more. So…I just let everybody know, like "yeah, it's true."

Overall, social media clearly throw privacy and information boundaries with friends into question.

Encounters with Doctors and other Professionals

Inexperience with the healthcare system. Because participants are 18 and younger, it is not surprising that they do not have a great deal of experience with doctors—especially OB/GYNs. Prior to 2006, the American College of Obstetricians and Gynecologists (ACOG) screening guidelines recommended starting Pap smear at age 18 or with the onset of sexual activity. However, guidelines were revised in 2006 to recommend beginning screening 3 years after the onset of sexual activity or age 21, whichever comes first. Guidelines were further revised in 2009, recommending that screening begin at age 21, regardless of sexual history (Karjane, Ivey, & Chelmow, 2014). Therefore, even though it was not discussed as much among Black participants, it can be assumed that this was each participant's first experience with an OB/GYN. The only exception would be Jade and Alisha, who had been pregnant previously.

Amanda, who greatly disliked her first OB/GYN, initially did not realize that she could switch doctors:

> I didn't know you could switch! Because of my age, it's not something that's like, oh yeah you can. I thought you get a doctor and you're stuck with him. And my mom was like, "Well let's switch doctors." And I was like, "How do you do that?" She's like, "We'll call around to find you one." I was like "Okay, yeah!" I was pro-choice for that one!

She even attributes her ignorance about the system to her age and has had to rely on the advocacy of her mother to find a doctor she liked. Heidi provides a colorful description of her

first visit to the OB/GYN upon finding out she was pregnant. She is so unnerved by her experience that she shares images and details with her baby daddy, Aaron:

> H: Then like…I dunno, like I went for my first, it wasn't a pap smear, but they were like, examining me down there, and it was just like, "What is this?!" You know, cause I ain't never had this done. I took a picture of what they used on me because it scared me so bad! You know that little metal thing they use, and they like, pokin' you?
>
> B: Oh yeah, yeah.
>
> H: I took a picture of that and I sent it to my baby's dad, and was like, "Look at what they just put inside of me!" He was like, "They put that in you?" And I was like, "Yeah."
>
> B: So you've never had a pap smear before?
>
> H: No! I was freakin' out. And they said it wasn't a pap smear cause they can't give you a pap smear till you're 21. That's what they told me, I was just, I didn't know that.

Her description speaks to the importance of educating young people about how medical encounters work, and easing their fears about medical procedures. Pregnancy, as participants' descriptions have demonstrated, is a mystifying experience by itself. This is amplified when encounters with providers and procedures are not thoroughly explained in terms they can understand.

Professionals' incompetence. The only distinct theme that broke down along racial lines was related to contentious encounters with healthcare providers and other professionals, such as teachers. This pattern emerged among white participants, but not among black participants. White participants alluded to inexperience with the healthcare system and voiced complaints about the incompetence of doctors and other professionals who were supposed to be trustworthy.

Amanda, Molly, Heidi, and Rachel, the four white participants, all told stories of how they had been failed by doctors and other professionals. Their descriptions are characterized by unmet needs and misunderstanding. Heidi and Rachel both talked about problems with teachers. A health teacher, according to Heidi, might be a good resource for a pregnant teen who was seeking information and resources. However, she explains that she herself would not go to a teacher because she doesn't trust her teachers. The problem, she says, its that "They run their mouths about everything!" After overhearing a group of teachers saying negative things about students, "I was just like, gah! Y'all think that about us? That's terrible, I was like, I'm ready to go! I don't wanna know all this. So I was like, nope, don't trust 'em." For Rachel, her dislike of teachers was not about breaching confidence, but about not being understanding of pregnant students' needs. They had done away with what she called the "pregnancy plan," where pregnant students got to eat snacks throughout the day. A few teachers still allowed her to snack, but her math teacher did not:

> That's another reason I wanted to leave so bad, cause I had to have that class. It's a math class. Discrete math. I hate the teacher, he would never let me eat. Or drink anything. And I'd go to the office, and they'd be like "You can eat, and you're fine." I go back and it's like, he's…he acts different. Because I get to eat.

Feeling victimized, she ultimately decided to finish the school year from home.

Amanda, Molly, and Rachel also describe how they had been mistreated by medical professionals. Prior to discovering her pregnancy, Amanda's mother had asked her pediatrician to prescribe birth control for her, but for reasons that were unclear, the doctors at that practice had refused:

> My mom was like, "Ok, we need to get her on birth control," and all this. They were like, "No, no she's fine." And mom was like, "She's sexually active, she told me! She needs to be on birth control." They were like, "With you guy's family history, we don't think that's good. We don't wanna put her on birth control." And my mom was like, "Ok, whatever"…So then a few weeks later when I walk back in there, my mom was like, "Good job guys." They were like, "What? What's going on?" And she was like, "She's pregnant!" And they were like, "AAAHHH!"

Later, Amanda had taken paperwork to her local health department to enroll in the WIC program, which provides nutrition education and supplemental foods to low-income women. It was allegedly a WIC employee who leaked the news of Amanda's pregnancy to her daughter, a classmate of Amanda's, and subsequently her entire high school. Again, someone whom she thought she should be able to trust had violated her privacy. When she began seeing an OB/GYN, Dr. Rice, her experience was initially satisfactory. Then their relationship began to sour:

> I was like…I had heard it from so many people that were like, "Oh we don't really like Dr. Rice because of the way he is," and in the beginning of my pregnancy, I was like, "Oh he's not that bad. He's actually pretty good!" And then, when I started having an opinion on things, that's when I seen the other side of him. When it was, I wanted to choose something, but he wanted to be in control…and I was like, "No…I'm not up for this. No thank you."

In the struggle to plan her birth and make decisions for herself, she came to the conclusion that she was being shut out from controlling her own experience due to her young age. After switching to Dr. Hansen, she finally felt that she was being heard: "It's not…he talked to me like

I was a person, and not just a child. Cause it was more, he was interested in what I was saying instead of telling me I was wrong."

When Molly began to suspect that something was wrong with her pregnancy, she, too, felt that she was not being heard because of her age:

> It's kinda…cause I wasn't going to Mercy West, I was going to the hospital up here, and they weren't very helpful at all. I'd go in and a lot of the nurses there don't approve of teenage pregnancy, so they were really rude to me when they'd go to triage and say something's wrong and they wouldn't even check me out hardly or anything, they'd just send me home.

When she began leaking "some kinda pink fluid," she again went to the local hospital. But, "the woman just looked at me and said no…they still couldn't figure out what that was." As soon as she switched to a larger city hospital, they began running tests to determine what was wrong. Even without definitive answers, Molly was relieved to be taken seriously as a pregnant woman and not just another teenager.

After a serious car accident with her boyfriend earlier in her pregnancy, Rachel was airlifted to a hospital and eventually given an ultrasound. The nurse conducting the scan, however, would not let Rachel look at the screen. Flanked by family members who were also trying to peek at the screen, the nurse insisted that she could not show them the ultrasound screen. Angry and scared, Rachel appealed to the doctor as soon as he appeared:

> And then that doctor come in, I was like, "Why didn't that nurse let me see the ultrasound?" I mean, hello! I was like, "I'm scared to death as it is, and I can't even see it?" That's even more scary. I was like, "Why wouldn't she let me see it?" He was like,

"What are you talking about? You're allowed to see your ultrasound." He got all kinds of mad and he apparently went and made a report about it.

In each case, the perceived unjust treatment of the participant was rectified by finding a different provider—one who, in her portrayal, was an exemplar of understanding and fair treatment toward a pregnant adolescent. Their "good vs. evil" portrayals of healthcare providers are extreme, characterizing these people as either "for us" or "against us."

A possible theoretical explanation could lie in the idea of constructivism (Delia, O'Keefe, & O'Keefe, 1982). Central to this theory is that people vary in cognitive complexity, which is the mental ability to distinguish subtle personality and behavior differences among people. As we form impressions of people and social situations – in this case, the healthcare provider in the treatment setting – those with a larger set of *interpersonal constructs* will have better understanding of others' personality traits, their relationship to us, what they are doing, and why they are doing it. Interpersonal constructs are mental templates we use to bring order to our perceptions, and categorize our impressions of others (Delia, O'Keefe, & O'Keefe, 1982). People who are more cognitively complex, therefore, are able to see the "gray area" of situations and other people, rather than just quickly categorizing them into one of a very few "types." Research has found that complex thinking is a product of cultural transmission, suggesting that parents pass on different levels of complexity through messages of nurture and discipline to their children (Burleson, Delia, & Applegate, 1995).

Within this theme, uncertainty arises from participants' unfamiliarity with the medical system. Seeing scary instruments, not knowing what to expect, and being told that their input does not matter are all experiences that augment uncertainty. They feel out of control over what will happen to their bodies; some, however, try to regain control by attributing blame for their

confusion, fear, and even the pregnancy itself to the behaviors of providers who have wronged them. Questioning and ultimately switching providers take that attempt at control a step further. In addition, people like Heidi's and Rachel's teachers and Amanda's WIC personnel have some degree of control over their lives, yet cannot be trusted. Defensive reactions to these violations of trust seem to empower their decision-making ability and help them feel some self-efficacy in a difficult situation.

The Future

The final theme reflects participants' feelings about the future. Interestingly, uncertainty does not really emerge in their discussions beyond the birth experience. In other words, they do not express a great deal of uncertainty about motherhood, parenting, the baby beyond infancy, or their future selves. This can in part be attributed to adolescent brain development, and their inability to think abstractly about events that are not immediately eminent (Freeman & Rickles, 1993; Jorgensen, 1981).

Birth. Participants reflected on their impending birth experiences in a variety of ways. Birth is constructed as a great unknown and the possibility of different outcomes shrouds the idea of birth in mystery and uncertainty. The only exception to this mindset is Alisha, who had had two successful birth experiences already. When describing birth, she says, "It's not bad! I just don't wanna have, I would prefer the epidural." Even for Jade, who had experienced full-term stillbirth, questions about the possibility of live birth lingered: "Am I gonna make it though all the way?"

For the other participants who had not experienced birth before, there was a great deal of uncertainty about what the birth experience would be like. Their primary frames of reference included family and friends who had given birth before them and who offered stories and advice

to prepare them for the experience. Even so, participants overall seem to dwell on the possible negative aspects of birth. Heidi explains:

> B: So you said you're nervous about like, labor and delivery?
>
> H: MmHmm…that's like, the only thing that scares me. Like, what if I don't make it to the hospital in time? Or if like…anything can happen! That's why I'm just like, scared. Like I'm real, um, I worry a lot. So I'm just like, thinkin' about it. It makes me worry. I worry all the time. That's like my worst thing, worrying. Cause I'm just like, anything can happen!

Imagining a myriad of possible outcomes, she explains that she quickly becomes overwhelmed when she thinks too much about the unknown.

Participants' primary patterns of birth-related uncertainty center on the pain of birth and the possibility of cesarean section. As Molly describes, "But I really don't wanna…delivery is about the only part that really scares me about the whole pregnancy, cause I'm going ok, I know she'll be here, but that's gonna hurt so bad that I really don't wanna think about it!" Maria, too says she worries about the pain: "I'm very nervous! Because of the pain. I don't know what I'm gonna be feeling, like, I'm just…I don't know if I'm gonna have a long labor. So it's just, I'm all nervous." Rachel says she is torn between fear of the epidural and the unknown pain of labor:

> I was gonna do [the epidural] but now…I'm terrified of needles. And I saw on there like, they're digging it in and stuff like that. I was like, "Oh my gosh, no! No way"…They say as soon as you get there and you feel the pain you're gonna ask for it. Which, I probably will, maybe, I don't know, I'll probably think about that needle. They was like, "You probably won't even think about the needle!" That's what everybody says. I don't know,

> I just can't see myself saying, "Give me that epidural." But, you never know. It might really hurt, so…I really don't know what it'd feel like. That's kind of the scary part.

The unknown extent of the pain experience is repeatedly described as "scary," as participants face something that they do not know about themselves—namely, how they will tolerate this unknown level of pain.

As Heidi explains, "anything can happen" in the birth scenario. Participants express a preference for vaginal delivery over cesarean section, yet seem to have very little efficacy for increasing the odds of a vaginal delivery. When it comes to avoiding a C-section, there are certain steps that can be taken, including finding a doctor with a high vaginal delivery rate, delaying going to the hospital after labor begins, avoiding inductions, and avoiding epidural anesthesia (American Pregnancy Association, 2006). None of the participants alluded to an awareness of these factors.

Not knowing what her possible IUGR diagnosis means for her delivery, Molly explains:

> I wanted to deliver her natural with an epidural. But…with this I don't know, I don't know if I'm gonna be able to do that, or if they're gonna have to take her by C-section. But for the delivery I wanted to do the epidural, and that was…I'm scared! I don't wanna do it but I have to [laughing].

Heidi worries that her small size will leave her unable to deliver vaginally:

> I'm just really scared somethin's gonna happen cause I'm little. And like, I don't care to have a C-section, but I'm just, I don't know, I'm nervous about that. Like all that, like havin' it is the main thing I'm worried about.

Rachel's description of her hospital tour indicates that whatever mode of delivery she has, it is something that will happen to her based on events and decisions that are outside of her control:

R: And I think they take me into a different room, I don't think they could show me that room where they do the c-section.

B: Yeah, it's like a surgery room.

R: And they was like, well if you're having that, then you'll be tooken down this hall and they showed me what hall it would be. Then they was like, it would be whoever the main person is, which is him, and somebody else during the natural part. But the c-section it can only be him. So they just kinda, you know, went through the order…That's the scariest part, whether it's gonna be natural or your stomach. I don't know! I don't know how I'd feel laying there.

B: Yeah. How would you feel if um, if they told you you had to have a c-section?

R: I don't know…I'd probably be nervous—even more nervous. Cause I've never really had surgeries before. So I wouldn't know, like, at all. And I don't know what's gonna happen to her, like, I seen videos and stuff, but still, that's scary. I couldn't see what's happening myself…weird.

Christina and Aria expresses slightly more confidence about handling the delivery as a whole. But Christina acknowledges that she only has so much control:

B: Yeah, so how do you feel about the delivery?

C: I feel…like I've got like—I got this, I think! I'm not gonna try to go natural, but I'm gonna try to stay calm, stay as calm as possible, and just hope for the best.

Aria has considered alternate modes of delivery, but is still unsure what will happen when the time comes: "I guess we've said that that's…that's the main, it seems like I'm gonna be doing the epidural, whatever. We did think about the water birth, we did think about that, but I just, I

don't know." She also talks about decisions as something "we" make, although she is unclear about the identity of other people in "we."

The fear about birth that these participants express is tied to their sense of control over the impending event. Previous research has found that women with higher amounts of fear about childbirth tend to have higher learned helplessness, a higher chance (external) locus of control, meaning a belief that health events are subject to fate, and higher powerful others locus of control, meaning a belief that health outcomes are controlled by other powerful people, like doctors (Levenson, 1974; Lowe, 2000; Wallston, Strudler Wallston, & DeVellis, 1978). Women with higher fear about birth also tend to have significantly lower self-esteem and generalized self-efficacy than those with low fear. The aspects of birth that women fear include loss of control during delivery, the birth process itself, something being wrong with the baby, and painful contractions (Lowe, 2000).

The apprehension expressed in the current study could point to fatalistic attitudes toward birth and birth outcomes. Fears expressed by these participants are not uncommon, and not necessarily unique to adolescence. Instead, these fears may be a function of how uncertain they feel about childbirth, and how little control they think they have over the situation. Though a few participants described steps taken toward preparing for the delivery, such as taking hospital tours and considering alternate modes of delivery, overall, birth is something that they are going to let happen to them. When considered against the decisive action white participants took against "powerful others" – health practitioners – who had wronged them, this is an interesting paradox. When it came to switching doctors, going to a larger hospital, and complaining about care, participants seemed well-armed. Once they were satisfied with personnel, they retreated to a fairly passive approach to birth.

One negative case emerges when it comes to approaching birth. Amanda, whose midwife aunt Nancy had a strong influence on her knowledge and attitude toward the birth process, had devoted much more time thinking about and planning her birth than the other participants. Though barely six months pregnant, she described an evolving birth plan:

> I think, like, well…cause in the beginning I was like, I'm gonna have him at the hospital, I'm gonna get an epidural, and that's it. Because Corrine had to be woke up to have her baby because she was on so much pain medication that she was passed out and she doesn't remember it or anything, and I'm like, that's terrible. So I was like, just epidural, that's it, nothing else. And they were like, yeah that's fine. And then when I talked to my aunt about all-natural water birth and all this, I was like, that is awesome, I wanna do that! And then my mom kind of…I was like, FIXED on that. I wanted an all-natural home water birth. I didn't want medication, I didn't want none of that. And then my mom kind of made me change my mind. Well, my mind didn't change- she was like, we're not doing that. And I was like, but I want to! And she's worried about if something goes wrong or something like that. And I was like, oh yeah, okay.

She describes the nature of her interactions with Nancy:

> Cause we talked about everything, cause she wasn't forcing me into anything, she wasn't like, "Oh you have to this you have to this," she was like, "So, what do you think about this?" I was like, "Well, you're about to tell me about it, so come on- give me the info!"

Suggestions and information from Nancy made Amanda excited about different options related to pain management and the birth process in general. Nancy even had Amanda convinced that she wanted to encapsulate and eat her placenta after the birth. Overall, the large amount of information Amanda had gained through conversations with her aunt had reduced her uncertainty

about birth. She expressed no fear about the process, instead talking with fascination and excitement about delivering her son.

Motherhood. Because all participants plan to keep their babies, ideas about what it will mean to become a mother were explored. Despite their lack of future orientation, participants talk about the "forever" love of motherhood. According to Amanda, a mother is "the one person that like, no matter what, they're supposed to be there." The best part of pregnancy, according to Christina, is "Um, just knowing that soon, I'll have something that's…like somebody that I believe would like, never leave, or like…that I can love on and just really care about and…yeah, I'm just excited." Heidi echoes the idea that having a baby will give her "someone to love on." Molly describes what is best about pregnancy for her:

> I think gettin' ready and knowin' that I'm gonna have a little girl and, I lo--, and knowing that no matter what, she's always gonna be mine, and she's always gonna love me for me no matter what cause I'm her mother.

Aria and Isabelle talk about motherhood as a gift. Aria's description is somewhat fatalistic: "So I'm just like, God—if God wanted you pregnant, and He made you pregnant, you was supposed to be pregnant." She explains that babies are something that is "meant-to-be," and that can happen no matter what age a girl is. Isabelle, who once thought herself unable to conceive, says:

> I: I just feel like that's, I mean, it's a gift! You know, like, I feel like I'm not mad at HIM, like, you know, I don't regret him or anything.
>
> B: So it's a boy?
>
> I: Yeah…I never regretted him or anything like that but, I mean I just feel like that's somebody that's gonna be in my life forever.

Overall, participants look forward to the love and relational permanence they believe motherhood will provide. Previous research has found that pregnant teenagers believe in certain advantages to teenage pregnancy, including having someone to love and be loved by, possessing something, giving them purpose in life, and being able to grow up and take responsibility (Rosengard, Pollock, Weitzen, Meers, & Phipps, 2006). Women looking back on their experiences of becoming adolescent mothers, particularly those from disadvantaged backgrounds, confirm that motherhood has given them purpose and love, as well as an alternative to a life of crime, drugs, and meaninglessness (Dalton, 2014; Flanagan & Kokotailo, 1999). Participants in the current study express little doubt about their own abilities to be good mothers and foresee the connection with their children as something that will be automatic, natural, and permanent. However, more nuanced descriptions of responsible parenting emerge when they talk about other pregnant adolescents and adolescent mothers in their social networks.

Responsibility. Participants also provide descriptions of "good" versus "bad" parenting within their worldviews, using both hypothetical and real-life examples to illustrate their perspectives. Instead of asking participants directly about how *they* plan to parent, this approach was chosen because of the difficulty pregnant adolescents have connecting their pregnancy and parenting (Spear, 2001) due to their inability to think abstractly about future events (Jorgensen, 1981). For many participants, the first step in being a responsible parent is deciding to keep the baby. Aria explains:

> But I knew from like, when I took the test that wasn't gonna give up, give up my child. Cause of the simple fact that I've always taught myself that I was not gonna be like my mom nor my dad. If I'm gonna do grown-people stuff and take the responsibility, then I'm just gonna have to take care of my child…when I found out I was scared of course,

emotional and stuff, but I knew I had to do what I had to do, and take care and just…woman up!

For Heidi, too, giving up the baby would have been irresponsible: "Abortion NEVER crossed my mind, or adoption, I just don't, like, NO. It's my baby, I did what I did and I want the baby."

A good teenage mother, on the other hand, is one who goes to school, works, and also provides the hands-on care for her child. Maria describes a friend, recognizing her as a model teenage mother:

> She works incredibly, so hard. And she's still going to school, and she's getting ready to start college. And, um, she's fixing to actually move out on her own. She has a car. Like, it just seems like she's doing so well. And she doesn't even really have her—I mean she has her mom. She actually stays with her mom. But she's not depending on her mom.

Molly describes her older sister, a woman who has overcome adversity through hard work and dedication to her family. Having been married to a man Molly describes as "very abusive," she admires her sister's perseverance:

> She got out of that relationship and she did what she had to do, and now she raises three kids. Her oldest is 16/17, her middle one is 14, and her youngest is 10. And even though the youngest one is having health issues right now, she still goes to work every day, she brings home, she takes care of her kids and she does what she has to do and I just, I look at her and I say, "Hey, I wanna be like that!"

Good parenting is also about the ability to provide material things for the child. Jade says she had advised another pregnant adolescent to go to the doctor, get a job, and stay in school:

> B: Why are those things important, do you think?

J: Because if you don't have, if you don't go to school, then you can't do anything. And if you don't have a job, then you can't buy any…things that you need.

Christina describes a "good" teen mother she knows: "Yeah, she makes sure she, she has a job. She makes sure that he has what he needs." Having the money that comes from an education and job enable a mother to "spoil" her child. As Alisha explains when describing a friend, "She don't do nothing bad, she take care of her son, get him everything he wants…He's, he's just right, like, he's just spoiled rotten."

On the other hand, there is also no shortage of poor parenting examples in these participants' lives. In Heidi's example, it is evident that she plans to be a different type of mother than her cousin:

Uh, my cousin Hayden. She had a baby when she was like, 12, 13. Yeah, and uh, she don't have nothin' to do with it. She don't take care of it, she leaves it at her mom's or her mamaw's all the time. Like, you hardly ever see that baby with its mom. Like ever—and it's gonna be the complete opposite with me! It's gonna be like baby, mom. Right there [laughs]. I'll probably not even need a babysitter—like, no…no babysitters!

Heidi's example taps into questions about what amount and what types of help are acceptable. Aria describes an acquaintance:

She started having them at an early age like 16, 17, and she only has custody of one. And…she like…that's just somebody I know…I, she, she just don't take care of her kids, and she put her kids off on people a lot, stuff like that.

Molly describes her close friend:

My friend Maggie. I love her to death, but she does not wanna work, she wants to go out and do everything she was doing before she got pregnant, and just have her mom watch

her child all the time…If you're gonna keep the baby, you need to be the one to take responsibility and take care of it and work for it, not ya know, your parents buy the baby everything because you don't wanna go work and you don't wanna take responsibility for what you do!

Her friend is denying the inevitable changes that motherhood brings, wanting to remain in her pre-motherhood life.

A good parent is resilient in the face of hardship, and takes responsibility for her child without "pawning off" the baby on others. The descriptions in this study raise important questions about what types of social support are okay to accept and which lead to categorization as a bad parent. Interpersonally, the idea of social support is broad, and not yet considered a single unified concept; however, within health communication, the term can be used to link social relationships to health and well-being. Social support can be divided into informational support, emotional support, tangible support, and appraisal support (Goldsmith & Albrecht). In the current study, informational support emerges when participants describe the interpersonal sources of knowledge they find so valuable. Emotional support occurs in the context of comforting, encouraging, and accepting the participant, and allowing her to express her own emotions. Tangible support includes relying on those with more resources, such as parents, to provide time, care, and material items for the participant and the baby. Appraisal support occurs when others help the participant to interpret her situation, and learn how to best cope with it.

But seeking and receiving social support can actually create uncertainty. Of particular importance to these findings, questions may arise about stigma and dependence on others (Brashers, Neidig, & Goldsmith, 2004). The two types of support that emerge most clearly in the data are informational and tangible support. The information provided by home-health visitors,

relatives, and friends with previous experience enable the participant to feel prepared for the birth of the child and beyond. These supportive conversations are an acceptable part of their interpersonal relationships. Although it is fine to accept emotional, informational, and appraisal support from others, relying too heavily on tangible support is constructed negatively. Participants are quick to condemn those who hand off their babies to the care of others, and "taking responsibility" for the baby is heralded as a great virtue. Yet a good mother is one who can provide the material things that her child needs and wants; therefore, completing school and obtaining a job are a necessary part of good parenting. The problem is that caring for a baby, attending school, and working all at the same time may not be realistic. Material provision for the baby may require relying on the tangible support of others. In the future, therefore, they may find themselves torn between providing care and providing material things for their child.

Role of baby daddy. Participants were also prompted to think about the post-pregnancy role of baby daddy. Only Jade indicates that she is not on speaking terms with her baby daddy. Everyone else is in a romantic relationship with the father, with the exception of Molly, although she remains in close contact with him. Heidi, Rachel, and Alisha feel certain that their baby daddies are not going to leave them, and will be there to help rear the child. Heidi mused about life 10 years from now:

> B: Like, think about what's your life gonna be like 10 years from now, maybe.
>
> H: I see me probably um…well, see he's already workin' on gettin' a place and all that, so…probably be livin' with him. Probably in Renfro county. And probably just raisin' the baby. Probably be just a stay at home kinda mom…He's the one that works and all that. So…it'll probably be like 'at. I'll just be at home, takin' care of the baby and the house, then he come home and all that…so. And he's a real trustworthy kinda guy, and

> it's hard to find a guy that you can trust, ya know? But like he don't talk to no girls, he don't do anything like 'at, so…I really trust him, and that's hard to find. That's one thing I love about him. Real trustworthy. Honest.

Her response indicates that she has great trust in her boyfriend, who will remain steadfastly dedicated to her and the baby. She also envisions still being a stay-at-home mom to a baby, failing to take into account the inevitable changes that 10 years time will bring. The baby, for instance, will be a 10-year old. The idea of being a "stay-at-home mom" while the father supports the family hints at a certain level of affluence; in reality, the county to which she refers (pseudonym used) is predicted to remain economically at-risk into the 2015 fiscal year (ARC.gov) with one of the highest poverty rates in the state. Currently, her boyfriend does not have a car that works well enough to visit her in the next county. It is likely that she will either have to work or rely on government assistance.

Alisha and Rachel also feel certain that their baby daddies are not going anywhere. When asked if she thought her baby daddy would still be "in the picture" 5 years from now, Alisha unequivocally responds, "Yeah, he will." Even so, she expresses concern about what kind of father he will be and how much tangible support he will provide: "He don't want a job. He say a 9-to-5 is not his thing. He like to be in the streets a lot. He…he just, he's just a gangster…" When asked about her plans for the future, Rachel's response indicates that they haven't thought about the future in very concrete terms. Her boyfriend has just lost his job, so it is unclear how they are currently supporting themselves: "I think we was planning on getting a house sometime. Like later on, like a house, trailer, something like that. You know, not an apartment for the rest of our lives." Like Heidi, when she talks about "the rest of our lives," she hints at a lifelong relationship with her boyfriend.

For other participants, the future of their romantic relationships is less certain. Their responses indicate that the most they can do is hope for a future where the baby daddy is involved and supportive. According to Amanda, "And I kind of want that with Jacob, he's been there the whole time, but then it's only AFTER when we're gonna find out if he's really gonna handle the responsibility." She later says that for the sake of their son, she hopes he is still "around" in the future:

> Cause like I told him, "I'm not forcing you if you don't want to be around, just let me know so that way I'm not wasting my time." But hopefully he stays. Cause I mean, I would want Brayden to have that in his life. Especially cause I didn't really get that until my stepdad came around. So it's like, I would really hope Jacob would stick around so Brayden could have a dad around him and with him and be there for him. So I would hope we were together still.

Aria's baby daddy, who is currently incarcerated, wants for them to get married as soon as she turns 18. However, she feels that they should wait and that having a child together does not necessitate rushing to the altar:

> Cause like I said, we're still young. And just because we have a child don't mean we have to be married and all of that. I mean, I would love for it, but at this time, I don't wanna push into something so fast and it not be what it's supposed to happen, so…I'm just, just pretty much just playing it now, day by day, just keeping it like that.

Her sense of fatalism about her pregnancy and the future emerges again as she talks about her relationship. Like many other participants, what happens in the future is constructed as "meant to be," an attitude that helps them make sense of romantic relationships they cannot control. Maria, for instance, says that she only "hopes" that she and the father are still together in 5 years. Like

Amanda, Aria, and Maria, Isabelle doesn't express a great deal of efficacy about maintaining her relationship with her baby daddy. When talking about the future of relationships in the context of unplanned pregnancy, she says, "you never know what'll happen." But for her and her boyfriend of three years, she has reason to hope: "I would honestly say that our relationship is…hasn't changed, if not, it's gotten better. Like we're not really, it's not falling off or anything." Given that their relationship has not gotten worse, she has reason to hope that he might be part of their future.

Molly goes so far as to point out the naivety of young women who believe in a romantic future with their baby daddies:

> M: And I, you know…people say, "Oh when you get pregnant, things get better!" Well things get harder. And I don't, I'm not trying to be mean, but these little girls that think, "Oh they're gonna stay. They're gonna work, I'm gonna live at home and take care of my kid, and they're gonna go work all day." And that usually don't happen. I mean-
>
> B: That's what people think happens?
>
> M: That's what a little...it's, and I know it's what a lot of girls think. Because I have a, I have a little friend, I have 2 little friends that are having babies, and they think that they're gonna stay at home, and take care of the baby and he's gonna go work. Well, the father don't have a job, the mother don't have a job…And a lot of girls think, "Oh they're gonna stay with me," and when the father faces reality, they're like, "Um, I gotta go!"

Her use of the term "little" to describe her friends and other young women she knows seems to indicate that she perceives in them an immature outlook on life. If Molly were to hear Heidi's description of her own future, Molly would probably categorize her as one of the unrealistic "little girls" who believe in this idealized household of mother-father-baby. Molly, in a sense, is

correct. It is not likely that these romantic relationships will last; in fact, they will probably end before the child even starts preschool (Edin & Kafalas, 2011).

However, there is no mention of a desire for marriage. Some, like Aria, even speak of being too young for a commitment like marriage. This is consistent with previous research, which found marriage is not seen as an essential part of parenting among pregnant teenagers; in fact, they are constructed as two separate tracks in life (Spear, 2001). In addition, African American women do not see a necessary connection between marriage and childbirth, and pregnant African American teenagers are less likely to marry than their White counterparts (Burton, 1990; Collins, 1990). But in the current study, there are no discernable differences between African American and White participants' attitudes toward marriage.

Uncertainty about the role of the baby daddy is what allows the young women to maintain hope about the future of their relationships. With the exception of Amanda, their ideas about the future of these relationships do not appear to be based on any actual conversations they are having with the baby daddies; instead, participants can only speculate about the young men's future involvement and rely on his current behavioral cues to predict what may happen between them. Perhaps avoiding direct questioning of the baby daddy about his post-pregnancy intentions is a way to avoid relational turbulence and maintain optimism. Uncertainty, after all, can function as an opportunity to preserve hope or optimism (Hogan & Brashers, 2009). And perhaps not knowing exactly what will happen – by engaging in information avoidance or seeking information that helps to maintain uncertainty – participants do not have to face the future prospect of being alone.

Professional Aspirations. The final aspect of the future that is explored in the current study is school and career aspirations. These details usually emerged when participants were

asked about where they see themselves in 5 or 10 years and were prompted to expand on ideas about schooling and jobs when those topics arose. All of the participants except for Heidi, who says she is "not a school person, I cannot STAND goin' to school," see themselves earning a college degree. Molly has already graduated high school, and Aria, Rachel and Isabelle are within weeks of graduating at the study's completion. They view school as a noble and important accomplishment and do not feel that having a baby will disrupt their plans to complete school. Jade explains how limiting life is without a degree: "Because if you don't have, if you don't go to school, then you can't do anything." As Rachel says of her family,

> Cause I've had so many speeches, they're like, 'You're ruining your life, you had sports, you coulda went to college for sports, and you got college,' and I'm like, 'I could still go to college…' Ain't that big of a deal, I'm still going to high school.

Some participants, like Molly, as described below, have a very detailed plan for how they will achieve their ultimate career goals; others, like Christina, are less certain about how they will make those goals happen: "Well, I plan to go to a 4-year college, actually. I'm not sure how that's gonna work out yet, but those are my plans." This is not surprising as Molly is older (18) than Christina (15), and may have begun thinking about her professional plans in more concrete terms than some of the younger participants.

When discussing careers, a pattern of wanting to work in the medical field emerges. Maria, Molly, Rachel, and Alisha all want to become registered nurses (RNs). Amanda wants to become a midwife and Aria wants to become a physical and/or massage therapist. When describing her future, Maria says, "I hope to be a RN. And hopefully I would have graduated from um, college…and have my degree as being an RN." Molly does not let the amount of schooling and work experience her dream job demands deter her:

> I wanna start out as an RN, then I wanna eventually work my way up to nucular medicine. But after, but I'm gonna start workin' just work my way up. For now. Cause the years for nucular medicine, you're lookin' at about 8 years. I figure I can go get my RN degree, registered nurse, and then work my way up from there. Cause if I go that way, I'll only have to go for like, 6 years I think it is…so.

As stated previously, Molly is among the older participants, and may have dedicated more thought and planning to future than younger participants. Rachel explains that becoming a licensed practical nurse (LPN) is an idea she got from volunteering with her mom:

> I wanna be an LPN. My mom's a CNA [certified nursing assistant]. Like, I've had a LOT of experience. Like I had to do um, gosh what do you call it—volunteer work? To like look good on a scholarship I was trying to get. It was 80 hours I was supposed to get. And so I went to work with my mom a lot.

After getting her LPN license, she describes the trajectory of the remainder of her career:

> Then I'll go ahead and get my RN, cause I wanted to do that first, like for a long time—well, my mom kinda wanted me to do that. But I mean it pays a lot and you don't have to do much. So like, as I'm getting older, I probably want to be an RN, not wanna move around as much and work with people. Just you know, kinda sit down and be chill.

The description of not doing much, not moving around, and sitting down and being "chill" as an RN indicates that Rachel sees this as an easy, relaxed job compared to the physical work of CNAs and LPNs. But nursing is quite physical, so much so that the physical demands of nursing may contribute to the shortage of registered nurses (Trinkoff, Lipscomb, Geiger-Brown, Storr, & Brady, 2003). Rachel's description shows a somewhat warped perception of the profession to which she aspires. But this does not indicate that she is experiencing uncertainty about it—

uncertainty is the self-perception of one's own state of knowledge, not how much knowledge a person actually has (Brashers, 2001).

This begs the questions of what is so appealing about nursing as a career choice. Aspirations to enter this line of work may be a function of participants' recent increased exposure to the world of healthcare. When participants go to the OB/GYN, they may interact with nurses who have features with which they can identify—namely, being young, female, and local to the area. Previous research (McCabe, Nowak, & Mullen, 2005) indicates that working RNs report both intrinsic and extrinsic aspects of nursing that appealed to them when choosing a career. Intrinsic advantages include doing interesting and challenging work, and the opportunities to help others and work with people. Extrinsic advantages include employment security and the flexibility to work and have a family. It is possible that older family members, like Rachel's mother, have impressed upon these young women that nursing is a secure job with the flexibility to both work and parent.

Regardless of what kind of career they have chosen, this is not, at the time of pregnancy, a topic that seems to produce a great deal of stress or uncertainty for the participants. They seem to feel confident that "it's all gonna be okay" (Molly), and school and career plans will not be fundamentally altered by having a baby. For some, this may turn out to be true; for others, however, their lives may more closely mimic what previous statistics predict for them. For those still in high school, they are far more likely to drop out than their non-pregnant peers (Mollborn & Morningstar, 2009). For many adolescent mothers, when they encounter the demanding reality of parenting, they are unable to complete their education. They face higher rates of under- and unemployment, and must depend on parents and other family members, as well as public assistance, for support (Mollborn & Morningstar, 2009; Witte, 1997). Participants may maintain

optimism about their professional futures by avoiding information or stories about the professional failures of other adolescent mothers, or by envisioning themselves as being different from those young women. They may also struggle to think abstractly about future plans; therefore, when it comes to careers, there is nothing concrete about which they would feel uncertain.

Overall, uncertainty about the future is multifaceted. Birth, for instance, is an imminent event, one which causes great uncertainty and even fear among the participants. Some, like Amanda and Alisha, express more confidence about birth than the rest. However, birth is always full of factors that the participants can neither predict nor control. The uncertainty about birth is especially acute given their lack of efficacy to have the kind of birth they desire—specifically, a vaginal delivery. Motherhood, however, in all of its complexity, is constructed as somewhat of an automatic bond. Because of the natural and automatic nature of motherhood, the young women have little doubt about their ability to be good mothers. Ideas about responsible parenting, too, show that they believe themselves to have sorted out "good" versus "bad" parenting behaviors. They plan to provide all of the hands-on care for their children and do not worry about the logistics of doing so. They seem to hold on to a blissful uncertainty about the future role of the baby daddy, knowing that he cannot be controlled yet hoping that he plans to stay involved. Similarly, particularly for younger participants, ideas about school and careers are not very concrete. They do not dwell on possible interferences, or on the development of contingency plans if education in addition to parenting proves to be too much for them. In the absence of imminent reality, there is little about which to be uncertain.

CHAPTER 4: DISCUSSION

Phenomenology has been used in this study to describe the lived experience of uncertainty in adolescent pregnancy. The first research question asks: How do pregnant adolescents experience uncertainty during their pregnancies? Essentially, uncertainty is experienced as a lack or loss of control over life events. The second research question asks: How do pregnant adolescents ascribe meaning to uncertainty during their pregnancies? They ascribe meaning to uncertainty by attempting to regain control, thereby reducing uncertainty, and enduring uncertainty by accepting that time will move them through the aspects they cannot control. Pregnancy has brought these young women face-to-face with a variety of personal, health, and relationship situations that challenge their self-efficacy or their belief in their own ability to influence events that affect their lives (Bandura, 1994). Self-efficacy, then, is fundamentally about how much control they think they have over their lives as pregnant adolescents. Control over health events, people's reactions, the spread of the news, the sex of the baby, the birth scenario, the baby daddy, and other aspects of the pregnancy are thrown into question at various points along the pregnancy trajectory.

Time, of course, does not stop on this very finite countdown to birth. As she is thrust forward toward different hurdles—disclosure, health issues, birth, etc.—it is time that she ultimately cannot control. Time is both a cause of and a solution to uncertainty. For example, she may want to delay revealing her pregnancy to others and may not know how best to disclose; but, time will eventually reveal the pregnancy for her anyway. She may not have the desired amount of time to satisfactorily resolve her interpersonal conflicts, but time will determine how much those conflicts actually matter once the baby arrives. Trying to slow down long enough to gain control during adolescent pregnancy is like trying to stand still on a moving sidewalk.

Uncertainty and Control

Eight themes have been identified that describe how uncertainty is experienced and how meaning is assigned to uncertainty in adolescent pregnancy. Suspicion and denial surface early in the pregnancy and often characterize the experiences of participants and those with whom they have close relationships prior to pregnancy confirmation. With suspicion, there is uncertainty about what unusual physical symptoms mean. In addition, when suspecting pregnancy, the outcome of the pregnancy test cannot be controlled. Denial, on the other hand is about maintaining uncertainty about the truth of pregnancy. In this way, it is an attempt to delay, pause time, and keep control over life for as long as possible.

With disclosure and the ensuing reactions to disclosure, uncertainty comes from not knowing how the disclosure will be received or what the outcomes of disclosure will be. Strategic disclosure is an attempt to reduce uncertainty—to control how others will react, and to control the flow of information by determining who can be trusted with that information. Reactions to the disclosure of pregnancy also cause uncertainty. Participants struggle to make sense of unexpected reactions and tend to find comfort in positive reactions, both expected and unexpected. Self-oriented reactions, on the other hand, increase the perceived sphere of influence the pregnancy has. As more people point out their own perceived involvement with the pregnancy, more variables are introduced as she struggles for meaning.

Of course, not everyone who knew about the pregnancy found out through the participants' direct disclosures. Other people finding out about the pregnancy exemplifies a loss of control. Each participant eventually lost control over her pregnancy information and almost immediately gave up hope that she could ever completely regain it. However, participants told themselves that with time, everyone will know about the pregnancy anyway. In this way, they

surrender to time and relinquish control as they move toward birth and beyond. As Molly states when word of her pregnancy began to spread, "guess it's time to tell."

When information is revealed, there are natural changes that occur in these adolescents' relationships. Often, relational changes mean that those involved need to talk about and negotiate how, if at all, the relationship will continue. Relational renegotiation occurs through instances of guilt, conflict, and the forging/severing of ties. These instances are referred to as renegotiations because of the turbulence surrounding them. The pregnancy is a transition, even for those who have been pregnant before. The transition produces relational turbulence, after which relationships are fundamentally different than they were prior to the transition. Because these close relationships are something different than they were prior to the turbulence, they become a source of uncertainty for the participants. When confronted with feelings of guilt and a sense of letting down other people, participants realize that they cannot control others' feelings about or expectations for them. The most they can do is accept this lack of control and all of the uncertainty it brings, apologize, and continue moving forward in the pregnancy.

When conflict arises, it is often over disagreement about pregnancy-related decisions, which raises questions and causes uncertainty in the participants' minds. Some conflicts are described as ongoing and produce a kind of chronic uncertainty that results from the lack of resolution. For instance, Isabelle is still not on speaking terms with her sister after she betrayed her trust. Isabelle cannot control her sister, but with the pressure of time, participants do not go to excessive lengths to repair relationships with siblings, grandparents, and others. Time does not slow down so that conflicts can be satisfactorily resolved. In addition, forging bonds and severing ties is often an active attempt by the participant to control influences in her and her child's life. Choices about who is "in" and who is "out" mitigate uncertainty. For instance,

spending time with other pregnant adolescents and mothers helps participants gain useful informational, emotional, and appraisal support.

As the reality of pregnancy solidifies, others' support becomes even more important. Moments where the viability of the pregnancy are confirmed, through kicking and ultrasounds, show how overwhelmingly uncertain the physical aspects of pregnancy are. These windows into the uterus become extremely important moments where, for a time, uncertainty is relieved. Finding out the sex of the baby is an important encounter with control—the participant cannot control the sex, but she can reduce uncertainty by finding out that information. With the changing pregnant body, which sometimes does not change as expected, a great deal of uncertainty results. Participants express no self-efficacy when it comes to controlling unpleasant symptoms—through exercise, medication, or diet—so they endure them with the hope that they will fade with time. They do, however, engage in certain behavioral changes that help them feel a sense of control over their pregnancies. They describe a new version of themselves: one that stays home, does not do drugs, and avoids physical altercations or fights. Their own behavior is one aspect of their lives they feel they can control. By reducing their engagement in questionable behaviors, there are fewer possible negative outcomes for their pregnancy health and uncertainty is managed. These instances of finding out information, making choices, and being swept along with change are fundamentally about control: gaining control, losing control, and accepting what cannot be controlled in adolescent pregnancy.

There is a marked reliance on interpersonal sources when it comes to seeking information about pregnancy. Participants choose to rely on people whom they trust. They choose them and listen to them because those people reduce their uncertainty. Though they may not be able to control what kind of information those interpersonal sources provide, by listening to people of

their choosing, they reduce the chance of hearing and learning something unsettling—something that would increase uncertainty and threaten their sense of control over their pregnancies. Perhaps this is why the Internet is largely ignored in this study as an information source. Participants seem to be passive information seekers; sifting through the plethora of information online requires both time and the self-efficacy to actively evaluate that information. Social media still stand as a platform for creating and attempting to control personal information. Perhaps participants feel that offering information about themselves to their social media audience helps to construct their self-images, and reduce uncertainty about how people see them.

In a world of passive information seeking, these adolescents often encounter confusing and frightening healthcare situations. Many lack experience with OB/GYNs. Unfamiliar instruments and unexplained actions by practitioners serve to increase participants' uncertainty. In a world where practitioners take people's knowledge for granted and pregnant teens avoid actively seeking information, uncertainty rises to higher and higher levels. Sometimes, among the white participants, these encounters become contentious. They attempt to regain control by complaining and finding new practitioners. This pattern does not emerge among African-American participants, who seem to give much less thought to medical encounters in general.

While these medical encounters continue and time marches toward the impending birth event, an externalized locus of control emerges. The mode and outcome of the birth are in the hands of fate and the doctor; participants seem to have low efficacy toward controlling the outcome. Time is moving each of them toward this birthing event, which is constructed as something that will happen to them rather than something they will do. Thinking about life after the birth seems almost too abstract to warrant uncertainty. When discussing motherhood and responsible parenting, participants seem quite certain about what it takes to be a mother—which

should be natural and automatic anyway—and how to parent responsibly. Though some participants are uncertain about their future relationship with the baby daddy and they know he cannot be controlled, they can maintain hope. Time will tell, according to Amanda: "It's only AFTER when we're gonna find out if he's really gonna handle the responsibility." Professional aspirations are more detailed among some participants than others, but overall, there is little indication that having a baby has disrupted these plans. These, like ideas about parenting, are part of the abstract future. They are part of a time that is beyond the moving track of pregnancy. Given the nature of adolescent cognitive development, they are too abstract to cause a great deal of worry. There is no profound struggle to create meaning or spend time recognizing and reducing uncertainty about non-imminent events.

The Certainty of Childbearing

Among the most salient of the findings, participants express very little uncertainty about their ability to rear a child. When employed, educated, partnered women in their 20s and 30s become pregnant with their first child, they generally have a great deal of uncertainty about life beyond birth. Pregnancy and the decision to have a child, therefore, are constructed as a great risk. Mothers-to-be express concerns about breastfeeding, isolation at home during early postpartum weeks, and the labels that others may apply to them, including "success," "failure," and "risk taker," (Svensson, Barclay, & Cooke, 2006). There are also concerns about postpartum physical issues, especially those related to sexuality (Pastore, Owens, & Raymond, 2007). It is possible that participants did have these types of physical concerns, but were hesitant to express them. But when asked about their future in general, they expressed very few uncertainties; in fact, only Molly mentioned some financial concerns.

There are two possible factors that may be useful when trying to understand the lack of uncertainty about motherhood and parenting. The first is adolescent cognitive development. Life beyond the birth is too abstract for them to fully conceptualize and will not likely be "real" to them until that time has arrived. They do not sense any gaps in their parenting and motherhood knowledge because they are not yet directly immersed in those processes. But, there may also be a larger cultural explanation, one that is driven by the idea that adolescent childbearing is just not a "big deal."

Anthropologist Margaret Mead (1942) compared American parents and children to those of other cultures in places like Europe and the South Pacific. Although her observations took place many decades ago, her assertions about American culture have implications for our understanding of uncertainty today. In American culture, which lacks the extended family or clan-like households seen in older societies, children are relegated to what she terms the slender family structure of mother, father, and children. Mead describes the "desperate uncertainty" (p. 88) that results from the isolation of these families within a fractured society, an uncertainty that a mother feels when determining what exactly her expectations for her child are. The mother therefore resorts to comparison with the other families around her. Furthermore, Mead describes the "old static cultures" in which the standards of behavior are predetermined and set for many generations; but, in American society, these standards are in constant flux. As children age, American parents expect that they will move away from them, perhaps going to a new geographic location, living on their own, and finding their own occupation instead of simply taking over their father's trade. Therefore, there is little "folk wisdom" available to guide parents in preparing children for the future because the content of their futures is uncertain. Mead asserts

that the best American parents can do is rear the children so that they are equipped to venture out on their own.

For employed, educated, partnered adults deciding to bear children, pregnancy is constructed as a great risk (Svensson, Barclay, & Cooke, 2006). These parents-to-be experience great uncertainty associated with the prospect of parenting. Those from the middle and upper classes see before their children a vast future full of possibility, leaving room for great success as well as great failure. As they usher their children up the ladder of achievement, they will have to set them up to be competitive with their peers. They may be competing for everything from a space in the best preschools to college baseball scholarships. Beyond their educational experiences lie any number of career possibilities—possibilities that typically have little to do with parents' own careers and therefore lack a distinct roadmap. They may become doctors or lawyers, go into sales, or pursue an MBA. Parenting, then, becomes about preparing children for unknown futures while nurturing the child's thirst for success. Uncertainty arises from the multitude of possibilities and pitfalls they can see for both their children and for themselves as parents. As Mead (p. 41) says, "Parenthood in America has become a very special thing," as we train our children for unnamed success that will hopefully surpass our own. Parenting, then, is a big deal.

But adolescents who become pregnant are more likely to come from impoverished backgrounds (Lau, Lin, & Flores, 2013), as the majority of these participants do. Perhaps, then, when those from a lower socioeconomic status look into the future, they do not perceive a vast array of different opportunities for themselves or their children. Possibilities for the children are limited compared to those who are wealthier, just like they were for the parents. They may perceive a few recognizable options for the child's life, but this does not produce enough

uncertainty to cause them to delay childbearing or reconsider becoming a parent altogether. These perceived limitations may simplify life considerably. In many ways, those who are underprivileged constitute a culture that is similar to the old static cultures to which Mead refers. Indeed, many participants in the current study reside in more clan-like households with three, four, and sometimes five generations of family members living under the same roof. If people expect that their offspring will remain in the same geographic vicinity, perhaps attending the local community college and living a life very similar to their own, parenting is strikingly less complicated—and less fraught with uncertainty—than it is for middle- and upper-class parents. This is one possible explanation for the phenomenon of adolescent pregnancy among the young and poor: it causes neither uncertainty nor the hesitation that can result from uncertainty because childbearing and parenting are not extraordinary events.

These findings are interesting given the previous negative relationships found between uncertainty in pregnancy and age, education, and income in pregnancy for women who are over the age of 18 (Handley, 2002). In the current study, it seems that age and education in particular are what actually mitigate uncertainty, at least uncertainty pertaining to parenting. This can be explained by several factors. As the age of the pregnant women increases, particularly if she is a first-time mother, she may be aware that the number of possible offspring in her future is lower than if she were in her teens or early twenties. Therefore, she may experience more stress and uncertainty about he quality of that one child's future. Previous research also found that pregnant women from rural areas experience more uncertainty than pregnant women from urban areas (Handley, 2002). That is not a difference that can be surmised from the current study, and should be explored further in adolescent populations. As those under age 18 were not included in

previous research, adolescence may produce a threshold effect wherein these relationships between uncertainty and demographic variables no longer exist.

Having a baby is not constructed as a great risk in the current study. Although only one participant had become pregnant intentionally, and many participants describe being shocked and frightened upon finding out that they were pregnant, each of them had quickly come around to being excited by the prospect of motherhood. The only one who expressed any lingering doubt about a lost future was Isabelle. For most of the participants, their mothers had also become pregnant as adolescents. In addition, they discuss family, friends, and peers who are pregnant or parenting as adolescents and describe adolescent pregnancy as a normal occurrence. We know the implications that limited cognitive development has for adolescent childbearing; but if adolescents do not perceive that pregnancy will ruin their lives, they will be even more ambivalent about taking steps to prevent it from happening.

Theoretical Implications

The purpose of examining uncertainty in a new context is that we can begin to view existing knowledge about uncertainty—and how it drives health behavior—in a different light. This section revisits uncertainty and its existing definitions as well as how the lived experience of uncertainty in adolescent pregnancy adds new dimension to the construct. From there, existing communication theories can be extended by considering the data's emergent themes.

Uncertainty, Time, and Health Behavior

Adolescent pregnancy. In the current study, uncertainty is an indication that a pregnant adolescent is struggling to assign meaning to events in her life. Uncertainty arises from insecurity about her state of knowledge (Brashers, 2001) and a lack of confidence in her own ability to predict future events or explain past events (Berger & Bradac, 1982; Berger &

Calabrese, 1975). It can intensify when the quantity of possible outcomes is higher, and when the probability of each outcome occurring is equal to the probability of that outcome not occurring (Babrow, 1992; Shannon & Weaver, 1949). In adolescent pregnancy, uncertainty is experienced as a lack of control over life events. Within the current study, we see participants encountering events that they attempt to control as well as events where it is easier for them to accept a lack of control than to try and regain it.

With many aspects of the adolescent pregnancy experience, participants find it less complicated to be carried through obstacles by time than to attempt to control everything. Concurrently, time creates uncertainty by reminding participants of what is outside of their control. The experience of lived time in health has been examined among adults experiencing chronic illness (Charmaz, 1991b). Being ill can have a major impact on people's perceptions of what they can and should do in the present. In the current study, this also holds true for pregnancy. But Charmaz also states that the past, present, and future build the self-concepts of chronically ill people. They make meaning from past turning points within the illness and have a sense of the developing self as they look to the future (1991b).

Charmaz's observations differ somewhat from those of the current study. With these adolescents, we often see them become passive about changing or controlling events in their lives, either because they cannot envision future events (without engaging in hypothetical thinking) or they lack the self-efficacy to control those events. In addition, they do not have a very deep past into which they can look for clues on how to make meaning in the present. This is evident in their struggle to answer interview questions about what "growing up" was like—they are still growing up or are not temporally far enough from that experience to be able to reflect on it. Many participants also struggled to identify turning points within their pregnancies, which

chronically ill adults are able to utilize when informing sense-making. Ceding control to the power of time allows them to accept and endure uncertainty. A pregnant adolescent may believe that her state of knowledge is insufficient in this moment; but, with time, that knowledge will either increase or it will no longer matter. Given the very specific 40-week trajectory of most healthy pregnancies, these findings may extend to the pregnancy experiences of adults as well.

When uncertainty largely determines where pregnant adolescents decide to dedicate the effort to control their lives, they are also making decisions about their health behavior and overall wellbeing. This can have a direct effect on health outcomes. For instance, in the presence of a healthcare provider, a pregnant adolescent may withhold any questions that she has about topics like physical symptoms or birthing options. She may not feel that it is worthwhile to try to overcome her hesitation about asking questions or may endure unpleasant physical symptoms because she perceives them to be temporary. Instead of working to find out how she can alleviate symptoms like nausea and swelling, she simply accepts the unpredictable nature of these difficulties and hopes that they will pass. In addition, she is likely to be a passive information seeker, believing that in time, answers will be available as need arises and as her own personal experience builds a useful knowledge base. Taken together, a pregnant adolescent may also endure uncertainty and discomfort because she does not know *what* questions to ask or how to obtain information that would help her.

Wellbeing is also affected by the health of her close relationships. We see in this study instances of conflicts remaining unresolved. Perhaps they believe that these will be resolved with time and the arrival of the baby will be a significant enough event to prompt a reunion and let bygones be bygones. Similarly, participants expressed different levels of certainty about the future of their relationships with the fathers of their children. Those who express hope that he

will remain an active part of their lives seem aware that time will ultimately determine the nature of their future relationship. Therefore, they do little to attempt to control his future actions. When decisions are made about disclosure and news of the pregnancy spreads, participants express that time will inevitably force the pregnancy out into the open.

In this way, participants are enduring a kind of "temporary-chronic" uncertainty that is unique to the pregnancy experience. It is chronic in the way that, according to uncertainty in illness theory, the sick person experiences uncertainty during acute phases or chronic-illness situations. He or she may come to appraise uncertainty as a natural part of life (Mishel, 1990). Similarly, in pregnancy, the young woman may develop a tolerance for ambiguity and unpredictability. This tolerance is tempered by the knowledge that pregnancy does eventually end and is not perceived to be something that must be managed beyond the birth. When someone has been managing illness for a long period of time—possibly many years—the quantity of possible health outcomes of behavioral decisions is fairly well known. There is probably a distinct list of possibilities from which that sick person can draw inferences about his or her health events. But with pregnancy, there is a roughly 40-week period of near constant change—both physical and social. Again, if we apply Mishel's uncertainty in illness theory, uncertainty may come to be appraised as a natural part of pregnancy. It is likely that this experience is universal to all pregnancies, especially first pregnancies, and not just among adolescents.

Other health experiences. The link between uncertainty and control raises questions about other health experiences that are affected by the element of time and where else "temporary-chronic" uncertainty may exist. For instance, when managing an illness like HIV or diabetes, the sick person must learn about and be able to predict the kinds of outcomes that result from different behaviors. In many ways, he or she must be able to look forward in time and take

action to account for what might happen. However, in the early stages of illness following initial diagnoses, the sick person may have to rely on time to see what works and what does not when it comes to promoting optimal health outcomes. Therefore, the ability to conceptualize and manage time may be a predictor of health outcomes for those dealing with a chronic condition in a way that it is not for those who are dealing with a time-bound condition.

Uncertainty may also affect health decisions due to skewed conceptualizations of time. An example of this is how people conceptualize fertility and fertility interventions. On the one hand, there has recently been a sharp increase in the proportion of women who delay childbearing beyond the age of 35 (Balasch & Gratacós, 2011). Despite popular beliefs about advances in new reproductive technologies, age remains the single most important determinant of male and female fertility. The false reassurances these technologies provide (Balasch & Gratacós, 2011) can lead couples to disregard time, resulting in increased risk surrounding conception and pregnancy. They may suddenly be thrown into a state of uncertainty due to their inability to control their own fertility. On the other hand, impatience can also affect how people approach conception. It appears that, with the support of the medical establishment, people who are having difficulty conceiving are very quick to embrace medical interventions and choose these options over alternative treatments (van Balen, Verdurmen, & Ketting, 1997). According to the latest annual report from the Society for Assisted Reproductive Technology (2012), more American women have used medical interventions to conceive than ever before. In the last 20 years, the scope of IVF has expanded to include a wider range of indications, including unexplained subfertility (Kamphuis, Bhattacharya, van der Veen, Mol, & Templeton, 2014). But it has been suggested that doctors need to more carefully evaluate which couples have a reasonable chance of natural conception and may not yet need medical intervention (Kamphuis,

Bhattacharya, van der Veen, Mol, & Templeton, 2014). This, in part, would require the promotion of realistic ideas about the time it may take (up to a year) for a healthy couple to conceive. Even in the current study, Rachel had been concerned and almost gone to her doctor because it took her 4 months to conceive. Uncertainty, therefore, has a huge impact on fertility-related health decisions.

Communication, Relationships, and Adolescent Pregnancy

Pregnancy, as a phenomenon that straddles the worlds of health and illness, needs to be built into the health communication research agenda more strongly. But pregnancy, especially among adolescents, is also bigger than health. Important social implications emerge clearly from the relational components that participants describe. The findings illustrate a variety of communication and relational issues that can be illuminated by existing theories from within the field. Theories about cognitive dissonance, communication privacy management, expectancy violations, and constructivism can all be applied to uncertainty experiences (as the findings demonstrate). In addition, the data within the current study have implications for extending existing communication theories and models.

Communication privacy management. Adolescent pregnancy is a very complicated but illuminating place to apply communication privacy management theory [CPM]. Pregnancy in general, elevates information ownership to a new and unexplored level. It is difficult to conceive of any piece of information that can be more intimately co-owned between two people. Boundary rules are set in an attempt to regulate the flow of information to third parties. When setting boundary rules surrounding private information, that is also an attempt to control the information co-owner's behavior. But with this extreme level of intimacy, questions of boundary ownership become even more important and have the potential to become controversial. Who

has the right to set the rules of confidentiality in this situation? Questions about who has more at stake in protecting those privacy boundaries can be very sensitive in the context of pregnancy. Applying CPM to pregnancy raises questions about evolving boundary permeability, the extent to which privacy boundaries are porous, and allows for information to flow to third parties (Petronio, 2002). Several participants point out the increasing physical manifestations that occur as pregnancy progresses; time, therefore, may naturally increase boundary permeability because it becomes less realistic to maintain a tight hold on the information. This could necessitate ongoing communication between the two information shareholders to engage in an almost constant renegotiation and coordination of evolving boundary rules. The relational implications of this would provide a rich opportunity for future research and theory expansion.

Eventually, because of time, the boundaries around the pregnancy news dissolve completely. In a typical pregnancy, it becomes difficult to hide the pregnant stomach, and a baby eventually emerges from the womb. As described by participants in the current study, these circumstances eventually reveal the pregnancy in spite of the most ironclad information boundaries. It appears that in adolescent pregnancy, this has a way of mitigating how disturbing the violations of boundary rules are to the relationship. These violations are ultimately, then, about not respecting the timeframe during which the information boundaries will dissolve on their own. When participants talk about not wanting to reveal the pregnancy "yet" and to just "keep it secret for a minute" (Maria), the implicit statement is that there exists a future time when boundary rules will shift to become more and more permeable and eventually disappear. The secret will no longer have to be kept. Because of the perceived inevitability of everyone knowing the secret in time, perhaps these violations—where, for example, a baby daddy prematurely tells his friends about the pregnancy—are more palatable to the participants. In addition, the

perpetrator may also more easily rationalize committing such violations. The situation is less turbulent than it might be if he had been expected to protect the secret forever.

At its core, CPM is about understanding confidentiality needs that can have important implications for how adolescents interact with healthcare providers and other adults who may be valuable sources of support for them. For pregnant adolescents, support can include anything from proper prenatal care to emotional support. The ability to control private information is also important for young people who may be struggling with identity and self-image issues. In the context of pregnancy, it may be useful for parents and doctors to emphasize effective ways to establish privacy rules with family members, baby daddies, and friends, as well as a realistic timeline for revealing the pregnancy to others. In addition, the impact of broken privacy boundaries on pregnant adolescents can vary widely in severity. Perhaps certain factors, such as a strong support system, being older, and having a healthy self-image, serve to mitigate and/or exacerbate the impact of these violations. Exploring these factors would extend CPM by pointing out the influence that different antecedents have on the meaning of boundary violations to the individuals involved.

Relational turbulence model. The relational turbulence model is a theory that was developed to examine transitions in close relationships (Solomon, Weber, & Steuber, 2009); however, up to this point, it has not really been applied beyond the romantic relationship context. Extending this model to other types of close relationships may provide an interesting new framework in which to examine the relational changes that adolescent pregnancy brings about. Although pregnant adolescents do experience relational turbulence with their romantic partners, family responses to the transition of pregnancy can also be characterized as instances of turbulence. The two main ingredients in the experience of relational turbulence are relational

uncertainty, or the degree of confidence people have in their understanding of their involvement in a relationship (Knobloch & Solomon, 1999; 2002), and interference from a partner (Berscheid, 1983; Knobloch & Solomon, 2004), which results when a partner's influence disrupts routines. Increased interdependence can produce interference as two people figuratively trip over one another in their struggle to coordinate action following a change in their circumstances.

In the adolescent family context, however, this study suggests that perhaps interdependence is replaced by dependence, which begs the question of who is interfering with whom. When pregnancy is incorporated, increased dependence or interdependence is sudden and intense: two people have created a new life together, amplifying interdependence, and a whole new set of needs for the adolescent and her child increase dependence. Paternal figures with angry or threatening reactions to participants' pregnancies may have been struggling with her interference with their control. This is a change in circumstances that highlights the limitations of his power: now that she herself is becoming a parent, who will make the decisions? How will dependency shift? Relational turbulence ensues, leading to increased conflict and uncertainty. These types of interferences extend to others within the family system as well. Further research should be done to extend this model into family and friendship contexts. Adolescent pregnancy is just one transition that sparks turbulence in a variety of different types of relationships.

Applied Implications

With phenomenology, we come to understand basic human lived experiences. It is often suggested that within healthcare, providers should base their practice on their understanding of the patients' lived reality (Goble, Austin, Larsen, Kreitzer, & Brintell, 2012; Van Den Berg, 1972). Because uncertainty is about control, what can healthcare practitioners, families, educators, and others do to mitigate the health questions and issues that accompany uncertainty?

It seems that the answer lies in identifying early on what can and cannot be controlled in the adolescent's pregnancy and life. This would require an honest discussion with the young woman about the different physical and social factors that play into her self-efficacy. It is a conversation that may take place between her and her parents, her doctor, case worker, counselor, or home-health educator. Because uncertainty is about a lack of control, it is important to recognize where increasing knowledge would enable a greater sense of efficacy for pregnant adolescents. Here, there is room for intervention. Information and education could lessen the uncertainties and discomforts associated with, for instance, disconcerting physical symptoms in pregnancy. Encouraging the young woman to write down questions for the doctor prior to a visit may give her the efficacy to ask the right questions and gain information to relieve both her uncertainty and her discomfort. It may also be useful to develop a pregnant adolescents' pamphlet containing common questions that arise during pregnancy. Having this sort of literature available in the doctor's office or waiting room may boost her self-efficacy when it comes to utilizing health providers for information.

Home Visitation Services

Findings within the current study have important implications for public health practices and services. Of particular importance is the focus on programs that include a one-on-one home visitation or telephone sessions with facilitators and nurse educators. These are considered innovative intervention approaches when it comes to reaching adolescents who are already pregnant and/or parenting (Asheer, Berger, Meckstroth, Kisker, & Keating, 2014). In addition, several participants in the current study spoke enthusiastically about their own involvement with these types of programs. Once the adolescent has become pregnant, the focus of interventions tends to be on preventing repeat pregnancies and improving parenting competency. Programs

that provide one-on-one support for pregnant and parenting adolescents can be an effective source of the informational, emotional, and appraisal support that participants in the current study deem acceptable. That support person, as a source of socio-emotional help for the mother and indirect support for the child, may buffer the family from the deleterious psychological and economic impacts of adolescent parenting (Brooks-Gunn & Furstenberg, 1986; Letourneau, Stewart, & Barnfather, 2004).

Among the more traditional community-based programs that do not necessarily implement home visitation, problems arise from the complicated circumstances involved in participating. Attending classes or other activities that take place outside of school or work can be difficult due to financial pressures and parenting demands (SmithBattle, 2000, 2006). When services are perceived to interfere with parenting or other responsibilities, the partners or families of teen mothers might discourage them from participating (SmithBattle, 2006). Home visitation approaches attempt to mitigate some of these issues by bringing services to the participants.

This model of intervention, however, also faces great hurtles when it comes to enrollment and retention. Launching and promoting such a program may have issues, as building links and promoting trust and buy-in with community partners can be difficult. Once participants are enrolled, sustaining contact and keeping them engaged in activities can also be difficult, despite the convenience of home or telephone appointments. Problems with scheduling and missed appointments may also persist as the logistics of reaching teen mothers are often complicated by unstable living conditions. Therefore, communication channels must be considered, and staff may be required to think creatively about reaching participants (for example, texting and phone calls during after-school hours or at beginning of the month when cell phone minutes have been replenished). Lack of transportation may also affect the extent to which they can be involved in

other aspects of programs, like group classes. Finally, teen mothers and their home visitors often develop a valuable bond through these programs. But some, such as California's AIM 4 Teen Moms program, end after 12 weeks. The loss of that home visitor is especially acute for teen mothers who are not involved with a case manager or any other type of support program (Asheer, Berger, Meckstroth, Kisker, & Keating, 2014).

Healthy Families of East Tennessee. Among the negative consequences of adolescent parenting is that, compared to older mothers, adolescent mothers tend to use more punitive discipline strategies (Coll, Vohr, Hoffman, & Oh, 1986), which can quickly lead to child abuse. One of the primary national home visitation programs aimed at combatting the problem of child abuse due to insufficient parenting skills is Healthy Families America (HFA). In addition to preventing child abuse, the program's goals include promoting positive parenting and encouraging child health and development. The model used by HFA provides an initial assessment and supportive information to all mothers giving birth within a defined geographic area. For those mothers who are facing the greatest challenges, they have the opportunity for more intensive continued home visits. HFA strives to retain families in the program until the child's fifth birthday (Daro, McCurdy, Falconnier, & Stojanovic, 2003).

An examination of this particular program looked at different participant, provider and program factors that contribute to enrollment and retention rates. Program sites with lower caseloads and greater success in matching their participants and providers tend to show stronger enrollment. (Daro, McCurdy, Falconnier, & Stojanovic, 2003). Some factors, however, are unique to each geographic region. Part of the area covered in the current study is supported by home visitation services from Healthy Families of East Tennessee (HFET). In this area, which is part of the South Central Appalachian region, enrollment poses more challenges than retention,

especially in rural areas. Among the urban populations of this region, having a home visitation worker is a culturally accepted norm. They are considered a valued part of the community and tend to be readily welcomed into the homes of new mothers. In rural areas, however, there are issues achieving buy-in and support from local referral services as well as overcoming the stigma perceived by eligible families. Programs like HFET rely on doctors, health departments, Department of Children's Services (DCS), and families to refer qualifying families to their services. This issue has been attributed to the perception that services like HFET are not needed in their region, and that the presence of such services raises uncomfortable questions about community-level problems (S. Rollins, personal communication, July 1, 2014).

For the eligible families, there is a hesitation to become involved in such a program because of stigma. For example, people do not want their neighbors to see them receiving any kind of social services. They fear that they will be seen as having difficulty, being in trouble, or needing help. HFET, however, is a completely voluntary program. To overcome this stigma, advocates try to reframe their service as something that families proactively adopt, and emphasize that it is an honor to be invited into people's homes to educate and assist them. In addition, HFET has targeted these counties by hosting "community baby showers" that provide a free car seat or other raffle items to all who decide to enroll in the program (S. Rollins, personal communication, July 1, 2014). It is useful to consider the role of uncertainty at the community level, as people who are fiercely protective of their privacy may worry about controlling their reputations. But with community-based events such as the aforementioned baby shower, this invites the possibility for public recognition and understanding of what a program like HFET is meant to do.

Successful retention rates in HFET are attributed to the persistence of home visitation workers, who accommodate the needs of clients by providing night and weekend visitation appointments when necessary. They are also quick to reschedule cancelled appointments so that they stay on track with the program's progression. Being diligent early in the client's involvement with the program helps establish the home visitation worker as part of the family "with boundaries" (S. Rollins, personal communication, July 1, 2014). Personal disclosures on the part of the home visitation worker, for instance, are rare but sometimes necessary to facilitate trust and motivate action. Cultural competency, too, helps home visitation workers develop deeper relationships and trust with these families, which encourages retention in the program. Aside from home visitation services, group classes and events are offered. These are successful because younger mothers enjoy showing off their babies and being with other young mothers they already know, while older mothers enjoy the social aspects of meeting new friends. One technique embraced during these classes is to do activities, such as nail painting or decorating a baby "onesie" while talking about knowledge or skills; therefore, it feels less like a class and is more engaging. In addition, special attention is given to titles and labels placed on such events. For instance, an event titled "Health and Safety Event" is in the process of being renamed because its current title will not likely draw a crowd (S. Rollins, personal communication, July 1, 2014).

It is worth noting that government funding for HFET has very recently been cut by nearly 80 percent. This has meant reducing their home visitation staff from 8 to 3 and cutting 150 of the 175 families from their services in Knox county alone (S. Rollins, personal communication, July 1, 2014). Funding has been reallocated evenly to each of the 8 sites under Tennessee's Healthy Start Program, despite the fact that HFET has been serving twice as many families and children

as any other site in Tennessee, including Nashville and Memphis (Masrejian & Slagle, 2013). The need for these types of services in the Appalachian region of Tennessee, therefore, is going to drastically increase in the absence of adequate funding and cuts to services.

Promoting Social Support

In the current study, those participants who were enrolled in one of these types of programs were in the very earliest stages of involvement. They spoke enthusiastically about the education and one-on-one support they received as participants in these programs and felt that being in the program would help them navigate whatever challenges lie ahead. But the data also reveal the participants' attitudes toward parenting and support. Again, they do not express uncertainty about their own abilities to parent; in other words, they have no concerns about their own levels of parenting knowledge. Many of these feelings will likely change after the baby's arrival, once the reality of day-to-day parenting solidifies.

Perhaps a useful component to incorporate into home visitation programs is the encouragement of seeking and accepting tangible forms of social support. This assumes, of course, that this type of hands-on help is available to pregnant and parenting adolescents, which will not be true in many cases. In addition, attitudes toward social support may shift during the transition from pregnancy to motherhood and the necessity of tangible support may become more palatable once the baby arrives. But if the prevailing attitude during pregnancy is one that shuns receiving too much tangible support from other people, this could contribute to gaps in childcare and other unfilled needs. For instance, young women may not plan ahead and make arrangements for daycare or initiate conversations about needing help with family members. Promoting realistic expectations about needs and attainable accomplishments after the baby

arrives should be an important priority for any intervention program that targets first-time mothers and/or pregnant and parenting adolescents.

The problem, again, is that pregnant adolescents tend to vastly overestimate the amount of support that will be available to them after giving birth. This lack of available support can have detrimental effects. For instance, without adequate social support, the pregnant teenager's ability to return to school and consider alternative career options may be limited (Quinlivan, Luehr, & Evans, 2004). Therefore, thinking about and making early attempts to set up any structural supports that *are* available become doubly important. One approach may include teaching young women how to request tangible support in an effective way. Encouraging them to reflect on their own social networks (El-Bassel et al., 2005) and to think beyond immediate family and friends to extend these networks would be a useful way to aid them in linking the present with the future. It would also be helpful to have them identify those who would encourage positive parenting behaviors. The current data show how finding and spending time with those who are in similar situations to the participants' helps to mitigate their uncertainty, which is especially helpful if these people demonstrate positive and effective parenting techniques. Teaching pregnant adolescents the communication skills to reach out and ask for help is also important. An effective setting for this, if possible, might be small-group meetings where they could practice these skills through narrative storytelling (Hsieh, 2004) and dialog with other young women like them. This has worked well in organ-transplant support group meetings (Hsieh, 2004) and might prove to be a useful setting for pregnant adolescents to practice communication skills. Incorporating lessons about these skills into a class that involves another activity might not only be more entertaining for adolescents, but also might more realistically mimic real-life situations where serious, help-seeking conversations take place.

Possible Selves

Encouraging pregnant adolescents to think about the future has utility beyond enabling them to gain needed resources. Although this is an uphill battle against the limits of cognitive development, there may be effective alternative methods to encourage a more future-oriented perspective. Abstraction is the ability to see what is likely to happen in the future as a consequence of present actions; this is where adolescents struggle. However, they are able to think hypothetically. One way to encourage future-oriented hypothetical thinking is the idea of possible selves, which are the future-oriented components of self-concept (Oyserman, Terry, Bybee, 2002). A hypothetical scenario is creatively developed through narrative processes, which pregnant adolescents can use to outline future self-concepts related to parenting, school, and career goals. This is distinct from abstraction, which is about foreseeing what is likely to happen; hypothetical thinking is about creating a possible future.

Early research about the future goals of poor adolescents suggests that when they sense blocked opportunities, they lower their expectations about what they can achieve in terms of education and career (MacLeod, 1987). But more recently, these assumptions have been challenged. Young pregnant and parenting women do express optimism about their ability to achieve high educational and occupational goals (Klaw & Rhodes, 1995; Hellenga, Aber, & Rhodes, 2002). Indeed, in the current study, most of the young women can create a picture of what they would like their future to be. They express little uncertainty about their ability to achieve their goals. But unfortunately, the odds of realizing their dreams of a college degree and professional career are against them (AGI, 1999; NCPTP, 2004). For these participants, the arrival of the baby may quickly obscure the path to achievement and the steps to attaining possible selves may become murky or no longer be a priority.

Therefore, home visitation interventions for pregnant and parenting adolescents will want to incorporate activities to encourage the delineation of concrete actions that result in positive possible selves. Activities such as keeping a diary would encourage reflection about what actions today will mean for consequences tomorrow. Writing down the narrative descriptions of whom participants want to become and detailed steps to becoming that person would foster creative hypothetical thinking. This can effectively modify future sexual risk (Clark, et al., 2005), thereby reducing the risk for repeat pregnancies. In addition, unlike simply talking about these topics, the diary provides something tangible to which participants could possibly refer at a later time.

Limitations

There were several methodological issues that arose when conducting this study. These are limitations that can serve as the impetus for future research on this and other topics dealing with uncertainty and adolescents. To begin, there were difficulties with recruitment of participants. Several factors may be at play, some that can be modified in the future and some that may be difficult to overcome with the given population. First, although a $30 Visa Gift card incentive was offered, this may have not been enough money to overcome hesitation about participating. In addition, some participants seemed confused about how and where they could use the gift card. It functions similarly to a debit card, but this population may have little experience using cards to pay for anything. In the future, cash may be a better option.

Trust issues may also be a factor, especially for those agencies and community contacts with whom the researcher was not able to meet in person. It was difficult to achieve buy-in and support from community contacts outside of the researcher's immediate vicinity. For potential participants from the target population, those who lived in a different state may have less familiarity with the researcher's institution, which could also have resulted in a lack of trust or

interest. There is already an abundance of trust barriers that must be overcome when trying to attract those who are young, poor, rural, and have lower education levels to participate in research. In the future, every effort to facilitate in-person meetings with community contacts must be made as well as whatever researcher-to-participant direct recruitment contact will be allowed by the institutional review board. If a potential participant has the opportunity to meet the researcher before agreeing to the do study, this may begin to build trust and mitigate any fear or hesitation she has to participating.

Another limitation was the inability to conduct thorough validation and verification with the participants. Within phenomenology, validation involves returning to the participant to ensure that the essence of the interview has been captured correctly. It was decided that validation could only occur if the participant was given the opportunity to do so before the birth of her child. The risk was that the birth would so fundamentally change her lived experience that she would be unable to retrospectively validate the lived experience of her pregnancy. Given the time it took to complete transcriptions, this was not possible—all participants would have been past term. Logistical issues related to the transience of these participants also made contacting them months after the interview very challenging. Changing phone numbers and living circumstances made them difficult to track down, even prior to the interview. In future research, a feasible alternative to verification and validation from this type of participant population needs to be determined.

When studying uncertainty, there are limitations to relying on transcripts as the sole source of data. In the current study, the researcher completed all of the transcription herself. Both the transcription process and explication of the data required listening to recordings of the interview, during which nonverbal expressions of uncertainty (vocalics) could be identified

through hesitation and intonation. Other nonverbal gestures that implicitly communicated uncertainty could also be detected and recalled from the interview. These, however, were nearly impossible to incorporate as evidence of emergent themes because they did not transfer directly into the transcripts. Only verbal content was transcribed. In the future, perhaps it is best to use video recording, in addition to audio, from which nonverbal communication can be coded. From here, it would also be useful to develop a taxonomy of nonverbal uncertainty. This would be especially useful for adolescents and other populations who communicate a great deal of meaning through nonverbal channels.

Finally, there are limitations to how computer-assisted qualitative data analysis software [CAQDAS] can be used in phenomenological research. For the current study, Nvivo 10 for Mac (beta version) was employed with open-ended expectations on the part of the researcher. Traditionally, CAQDAS is utilized to ensure greater rigor and validity for qualitative data analysis (Evers, 2011; Sin, 2007) and reduce the potential for researcher bias (Baugh, Hallcom, & Harris, 2010). Ideally, CAQDAS enables increased speed and coding for those who are familiar with the program (Roberts & Wilson, 2002; Welsh, 2002). This, in turn, allows for more time to be allocated to richer interpretation and deeper analysis (Morison & Moir, 1998), and for better handling of larger data sets (Atherton & Elsmore, 2007; Baugh, Hallcom, & Harris, 2010). But the most common reason for adopting CAQDAS is that it allows researchers to visibly track decision-making processes throughout the analysis (Evers, 2011). Memos can be used to create material evidence of analysis in the form of an audit trail, thereby facilitating greater transparency of method. This supports the credibility, confirmability, dependability, and transferability that make qualitative research trustworthy (Smyth, 2006).

The problem with using CAQDAS for phenomenology is that CAQDAS encourages endless coding of the data, which while not prohibited within phenomenology, is not necessary (Goble, Austin, Larsen, Kreitzer, & Brintell, 2012). Coding can be a useful way to familiarize the researcher with the data, but it can also lead to fracturing the meaning of the data into parts. This has the potential to erode the researcher's ability to see the phenomenon as a whole. CAQDAS can also tempt the researcher to code every little piece of the transcript, which is also unnecessary in phenomenology. If a piece of data does not further understanding of the phenomenon, coding it may only distract from understanding the essence of the lived experience. There comes a point where the researcher must move beyond the superficiality of the codes to recognize this essence. There may not be a specific code or piece of transcript that embodies the greater meaning (Goble, Austin, Larsen, Kreitzer, & Brintell, 2012). This is where the higher-order thinking of the human mind must take over and the utility of CAQDAS fades.

Therefore, in the current study, Nvivo 10 for Mac was useful up to a certain point. Immersion in the audio recordings of the interviews was accompanied by memoing for each participant, and a detailed audit trail was developed and tracked within Nvivo. It was also a useful organizing tool when returning to the transcripts to find concrete evidence of emergent themes. But querying, the analytic tool within Nvivo, was not used. Assigning attributes to each participant and running queries to detect patterns may have been an interesting exercise, but it was ultimately deemed unnecessary in the current study. Therefore, not only are there limits to using CAQDAS within phenomenological research, but there is a real danger of becoming lost in coding and losing sight of the essence of the greater phenomenon.

Future Research

Several suggestions for future research, already embedded within the findings and discussion, are reviewed here. First, the relational turbulence model may have utility outside of the romantic relationship context. Ideas about interdependence, interference, uncertainty, and conflict have new meaning when applied to adolescent family relationships. Mothers and daughters, brothers and sisters, fathers and daughters, and any number of possible family dyads and groups can experience turbulence in response to a transition. In addition, pregnancy as a transition within romantic relationships may also yield interesting results because of the sudden and intense interdependence it can produce in couples. Pregnancy also extends CPM by raising questions about boundary permeability. It would be useful to explore perceptions of boundary permeability in pregnancy and what it means when a secret eventually forces itself into the open.

Explorations of the role of time in health experiences are also warranted. In what other health contexts might the experience of "temporary-chronic" uncertainty arise, when a known end to the experience is imminent? What does this mean for how people conceptualize control? One possibility might be treatment cycles of chemotherapy in cancer, which often have a known end but an unknown outcome. In the wellness realm, another might be a training regimen for a specific race, which often happens along a planned timeline with what is hopefully a triumphant ending. The idea of a triumphant end to a health experience could be a unique perspective, and may also apply when studying pregnancy. Also related to time is the idea that those who conceptualize and manage time effectively might have more optimal health outcomes. This could be measured and tested empirically, for instance, among those with diabetes.

Rather than focusing on generalizability, an important criterion of qualitative research is transferability, which allows the findings to extend to other contexts or settings (Guba, 1981;

Shenton, 2004). To where, then, might the findings within this study be transferable? Adolescence will continue to be an important area in which to study uncertainty due to the increased risk-taking that occurs during this period of life (Arnett, 1999). Ideas about uncertainty and control can certainly be applied to different populations of pregnant adolescents, especially in different geographical regions. For instance, it would be interesting to compare these results to the uncertainty experiences of pregnant Latina adolescents. Future research should also focus on examining uncertainty in the people with whom pregnant adolescents have close relationships. The lives of family members, the baby's fathers, and friends who surround these young women are often heavily intertwined, and may have important implications for the health and wellbeing of mother and baby. If uncertainty continues to be about control, this may indicate underlying struggles for power that operate as yet another stressor in the lives of pregnant adolescents. This becomes especially important when power struggles damage ties with people who are able to offer different forms of social support. It would also be useful to explore the motivations and needs of young men who are about to become adolescent fathers and how uncertainty affects their sense of efficacy about parenting.

Although pregnant adolescents do tend to come from lower-income backgrounds, the poor are certainly not the only ones becoming pregnant. Uncertainty may be a completely different experience—with a completely different meaning—for middle- and upper- class adolescents who become pregnant. They may have a different perception not only of the resources available to them, but of how "big of a deal" pregnancy is. For those with more resources, there are a greater number of possibilities that lie ahead of them than lie ahead of the poor. Therefore, it would be useful to compare the lived experiences of pregnant adolescents from different socioeconomic backgrounds.

Furthermore, there are emergent themes in this study that may apply to adults who are experiencing pregnancy, especially if it is unplanned. The lived experience of suspicion and denial, uncertainty surrounding the physical aspects of pregnancy, and relational turbulence may still be characterized by a lack of control among adult populations. In addition, within the field of communication, disclosure and privacy management are no doubt rich and intricate processes within any pregnancy, not just adolescent pregnancy. It would also be interesting to extend the current study to those who are pregnant following a miscarriage or stillbirth. Understanding uncertainty, in many ways, reveals the needs people have when coping with challenging experiences. Exploring how those who are pregnant following a pregnancy loss experience uncertainty may provide information about how providers, family members, and other social systems can support these women.

The fields of both health communication and public health may also benefit from a deeper examination of culture in adolescent pregnancy. In the current study, for instance, there is an Appalachian component that is difficult to ignore; however, an adequate examination might require interviews with more participants. Because recruitment took place in the Central and South Central Appalachian region, the rural white participants displayed many of the cultural values that characterize the people populating this area. Anthropological research has categorized these overarching values to include concepts like egalitarianism, independence, individualism, family-centeredness, and a religious worldview (Hill & Fraser, 1995; Keefe, 2005). These are deeply ingrained values that shape Appalachians' worldviews and may have important implications for both the meaning of childbearing and their approach to healthcare. A common mistrust of outsiders and a sense of egalitarianism—meaning no one is "better" than anyone else—may explain the contentious healthcare encounters described by white participants in this

study. The more urban, African-American participants may be more tolerant of the power differential they sense between themselves and healthcare providers, while the white participants feel that authoritarian healthcare encounters challenge their sense of egalitarianism and independence. They may respond differently because they perceive they are being told what to do by people who think they are above them. Future research will want to explore this possibility as it can have detrimental effects on compliance in healthcare.

Another theme that was beginning to emerge was resilience. This is a ripe area for future exploration. Adolescent pregnancy has, in fact, been identified as an opportunity for developing resilience (Borkowski et al., 2007; Leadbeater & Way, 2001; Russell & Lee, 2006). When discussing resilience, it can be defined as "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543). Within adolescent pregnancy, adaptation to hardship is commonly marked by the achievement of normal developmental milestones (Breen & McLean, 2010). This might include things like graduating from high school, getting a driver's license, or obtaining a job. But what sets the current study apart is the way participants describe hardship: Both in their experiences and the experiences of others, it is constructed as a badge of honor. This is also tied into their condemnation of tangible support and the importance of "taking responsibility" for one's actions. Their descriptions indicate a great deal of meaning is derived from overcoming and persevering. This theme was on the verge of solidifying and with more data, may emerge more strongly for future research. In addition, though it was more strongly associated with white participants, African-American participants alluded to it as well. Hardship, including abuse, abandonment, and social marginalization, seemed to give meaning to all of the participants as well as strengthen their sense of identity. Becoming pregnant at an early age is not only an opportunity to overcome and

persevere, but also part of a system of cultural values that are passed on from generation to generation—without the opportunity for resilience, how else does one derive meaning?

In conclusion, this study demonstrates how uncertainty is experienced as a lack of control, and highlights the specific time-bound aspects of adolescent pregnancy that affect how uncertainty is handled. In addition, it brings adolescent pregnancy into the health communication conversation. It has uncovered important implications for adolescents' struggle to tie actions in the present to consequences in the future and made suggestions for overcoming these cognitive limitations. Some possible causes of adolescent pregnancy inequities between the poor and wealthier populations have also been suggested, with the idea that when the future is less complicated by possibility, having a child is not that big of a deal. Therefore, becoming pregnant at an early age is viewed as less problematic than it is for wealthier adolescents. This mentality may be what is contributing to the continued cycles of disadvantage and has important implications for future research.

Uncertainty in health makes us enact—and withhold—behaviors that can significantly impact health outcomes. Uncertainty can also lead to emotional distress. At the same time, uncertainty can provide a safe haven and allow for hope to be sustained. What sets pregnancy apart as a health context is the inherent intimacy that creates and often continues to characterize it, the very specific time-bound trajectory along which it can be traced, and the complicated social aspects that accompany it. Therefore, there is much more to be explored within the pregnancy experience. In addition, the Institute of Medicine (IOM, 2001) calls for a lifespan approach to research and practice in the field of health behavior and highlights the importance of time as a health dimension. There are certainly unique aspects of the adolescent period of life that set it apart in the uncertainty experience. For instance, we need to continue exploring other

health situations, including illness, to see how far into the future uncertainty exists for adolescents. In other words, at what point does the future become too abstract to warrant feelings of uncertainty? How does this affect primary, secondary, and tertiary preventative health behaviors?

Overall, this study is an example of how we need to continue expanding our theories of uncertainty to look more broadly at health and wellness rather than just illness. Mental health, nutrition, exercise, and hygiene, for instance, are all health and wellness contexts where uncertainty could be contributing to health outcomes. In addition, it is important to recognize when the absence of uncertainty may be playing a role in perpetuating health disparities. Beyond that, we need to keep exploring the temporal aspects of health, and how conceptions of time in health affect health behavior. Adolescent pregnancy is an incredibly nuanced and personalized experience and has revealed new depths within the construct of uncertainty. This population will continue to be a fruitful and important one in which to conduct pregnancy-related health communication research, as lifelong health and wellbeing begin in the womb.

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Appendices

Appendix A: Interview Questionnaire

PRELIMINARY QUESTIONS

Today's date:
Place:
Time:
Interviewer's Name:

Subject's Name/alias:
Age:
Birth Place:
Currently resides in: _____
Special comment:
Number of brothers: _____
Number of sisters:_____

Parents:
mother's age: _____
father's age: _____
Marital status: married _____ divorced _____ you were how old: _____

Highest educational level:
Occupation:
Marital status and history:
Children:
Age: _____ Gender: _____
Age: _____ Gender: _____
Religion:

How religious:	strong	moderate	inactive	indifferent
How often worships:	daily	weekly	monthly	several times a year
	yearly	once every several years		never

PRIMARY INTERVIEW QUESTIONS

1. *Tell me about your family, and what it was like growing up.*
2. *Tell me about the first time you suspected you might be pregnant.*
    a. *Have there been other times that you thought you might be pregnant? Tell me about those times.*
3. *Describe for me the day you found out you were pregnant.*
    a. *What's the first thing you thought?*
    b. *What is the first thing you did? Then what?*
4. *When you first found out you are pregnant, how did you decide whom you were going to tell and not tell about your pregnancy?*
    a. *Whom did you first tell, and why that person?*
    b. *Was there anyone that you did NOT want to find out? Who, and why?*
5. *Think about a person who had a positive reaction to your pregnancy. Tell me about when you told that person you were pregnant.*
6. *Think about a person who had a negative reaction to your pregnancy. Tell me about when you told that person you were pregnant.*
7. *Tell me about the father of the child.*
    a. *What kind of relationship do you guys have?*
    b. *How did you decided to tell him/not tell him about the pregnancy?*
8. *Give me an example of something that has made you feel good about your pregnancy.*
    a. *In other words, what is the best part about being pregnant? What has made you happiest?*
9. *Give me an example of something that has made you feel badly about your pregnancy.*
    a. *In other words, what is the worst part about being pregnant? What has made you the most unhappy?*
10. *Describe for me a point in your pregnancy when you started to feel differently about being pregnant- like reaching a turning point. For example, maybe you went from being sad to happy, excited to scared, scared to calm, etc. What was that like?*
11. *Do you know other girls around your age who have gotten pregnant? If so, tell me about one of them that sticks out to you (no names).*

a. *Can you give me an example of another pregnant teen that you consider to be a "success story" (no names)? This may be someone who, to you, is a good example of how to do things as a pregnant teen/teen mom.*
b. *Can you give me an example of another pregnant teen that you DON'T consider to be a "success story"? In other words, someone whose life you would NOT want for yourself (no names)? This may be someone who, to you, is a POOR example of how to do things as a pregnant teen/teen mom.*

12. *Suppose there is a girl your age named Brittany that you know. Let's say she comes up to you one day and says, "I just found out that I'm pregnant! I don't know what to do, and I'm having a hard time. I haven't told anyone else yet." What advice would you give her to help her deal with her situation?*
13. *Suppose there is another girl your age named Jennifer that you know. She approaches you and says, "I'm pregnant! I don't know anything about pregnancy or babies, where should I look for information?" What kinds of things would you tell her?*
14. *Give me an example of a way that your life has changed since finding out you are pregnant.*
15. *Give me an example of a way that your life has stayed the same since finding out you are pregnant.*
16. *How do you feel about the future?*
    a. *Paint me a picture of your life in 5 years.*
17. *Paint me a picture of your life in 10 years.*

Appendix B: Informed Consent Form

Informed Consent Statement

Thank you for participating in this study. The purpose of this study is to understand the experience of being a pregnant adolescent female. As a young woman who is in this position, your input is very valuable to me.

This research is intended to be very broad and open-ended. I will first ask you some specific biographical questions about you and your family. Then we will move into the broader, non-directive questions in which you are free to respond with as little or as much information as you would like.

Participant Involvement

Your participation is voluntary. You may change your mind later or stop participating even if you've already given consent without penalty. If you have any questions regarding the consent form, please do not hesitate to ask the researcher. The information collected in this interview will be entirely anonymous. Your name, the names of any friends or family members, your school, your work, and your hometown will all be changed to protect your identity.

Risk/Benefits

Given the confidential nature of your responses, the information you will be exposed to while participating, and the topic of the questions you will be asked, participation in this study carries minimal plausible risk.

Although this study will not be an immediate benefit to you, the research collected from this study will help those of us in the field of health communication to understand the nature of adolescent pregnancy, and how we can better meet the needs of young women in your situation.

Contact Information

If you have any questions, you may ask them now or later; if you have questions after completing the interview you may contact the researcher at (615) 478-0555; eddalton@utk.edu; 98 Communications Building, 1345 Circle Park Drive, Knoxville, TN 37996-0332.

Consent

With my signature, I consent that I am 18 years of age or older, and am voluntarily agreeing to participate.

Name: _____ **Signature:** _____

Appendix C: Parental Consent Form

Adolescent Pregnancy Study

Your child is invited to participate in a research project being conducted by Betsy Dalton, a Doctoral Candidate in the Department of Communication Studies at The University of Tennessee, Knoxville. The purpose of this study is to understand the experience of being a pregnant adolescent female. Approximately 25-30 young women will be participating in this study.

This research is intended to be very broad and open-ended. I will first ask you some specific biographical questions about you and your family. Then we will move into the broader, non-directive questions in which you are free to respond with as little or as much information as you would like.

Procedures

As a participant, your child will be interviewed about her pregnancy-related experiences. There will only be 1 interview, and the interview should last approximately 1 hour. The interview may take place in the child's home or in a mutually convenient location. The researcher may contact her via phone or email after the interview for follow-up questions and clarifications.

Risk/Benefits

Given the confidential nature of your child's responses, the information she will be exposed to while participating, and the topic of the questions she will be asked, participation in this study carries minimal plausible risk.

Although this study will not be an immediate benefit to your child, the research collected from this study will help those of us in the field of health communication to understand the nature of adolescent pregnancy, and how we can better meet the needs of young women. In the case of emotional discomfort resulting from participation in this study, appropriate referral for counseling assistance will be provided.

Payments to Participants

All participants will be reimbursed in the form of a $25.00 gift card. The payment will be provided at the beginning of the interview prior to asking the first question. The participant may keep the gift card even if she chooses to withdraw from the study.

Right to Refuse or Withdraw

Participation in this study is completely voluntary, and refusal to participate or withdraw from the study at any time will involve no penalty. Following your consent, participation of your child in this study remains voluntary. Your child will also be asked to provide assent to participate and

may refuse even if you consent. Your child can also refuse to answer any questions and may withdraw from the study at any time without penalty.

Confidentiality

Any identifying information collected will be kept in a secure location and only the researcher and a professional transcriber (also bound by confidentiality) will have access to the data. Participants will not be individually identified in any publication or presentation of the research results. Your signed consent form and your child's assent form will be kept separate from the data, and nobody will be able to link their responses to them.

Audio and Video Taping

The researcher requests permission to audio record your child during the interview. The digital audio recording will be used solely for transcription purposes, and all audio files will be deleted when the study is complete.

Contact Information

If you have any questions, you may ask them now or later; if you have questions after completing the interview you may contact the researcher (Betsy Dalton) at (615) 478-0555; eddalton@utk.edu; 98 Communications Building, 1345 Circle Park Drive, Knoxville, TN 37996-0332. The faculty advisor for this project is Dr. Michelle Violanti (violanti@utk.edu), (865) 974-7072. This project has been reviewed and approved by The University of Tennessee, Knoxville Institutional Review Board. If you have any questions about your child's rights as a research participant, you may call the IRB at (865) 974-7697.

Consent

I have read the information provided above and all of my questions have been answered. I voluntarily agree to the participation of my child in this study. I will receive a copy of this consent form for my information.

_____

Parent / Legal Guardian Name **Parent / Legal Guardian Signature**

Name of Child _____

VITA

Elizabeth (Betsy) Dalton was born in New Orleans, Louisana to Mary Jo and William Dortch, Jr. She has a younger sister, Claire. Betsy grew up in Nashville, Tennessee where she attended St. Henry School and St. Cecilia Academy. From there, she attended the University of the South (Sewanee) where she received her Bachelor of Arts in English with a psychology minor. While at Sewanee, she studied abroad at Oxford University where she met her now-husband, Robert Dalton. After college, Betsy moved to Wyoming to work on a ranch. Subsequent moves led her back to Nashville and then to Atlanta, where she worked in advertising. She returned to Tennessee and earned her Master's degree in Mass Communication at Middle Tennessee State University, during which her research focused on hate speech. But her first love was health communication, which led her to pursue a doctorate in Communication and Information at the University of Tennessee, Knoxville. During her time at UTK, she has taught Communication Theory, Communication Research Methods, Interpersonal Communication, and Public Speaking. She has also kept up an active research agenda on topics including adolescent motherhood, nursing communication, and health literacy. She married Rob during her second semester of the program, and they had their first son, Will, in June 2013.