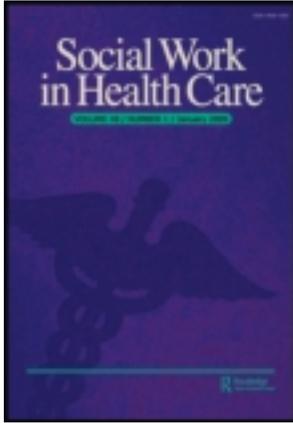


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## Social Work in Health Care

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wshc20>

### A Psychosocial Profile of Adolescent Pregnancy Termination Patients

Gretchen E. Ely PhD<sup>a</sup> & Catherine N. Dulmus PhD<sup>b</sup>

<sup>a</sup> University of Kentucky, College of Social Work, 639 Patterson Office Tower, Lexington, KY, 40506-0027, USA

<sup>b</sup> Buffalo Center for Social Research, SUNY Buffalo School of Social Work, 221 Parker Hall, Buffalo, NY, 14214-8004, USA

Version of record first published: 08 Oct 2008

To cite this article: Gretchen E. Ely PhD & Catherine N. Dulmus PhD (2008): A Psychosocial Profile of Adolescent Pregnancy Termination Patients, *Social Work in Health Care*, 46:3, 69-83

To link to this article: [http://dx.doi.org/10.1300/J010v46n03\\_04](http://dx.doi.org/10.1300/J010v46n03_04)

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# A Psychosocial Profile of Adolescent Pregnancy Termination Patients

Gretchen E. Ely, PhD  
Catherine N. Dulmus, PhD

**ABSTRACT.** This study examined the psychosocial problems of a sample of adolescent women who presented for a pregnancy termination appointment at a family planning clinic located in the southeastern region of the United States. The sample consisted of 120 adolescent women, age 14-21 who were administered the *Multidimensional Adolescent Assessment Scale (MAAS)* while waiting for their pregnancy termination procedure. The MAAS is a self-administered instrument with multiple subscales that measure a variety of psychosocial problems. Results indicated that most subjects did not score in the clinical range on the various subscales, thus indicating respondents as overall being stable and healthy. This paper reviews the specific findings from the study and discusses implications for practice and future research directions on this understudied population. doi:10.1300/J010v46n03\_04 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2008 by The Haworth Press. All rights reserved.]

**KEYWORDS.** Adolescent, pregnancy termination, abortion, psychosocial problems, MAAS

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Gretchen E. Ely is Assistant Professor, University of Kentucky, College of Social Work, 639 Patterson Office Tower, Lexington, KY 40506-0027 (E-mail: gretchen.ely@uky.edu).

Catherine N. Dulmus is Associate Dean for Research and Director, Buffalo Center for Social Research, SUNY Buffalo School of Social Work, 221 Parker Hall, Buffalo, NY 14214-8004 (E-mail: cdulmus@buffalo.edu).

Social Work in Health Care, Vol. 46(3) 2008  
Available online at <http://swhc.haworthpress.com>  
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doi:10.1300/J010v46n03\_04

## INTRODUCTION

Each year more than 50% of all pregnancies in America are unintended and about one-half of these unplanned pregnancies end in abortion (Dudley, 1997; Henshaw, 1998). Young women between the ages of 11 to 19 account for approximately 21% of pregnancy termination patients, as about 35% of all teenagers faced with a pregnancy choose to have an abortion (Dudley, 1997; Henshaw & Feivelson, 2000). Controversy exists related to the psychological risks associated with abortion (Cozzarelli et al., 2000). Yet few studies examine abortion patients and even fewer studies examine adolescent abortion patients.

Recently, Benson (2004) did address the topic from a practitioner standpoint, and recommended the following best practice approaches for social workers serving adolescents who choose abortion: social workers should help adolescents follow mandatory state parental reporting or consent laws, social workers should foster adolescents confiding in parents when possible in states not requiring parental consent, social workers should respect different views and changing opinions of adolescents who are considering abortion and their support systems, social workers should prepare adolescents for coping with their abortion decision, and social workers should encourage positive appraisal after the abortion.

While studies of pregnant adolescents have become more common, studies of adolescents who choose termination occur less frequently (Corcoran, 1999). Out of the studies related to adolescent abortion patients, many examine the effects of restrictive reproductive health policies and parental involvement laws on adolescent abortion rates and parental relationships (Ambuel, 1995; Crosby & English, 1991; Griffin-Carlson & Schwanenflugel, 1998; Joyce & Kaestner, 2001; Ohsfeldt & Gohman, 1994).

A few other studies exist in different areas related to adolescents and abortion. Researchers in one study investigated the competence of adolescents to make decisions regarding abortion, concluding that they are capable of such decision making (Ambuel & Rappaport, 1992) and other studies suggest that adolescents seeking abortions appear to make an informed choice (Adler, Ozer, & Tschann, 2003). Other study results indicate that adolescent termination patients and adolescents who were never-pregnant have similar levels of psychological problems, indicating that history of abortion did not cause psychological problems in that sample (Felton, Parsons, & Hassell, 1998). In another study that compared adolescents to adults after a first trimester elective abortion, findings indicate that adolescent levels of psychological adjustment did not

differ from adult levels of adjustment two years post abortion (Quinton, Major, & Richards, 2001). The majority of adolescents in another study described feeling sad and/or guilty about their abortions (Demb, 1991).

The above mentioned studies focus primarily on the decision-making capacities of adolescents who choose abortion. However, the characteristics of adolescent pregnancy termination patients prior to their abortion, procedure have never been measured to date. Researchers in one study did interview twelve African American adolescents as they awaited their elective abortion and then again at 6 and 8 months post-abortion and results indicate that the adolescents in their sample chose not to continue their pregnancies because they wanted to pursue an education and economic independence (Andrews & Boyle, 2003).

Research indicates that teen pregnancy does not occur in a vacuum, but rather occurs with many other factors such as poor school performance and problems with family (Foster, 2001). Yet, researchers have conducted only a few studies to find out what types of psychological, social, or health problems occur in adolescents who choose to end their pregnancies. Researchers have examined health-related behaviors in a sample of adolescents with a history of abortion compared to never-pregnant adolescents and discovered that both groups were similar (Felton, Parson, & Hassell, 1998). An analysis of substance abuse in another study indicates a significant association between substance abuse and abortion in adolescents (Reardon & Ney, 2000). Results from another study indicate that adolescents who choose abortion may have significant emotional and cognitive grief responses and may be at risk for depressive symptoms (Wheeler & Austin, 2001). This study also reports that adolescents who have experienced early pregnancy loss via abortion scored higher on grief responses and depressive symptoms when compared to never pregnant and pregnant adolescents (Wheeler & Austin, 2001). Although some information about adolescent abortion patients exists, it is clear that the knowledge of psychological factors in adolescent pregnancy termination patients remains limited.

In the absence of information related to adolescents, valuable information may be obtained from the results from studies conducted with adult abortion patients. In one study, women who aborted a first pregnancy were five times more likely to report substance abuse compared to those who miscarried their pregnancy naturally (Reardon & Ney, 2000). Another study examined the effects of abortion on the mental health of adult subjects and found that depression decreased and self-esteem increased from preabortion to postabortion (Major et al., 2000).

The above studies mainly focus on one or a few psychosocial factors and their relationship to abortion. No researchers to date have conducted a psychosocial problem study using a measurement tool that assesses many psychosocial problems at one time. It is also important to note that no study has examined psychosocial problems prior to a pregnancy termination in either adolescent or adult women.

The reproductive health literature indicates that abortions are underreported by adolescents in general surveys and in order to gain any knowledge about the characteristics of pregnancy termination patients, researchers must gather information directly from such patients (Smith, Adler, & Tschann, 1999). The purpose of this study was to evaluate adolescent pregnancy termination patients between 14 and 21 years of age in a reproductive health clinic to assess their levels of psychosocial problems.

## ***METHODOLOGY***

### ***Subjects***

Subjects consisted of a sample of 120 adolescent women who presented for a pregnancy termination appointment at a family planning clinic located in the southeastern region of the United States. All women who met inclusion criteria during the duration of the study who presented for a pregnancy termination appointment at this clinic were informed about the study and asked to voluntarily participate.

### ***Inclusion and Exclusion Criteria***

Inclusion criteria: participants were never married women, ages 14-21 years who were pregnancy termination patients with appropriate levels of psychological stability. Exclusion criteria: Patients who appeared to be emotionally distressed, as determined after intake by an LCSW level health counselor, were not asked to participate in the study. Patients who reported that they had become pregnant as a result of a sexual assault or rape were not asked to participate in the study. These limitations were in place to protect vulnerable patients from further distress.

Patients were approached to participate in the study until 120 completed study packets had been obtained. Clinic records indicate that 193 patients in the age range of 14-21 were seen at the clinic during the duration of the

study. Twenty-one packets were submitted incomplete and were excluded from the study. Thirty-two of the women in the age range reported that they were married and were excluded from the study. Counselors documented nine refusals to participate in the study. Counselors report that no one was excluded from being approached to participate in the study because of sexual assault or emotional instability. This left 11 potential participants unaccounted for, indicating that these patients were either not approached to participate in the study, refused to participate in the study, or were screened out due to sexual assault or emotional distress.

### **Consent**

Participant consents were obtained for women age 18 and above. Participant assents and parental/guardian consents were obtained for women age 14 through 17. Parental/guardian consent was obtained from the parent or guardian who accompanied the underage participant to the clinic for her appointment, as required by state law. Approval for research with human subjects was obtained from the Human Subjects Review Board at the University of Tennessee, Knoxville.

### **Instrumentation**

The *Multidimensional Adolescent Assessment Scale* (MAAS), developed by Walter Hudson, PhD (Nugent, Sieppert, & Hudson, 2001), was selected for use in this study because it measures many of the problem behaviors that are of concern to clinicians working with adolescents. The subscales on the MAAS have been shown to produce scores with reliabilities, as estimated by coefficient alpha, in excess of .70; the majority produce scales with reliability over .85 and many have produced scores with reliability estimates that exceed .90 (Nugent, Sieppert, & Hudson, 2001). In a recent study of the psychometric properties of the scores produced by the MAAS, all subscales except depression had alpha coefficients of .84 and above, while depression was still high at .74 (Mathiesen, Cash, & Hudson, 2002). Although evidence related to the validity of the MAAS is not complete, there is evidence of content validity, factorial validity and divergent validity (Nugent, Sieppert, & Hudson, 2001; Mathiesen, Cash, & Hudson, 2002).

The MAAS allows for the measurement of 16 psychosocial problem factors using one measurement tool. The subscales include: depression, self-esteem, problems with mother, problems with father, personal stress, problems with friends, problems with school, aggression,

family relationship problems, suicidal thoughts, feelings of guilt, confused thinking, disturbing thoughts, memory loss, alcohol use, and drug abuse.

### *Scoring*

Each subscale produces clinical scores ranging from 0 to 100 with lower scores indicative of less severe problems and higher scores indicative of more severe problems (Nugent, Sieppert, & Hudson, 2001). The guideline for the principal clinical cut score for each subscale is 30, except for the suicide, alcohol use, and drug abuse subscales, which have a cutscore of 15. The secondary clinical cutscore, which suggests guidelines for inferring a serious problem, is 70, except for suicide, guilt, alcohol use, and drug abuse, which do not have a secondary cut score, as any score on these subscales over 15 indicates a potentially serious problem (Nugent, Sieppert, & Hudson, 2001). Although all subscales do not contain the same number of questions, a formula, developed by Hudson, was used to make all subscale scores equal to 100%  $(D*100)/(B*6)$ , after appropriate items were reverse-scored (Nugent, Sieppert, & Hudson, 2001).

### *Statistical Analysis*

The small sample size was selected to accommodate the difficulty of recruiting subjects for participation and to allow the clinic to resume normal activity as quickly as possible. All eligible participants that came into the clinic were approached to participate in the study until 120 completed packets had been obtained.

The authors used SPSS to calculate the mean, the standard deviation, the percent of respondents who fell within the normal range on the subscales, and the percent of respondents who fell within the clinical problem range on the subscales. The purpose of this analysis was to construct a clinical psychosocial problem profile of the patients served by this clinic. This information was useful to the counseling staff at the clinic, as they wished to have an idea of what problems their patients experience that may warrant counseling and outside referrals.

### *Findings*

Table 1 represents the respondents' scores on the MAAS. As the table indicates, many of the respondents do not report scores that indicate a problem on the various subscales. These results are surprising considering that women who choose to terminate pregnancies may be perceived

TABLE 1. Psychosocial Problem Profile Scores on the MAAS

Psychosocial Problem	Mean	Standard Deviation	% of Scores Falling Within Normal Range	Range of Scores for Indication of Potential Clinical Problems	% of Respondents in the Potential for Clinical Problem Range	Cutscore for Indication of Serious Clinical Problems	% of Respondents in the Potential for Serious Clinical Problems Range	% of Missing Responses
Depression	28.63	17.78	59	30-69	38	70 and above	2	1.7
Self Esteem	24.21	11.63	68	30-69	31	70 and above	0	.8
Problems with Mom	17.04	15.85	83	30-69	16	70 and above	.08	5
Problems with Dad	23.54	21.35	69	30-69	25	70 and above	5	15
Stress	26.70	21.43	55	30-69	32	70 and above	5	7.5
Problems with Friends	12.67	12.01	91	30-69	9	70 and above	0	5.8
Problems with School	31.05	16.14	49	30-69	51	70 and above	0	20.8
Aggression	18.31	15.12	79	30-69	21	70 and above	0	16.7
Family	22.46	18.00	68	30-69	32	70 and above	.08	20
Suicide	2.48	6.92	94	15 and above	6	15 and above	6	20
Guilt	21.12	21.12	76	30-69	18	70 and above	6	12.5
Confused Thinking	21.36	21.88	69	30-69	26	70 and above	5	10
Disturbing Thoughts	10.64	16.57	89	30-69	10	70 and above	.01	15.8
Memory Loss	17.10	17.87	84	30-69	14	70 and above	1	16.7
Alcohol	9.53	9.25	79	15 and above	21	15 and above	21	32.5
Drug use	6.19	12.70	88	15 and above	12	15 and above	12	44.2

as having something “wrong” with them. This psychosocial profile indicates that most of the respondents report being stable and healthy overall.

However, it is important to note that 30% or more of the respondents report clinical levels of depression, problems with self-esteem, stress, and problems with family. Over one-half of respondents reported concerning levels of problems with school. Less than 20% of respondents reported problems with mother, problems with friendships, suicide risk, feelings of guilt, confused thinking, disturbed thoughts, memory loss, and drug abuse.

### *LIMITATIONS OF STUDY*

One major limitation of the study is that those who refused to participate in the study, or who were unaccounted for due to unknown reasons, may represent those who would have scored lower on levels of psychological stability. Thus, future studies with larger samples are needed to determine if similar levels of these problems would be reported again. Another important limitation of this study is that it is a convenience sample and is therefore not generalizable to the overall population of adolescent abortion patients.

Because this data was collected at only one point in time, it is possible that proximal issues such as mood or elevated emotional levels influenced the self-report process. The setting of this data collection makes this more probable. This demonstrates that measuring baseline mood in future studies with termination patients might change or influence research results. This approach has been suggested by other researchers (Wekerle et al., 2001).

A reliability analysis on the scores from this study has not been conducted at this time. Thus, the question of the reliability of data collected from adolescents just prior to a pregnancy termination procedure has not yet been examined. The measure used in this study was not designed specifically for use with pregnancy termination patients, who may have unique measurement needs that have yet to be addressed. There could have been problems with measurement interpretations as adolescents at age 14 may have different abilities for reading and interpreting the questions on the MAAS than individuals at age 21.

Making a decision to terminate a pregnancy creates a unique state of emotional being that much of the population does not experience during adolescence. Such an emotional state may have had yet unidentified effects on the way participants interpreted and answered the questions for

this study. There is no way of knowing whether the psychosocial reported by the patients can be attributed to the unwanted pregnancy or not.

## DISCUSSION

The results of this study indicate that the majority of patients in this sample do not report psychosocial problems at levels of clinical concern. These findings are consistent with postabortion results from a longitudinal study with adult samples indicating that most women do not experience psychological problems after an abortion (Major et al., 2000). These findings are also interesting in light of qualitative results from another study indicating that African American adolescents who chose to terminate a pregnancy felt confident about their decision, because they had specific goals for empowering themselves in the future and did not want an unwanted pregnancy to interfere with those goals (Andrews & Boyle, 2003).

The significant emotional and social problems found in one adult post-abortion study (Wheeler & Austin, 2001) were not found to be present in this pre-abortion adolescent study. It will be important in future studies to try and determine if this difference is a result of pre-abortion versus post-abortion problems or because there are differences in the levels of problems experienced by adolescents as compared to adults.

Although many of the patients in this study do not report high levels of psychosocial problems, it is clear that some do. The results of this study indicate that 38% of the sample reported levels of depression at or above the cutscore for problem indication. Although no other researchers have examined depression in adolescent prior to an abortion, the results of this study are in line with results from a similar study by Major and others (2000) indicating 26% of adult abortion patients had experienced an episode of clinical depression prior to the pregnancy and 20% had experienced an episode up to two years past their abortion. It is important to note that findings from that study further indicate that depression decreased pre- to post-abortion in their sample of adult women (Majors et al., 2000).

In the absence of studies related to depression in adolescent abortion patients, it is important to consider studies in other similar areas, especially in areas related to adolescent pregnancy as that literature base is more fully developed. In one study focused on depressive symptoms in pregnant and postpartum adolescents, 44% of the sample reported significant depressive symptoms in the third trimester (Joffe, Dugan,

Wilson, & Repke, 1996). Results from another study of at risk pregnant and parenting teens indicate that a majority of respondents reported symptoms of clinical depression (Sarri & Phillips, 2004). One doctor reports that it appears that depressed adolescents may engage in unprotected sex and thus become pregnant as a way to compensate for depressive feelings (Martin, 2003).

It is impossible to determine from this data set whether or not the reported levels of depression are a result of separate depression in general or if the reported levels of depression are directly related to the unwanted pregnancy and/or the decision to terminate. Even though further exploration of the roots of the reported depression is needed, the reported levels of depressive symptoms in this sample point to the need to assess adolescent abortion patients for depression in the pre-abortion counseling setting. When depressive symptoms are noted, referrals to outside resources should be provided. This is an opportunity for social workers in clinic settings to provide access to referrals that adolescents may not be aware of.

Thirty-one percent of adolescents in this study reported problems with self-esteem. Just as with the levels of depression, these reported problems with self-esteem are not surprising given the circumstances and the context of the administration of the instrument. We cannot determine here if these adolescents are reporting problems with self-esteem because they are ashamed of their pregnancy or of their decision to terminate or if it these young women had problems with their self-esteem before they became pregnant. Results from one study of adult abortion patients indicate that self-esteem has been found to increase from pre- to post-abortion in adult women (Majors et al., 2000). This is the extent of the availability of current information related to self-esteem and abortion patients.

The results of this study indicate that around 30% of patients report problems with their dad or family at clinical levels of concern. Although no other researchers have examined problems with dad or family in abortion patients, findings from one study did indicate that abortion patients did report interpersonal relationship problems when they also reported a history of abuse (Glander et al., 1998). Thus, it is possible that there could be some issues of family abuse in the patients who reported significant problems with family/dad. It is also possible that problems with family/dad are related to the fact that the adolescent is experiencing an unplanned pregnancy which causes tension in family relationships. This might be likely in light of findings from another study indicating that adolescents who chose to terminate a pregnancy reported that their families were very disappointed that they were pregnant because the families viewed the

pregnancy as a potential risk or compromise of the adolescent's future (Andrews & Boyle, 2003).

The results of this study indicate that a concerning number of patients report clinical problems with alcohol use (21%) while a smaller portion report clinical problems with drug abuse (12%). These results are consistent with results from another study indicating that self-reports of substance abuse were significantly associated with abortion in both women and adolescents (Reardon & Ney, 2000).

Since no other studies exist related to substance abuse in adolescent abortion patients, findings from adolescent pregnancy studies in related areas are again useful. One study from a related area indicates that adolescent respondents in drug treatment programs report more pregnancies than respondents from the general community (Tapert, Aarons, Sedlar, & Brown, 2001), while results from another study indicate that substance use disorder was associated with early pregnancy in a sample of adolescent girls with serious emotional disturbances (Yampolskaya, Brown, & Greenbaum, 2002). It should be noted that there is significant missing data in the areas of alcohol use and drug abuse in this study and given that many participants did not answer the questions in this area, the percentage of patients in this sample who have substance abuse problems may be even higher than these reports indicated.

About one-half of the respondents report problems with school. These results are interesting in light of findings from another study where dropping out of school was associated with early pregnancy in emotionally disturbed adolescent girls (Yampolskaya, Brown, & Greenbaum, 2002). It is possible that these girls are having problems in school because they are worried about dealing with their unwanted pregnancy and/or other relationship issues that have yet to be explored. This relationship needs to be explored in greater detail.

## **CONCLUSIONS**

### ***Implications for Practice***

As professional social workers who operate from a strengths-based perspective, it is imperative that we recognize the overall strengths of adolescents who choose to terminate their pregnancy, as the decision itself may reflect an emotionally healthy adolescent who has distinct goals for her life that she does not want to be interrupted by an unwanted pregnancy, such as is suggested by Andrews and Boyle (2003). In light of that,

it is optimal to build in supports to assist the adolescent with her decision to maintain her emotional health. Because levels of depression and low self-esteem were found in a number of these respondents, it is important for social workers working in family planning settings to screen patients for these problems. When indicated, social workers should also offer referrals to counseling for patients who are found to have problems in these areas. Social workers should be mindful that depression and low self-esteem could have been present in the adolescent prior to pregnancy, so as not to assume it is an outcome of pregnancy termination.

The information generated by an assessment instrument like the MAAS is very valuable for social workers and counselors in reproductive health settings. One medical doctor indicates that a depression screening can be useful as part of the health care of pregnant adolescents (Martin, 2001). This instrument was administered prior to the pre-abortion counseling setting and could have been very useful to the clinicians in the counseling process. A case could be made here that pre-abortion counselors should incorporate the MAAS and/or other rapid assessment instruments that foster assessment for a variety of psychosocial problems, thus taking advantage of an opportunity to help these adolescents with a variety of potential problems. While it is important to consider that client self-determination is of utmost importance in reproductive health settings, offering a more thorough assessment of psychosocial health in these settings may be a service that could prove to be very advantageous to the health of these adolescents.

### ***Research***

Empirical literature related to adolescent pregnancy termination patients is limited, especially in relation to the number of adolescent women who terminate their pregnancies each year. For example, when searching for literature related to adolescent pregnancy termination, only one peer reviewed journal article can be found in the social work literature base. Thus, social workers doing research in this area must turn to the medical and psychology literature for information on this subject, and even those sources have limited information available. The absence of social work research related to abortion in adolescents reflects a lack of commitment to generating knowledge about this topic and results in a disservice to our adolescent clients. This also reflects a lack of social workers' commitment to this pertinent issue of social justice, even though the National Association of Social Workers (2006) specifically state in their Policy Statements that the social work profession is committed to

adolescent access to family planning services, including abortion, based on the profession's commitment to client's rights to self-determination. It is possible that social workers are undertaking research on this topic and are publishing in interdisciplinary or medical journals. Based on the literature examined for this paper, researchers tend to be from medicine—in gynecology, psychiatry or nursing, and the social science research tends to come from psychology. However, many counselors in reproductive health settings may come from the social work background.

Misconceptions about the characteristics of pregnancy termination patients are common. More research related to the characteristics of pregnancy termination patients is needed. Longitudinal, controlled studies of the psychosocial problems present in adolescent pregnancy termination patients are essential to determine whether or not the levels of psychosocial problems that are reported will change post-abortion or remain constant over time. In this study, it was impossible to determine if problems such as depression and low self-esteem are related to the fact that the patient is terminating a pregnancy, or if those problems are present in the respondent over time. More research on adolescent pregnancy termination patients is vital if practitioners are to begin to understand the needs of this forgotten group of women. Efforts to reduce abortion rates in all populations must begin with generating knowledge about what problems are experienced by such patients. The more that is known about this forgotten group of women, the more social work as a profession can do to prevent unwanted pregnancy, and thus the need for abortion in adolescent women.

Date Received: 02/21/05

Accepted for Publication: 03/01/06

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doi:10.1300/J010v46n03\_04