To Be Rather Than Not To Be—That Is the Problem With the Questions We Ask Adolescents About Their Childbearing Intentions

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**Objective:** To demonstrate that rephrasing the questions used to assess childbearing intentions to quantify the strength of the intent to remain nonpregnant, rather than the strength of the intent to become pregnant, would make teenagers' responses more useful to health care providers, family planning counselors, and health policy makers.

**Methods:** Examples from the teen pregnancy prevention literature are used to support the recommendations for change.

**Results:** Teenagers rarely plan their pregnancies. However, because those who are having sexual intercourse must actively try not to become pregnant or they will likely conceive, teenagers often become pregnant because they lack a firm commitment not to do so. Thus, to accurately profile the antecedents of adolescent pregnancy, (1) the questions used to assess childbearing intentions must be rephrased so that teenagers who intend to remain nonpregnant can be distinguished from those who do not and (2) separate differential diagnoses must be developed for inconsistent contraceptive use within these 2 groups of teenagers who are at risk for unintended pregnancy.

**Conclusion:** Asking sexually active teenagers about the strength of their intent to remain nonpregnant will make the results of office interviews and national surveys more useful because the responses such questions elicit will enable health care providers and policy makers to target common, modifiable antecedents of inconsistent contraceptive use for interventions.

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DATA1,2 SHOWING that teenagers report most of their births as unintended (either mistimed or unwanted at any time) have drawn attention to the discrepancies between the childbearing intentions and the contraceptive behavior of sexually active teenagers in the United States. But this heightened awareness has not contributed significantly to the national effort to prevent adolescent pregnancy, because such statistics provide little insight into the cause of unintended pregnancies among teenagers or into their enigmatic sexual behavior.3 If this country is to reduce teenage pregnancy further, clinicians will need to ask questions about the strength and consistency of teenagers' intent to remain nonpregnant, rather than whether they intend to become pregnant.

This change in the manner in which questions about childbearing intentions are asked is essential because from a purely physiologic standpoint, the natural state of most sexually active teenagers is pregnant, ie, unless these young women actively strive to remain nonpregnant, they will probably conceive.4-6 Studies2,5,6 also show that the desire to remain nonpregnant must be strong to motivate the behaviors necessary to avoid conception. Because the motivation to remain nonpregnant typically fluctuates with changing feelings about the balance between the costs of contraceptive use and nonuse,2,4-8 even teenagers who do not intend to become pregnant may lower their contraceptive vigilance for brief periods. During these brief hiatuses, many become pregnant. Asking teenagers about this balance between the costs of contraceptive use and nonuse could produce information on ambivalent feelings about remaining nonpregnant and help clarify the cause of their seemingly irrational sexual behavior.

**PROBLEMS WITH CURRENT QUESTIONS**

The questions that clinicians typically ask teenagers about their intent or desire to become pregnant are theoretically and clinically problematic. From the theoretical
standpoint, questioning teenagers about their intent to become pregnant implies that teenagers make conscious, rational decisions to become pregnant. In reality, most teenagers become pregnant because they lack a firm commitment not to do so and, therefore, do not use contraceptives consistently. If the opportunity to have sexual intercourse arises and no contraceptives are available, a teenager who lacks a firm commitment to remain nonpregnant is likely to have unprotected sexual intercourse. This young woman puts herself at risk for pregnancy because she has no reason not to do so, not because she consciously intends to become pregnant.

Studies on the antecedents of cigarette smoking show a similar pattern. Although the dynamics are different because smoking can be a solo activity, whereas sexual activity requires 2 people, researchers have found that susceptibility, defined as the lack of a firm commitment not to smoke, is one of the best ways to identify teenagers at risk for tobacco use. Moreover, an increase in the perceived benefits of smoking may underlie susceptibility. The construct, susceptibility, is a better predictor of future experimentation with tobacco (and by extension of unprotected sexual activity), and differs importantly from measures of intentions because it does not imply that the teenager is consciously planning to smoke (or become pregnant). Rather, it suggests that the young person lacks a firm commitment not to smoke (become pregnant) and, therefore, might do so if presented with the opportunity.

In addition to these theoretical concerns, asking teenagers about their intent to become pregnant (rather than their intent to remain nonpregnant) can be counterproductive clinically. Sexually active people who only “do not intend to become pregnant” need not use birth control. Indeed, sexually active teenagers not using contraceptives who are ambivalent about preventing pregnancy often stop unwanted conversations about contraception by stating that they do not intend or plan to become pregnant “any time soon.” However, if a sexually active teenager not using contraceptives states that she intends to remain nonpregnant, the reasons for the discrepancy between her childbearing intentions and contraceptive behavior can be discussed, because a sexually active person who intends to remain nonpregnant must use birth control to do so.

ALTERNATIVE QUESTIONS

To assess the risk of conception, interviewers should ask questions that clearly separate teenagers who are not susceptible to pregnancy (those who intend to remain nonpregnant during adolescence) from their susceptible peers (those who are not firmly committed to remaining nonpregnant during adolescence). Such a question might be, “I know you said that you do not intend to become pregnant any time soon, but do you really intend to remain nonpregnant while you are a teenager?” Only those who respond with an unequivocal “yes” are not cognitively susceptible to pregnancy.

Teenagers not susceptible to conception because they clearly state that they intend to remain nonpregnant should be questioned about their use of contraceptives. If these questions reveal inconsistencies between intent and practice, the reasons should be systematically investigated by inquiring about factors that make it difficult to use contraceptives effectively. For example, teenagers are not apt to use condoms consistently if they find it awkward to do so or to use hormonal contraceptives if they believe that doing so will cause weight gain or acne. Within this context, studies showing that teenagers’ beliefs about the effects of oral contraceptives on physical appearance are the best predictors of their intentions and actual use of this method of contraception emphasize the importance of asking about such fears. Teenagers are also unlikely to use contraceptives when they do not perceive themselves to be at risk for conception. Some teenagers have experiences that make them doubt their ability to conceive, and others are emotionally incapable of thinking of themselves as sexually active. These young women are often genuinely surprised to be pregnant not only because they “only had sex once or twice” but also because they and the father of the child were “just friends” (not lovers) and, therefore, “weren’t really having sex.” Studies showing that most US teenagers still describe their first sexual encounter as something that “just happened” and explain their failure to use contraceptives by saying “I just didn’t get around to it” demonstrate how little progress has been made toward overcoming the guilt associated with violating the social taboos against single women planning for sexual activity. Thus, many teenagers who intend not to become pregnant put themselves at risk for conception because they are unwilling, unable, or afraid to make conscious decisions about their reproductive behavior. Finally, young women’s attitudes toward abortion may also influence their contraceptive behavior.

In contrast, teenagers susceptible to conception because they do not clearly state that they intend to remain nonpregnant should be queried about the cause of their ambivalence about remaining nonpregnant, not about their inconsistent or nonuse of contraceptives. Some teenagers are reluctant to actively try to remain nonpregnant because they think that a pregnancy might improve (or at least would not significantly worsen) their relationships with family members, peers, or sexual partners; help them cope with feelings of depression and loneliness; dispel their concerns about infertility; or signal their passage into adulthood. Because most of these young women ardently deny that they intend to become pregnant, the cause of their inconsistent use of contraceptives is apt to go undiagnosed (and, therefore, untreated) unless they are asked questions about how pregnancy would affect various aspects of their lives.

The answers to such questions should enable the clinician to identify modifiable antecedents of inconsistent contraceptive use that could then be targeted with motivational counseling at the individual level and programmatic interventions at the population level. For example, individual teenagers who are not intentionally avoiding pregnancy because they anticipate that becoming pregnant will enable them to achieve adult status in their community could be helped to develop future-oriented career goals that are incompatible with teen-aged parenthood. At the programmatic level, designing
The prevention of adolescent pregnancies is a complex problem. At the clinical level, health care providers must be able to distinguish between sexually active teenagers who are inconsistent contraceptive users but firmly committed to remaining nonpregnant and those who are not firmly committed to doing so. This strategy will enable clinicians to target specific risk factors that are modifiable during adolescence and that are prevalent in the population for intervention.

At the population level, surveys should supplement assessments of risk based on nonmodifiable, demographic characteristics with questions that assess the following: (1) the strength of the intent to remain nonpregnant, (2) the reasons that teenagers who report that they intend to remain nonpregnant do not use reliable contraceptive methods consistently, and (3) the personal and social functions pregnancy serves in the lives of teenagers who do not report that they intend to remain nonpregnant during adolescence. This type of information would help guide the allocation of adolescent pregnancy prevention resources.

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REFERENCES