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Social work students' attitudes toward teenage pregnancy prevention: the importance of religiosity and feminist ideology

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**SOCIAL WORK STUDENTS' ATTITUDES TOWARD
TEENAGE PREGNANCY PREVENTION:
THE IMPORTANCE OF RELIGIOSITY AND FEMINIST IDEOLOGY**

A Thesis
Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Master of Social Work

in

The School of Social Work

by

Pilar Thompson Borne
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ABSTRACT

Effective teenage pregnancy prevention is a topic of debate in current literature. Religiosity is frequently examined in the research, and studies typically assess associations between behavior patterns and level of religiosity. Feminist ideology is another theme found in the teenage pregnancy prevention literature that mainly examines how feminist perspectives contribute to effective prevention approaches. The current study examined the interrelationships among religiosity, feminist ideology and attitudes toward teenage pregnancy prevention. A self-report survey instrument was used to collect data from 69 MSW students, a sample surveyed for the first with the current study. A significant positive correlation was found between level of religiosity and a preference for abstinence-only sex education. Additionally, a significant positive correlation was found between feminist ideology and a preference for comprehensive sex education. Knowledge of condoms and oral contraceptives was high among participants overall. Results suggest that the religiosity and feminist ideology of MSW students influences attitudes towards sex education. However, knowledge of condoms and contraceptives does not appear to be influenced by religiosity and feminist ideology.

CHAPTER 1: INTRODUCTION

Teenage pregnancy is a problem with far-reaching effects. Teen pregnancy rate in the US are among the highest of other developed countries (World Health Organization [WHO], 2004). The incidence of teen births in the U.S. is 41.9 out of 1000 female adolescents, and among females aged 15-19, 750,000, or 7%, became pregnant in 2006 (Guttmacher, 2010). Most recent data show that the teen birth rate was at its lowest point in 2009 (Centers for Disease Control [CDC], 2011). These two reports show a flux in the teen birth rates that has been going on for some time. During the 1990s teen pregnancy rates showed a steady decline. The rates began to rise from 2000 to 2006, and then a decline again from 2007 to 2009 (CDC, 2011). U.S. teen birth rates are five times higher than the teen birth rates of other Western nations (Gilbert, Jandial, Field, Bigelow, & Danielsen, 2004). These data suggest a need for a teen pregnancy prevention approach that yields better behavioral outcomes. The social problems associated with teen pregnancy will be discussed below in further detail.

Teen pregnancy rates vary from state to state, and they appear to be influenced by a couple of different factors. In general, states with the highest number of teens tend to have the highest number of teen pregnancies (Guttmacher, 2010). This finding suggests that the problem is widespread, and as long as there are teenagers, there is a risk for teen pregnancy. The current study builds on the scholarly literature describing various approaches to preventing teen pregnancy. One factor that likely influences teen pregnancy rates are teen sexual behaviors. The relationship of religiosity and teen sexual behaviors will be discussed further in the literature review. Teen sexual behaviors could be targeted via prevention efforts that are effective and consistent.

Problem Statement

The purpose of the current study was to examine attitudes toward teen pregnancy prevention approaches, religiosity, and feminist ideology among Masters of Social Work Students. The current study is grounded in literature describing why teen pregnancy is a problem, who is affected by it, and why interventions are needed to prevent it. This chapter discusses the scope of the problem as discussed in current literature, the theoretical significance of teen pregnancy prevention, and the proposed study's contributions to the current research in the field of teen pregnancy.

Scope of the Problem

This section will examine the costs of teen pregnancy. Currently, 7% of teen girls become pregnant every year (Guttmacher, 2010). When a teen has a child that they cannot afford to take care of themselves, taxpayers must pick up the tab (The National Campaign to Prevent Teen and Unplanned Pregnancy [National Campaign], 2011a). This means that taxpayers are helping, in some part, to rear the children of up to 750,000 teens girls every year (Guttmacher, 2010).

The costs of teen pregnancy to teens and their children will be described in greater detail below. However, teens and their children are not the only ones who pay the price for inadequate teen pregnancy prevention. Taxpayers contribute to a number of social programs, including those for pregnant and parenting teens (National Campaign, 2011a). The total cost to taxpayers was \$9.1 billion in 2004 (National Campaign, 2011a). Also, the teen's age at childbearing is negatively correlated with the amounts that taxpayers will spend, the younger the teen, the greater the cost to the taxpayers (National Campaign, 2011a). In 2004, the majority of the total cost of teen parenthood was spent on programs addressing adverse outcomes that will be later discussed in detail and breaks down as such. For example \$1.9 billion was spent on health care

(i.e. Medicaid), \$2.3 billion for child welfare costs, \$2.1 billion for the increased costs associated with incarceration, and \$2.9 billion in lost revenues due to teen parents earning lower wages than their peers (National Campaign, 2011a). The good news is that such costs can be reduced. States, such as California and Wyoming, that have seen a decline in teen births that have also noticed a decrease in costs of social programs (National Campaign, 2011a).

The social cost of teen childbearing to taxpayers is just one of many problems associated with teen childbearing. The sections below will describe other problems associated with teen pregnancy in more detail.

Health Risks of Teen Childbearing

In addition to the social costs of teen childbearing, there are a number of other risks associated with teen pregnancy. There are health risks to both the teen mothers and children that are associated with childbirth (Chedraui, 2008; Gilbert et al., 2004).

Teen mothers endure several health risks and complications due to childbirth, and pregnancy. Pregnant teens are at an increased risk for requiring a cesarean section delivery and complications related to labor and delivery than adults (Chedraui, 2008). In another study that examines birth outcomes, findings showed that adverse outcomes cut across all races (African-Americans, Asians, Hispanics and Whites) (Gilbert et al., 2004). Specifically, preeclampsia (i.e. complications from high blood pressure) was higher among African-American teens than among adults, eclampsia was higher among Hispanic and white teens than among their adult counterparts, and infectious complications and pyelonephritis (i.e. kidney infection) were higher among teens in all groups (Gilbert et al., 2004). White teens showed significantly more complications as compared to white women, than in other racial groups (Gilbert et al., 2004).

Furthermore, after a teen has given birth for the first time, she is at increased risk for subsequent pregnancies (Klein, 2005).

Children of teen parents are also at an increased risk for adverse health outcomes compared to other children (Chedraui, 2008; Gilbert et al., 2004). Teens have a higher risk of preterm labor, which can cause a number of health problems for the baby (Chedraui, 2008). Infants born to teens have an increased risk of low birth weight, and neonatal death (Chedraui, 2008; Gilbert et al., 2004). These increased health risks (infant and neonatal death, preterm labor, and low birth weight) to infants born of teen mothers are prevalent across all races, when teen mothers are compared to adults of the same race (Gilbert et al., 2004). Gilbert (2004) used data from hospital records and birth and death certificates. The risk of prematurity is especially high for African-American infants born to teen mothers, and the risk of prematurity and low birth weight is high for infants of Asian teens (Gilbert et al., 2004). Infants born to Hispanic and White teens were at a significantly higher risk for all three adverse health outcomes (i.e. prematurity, low birth weight, and infant death) (Gilbert et al., 2004). In summary, infants born to teens are at an overall increased risk of suffering from major health complications.

Educational Outcomes

In addition to the health risks associated with teen pregnancy, there are a number of educational problems. Teen parents are also not receiving the education they are entitled to, and have higher dropout rates than their peers (Klein, 2005; Pillow, 2006). The children of teens also tend to suffer academically (Levine, Pollack & Comfort, 2001).

Educational outcomes of both the teen parent and the child are also critically impacted by early childbearing. Children born to teen mothers are also more likely to have lower math and reading test scores, and are more likely to be retained in school (Levine et al., 2001).

Additionally, the educational level of the mother is positively correlated with adverse behavioral outcomes, such as gang involvement and drug use (Pogarsky et al., 2006). Although it is possible to ensure that teen mothers continue their education, even after childbearing, to reduce these problems, research shows that, teen parents are not achieving educational goals, when compared to their peers (Pillow, 2006; Klein, 2005). Teen fathers have higher dropout rates in high school than their male peers (Klein, 2005). Although some teen fathers are not involved in their children's lives, many do attempt to stay involved and support their children, which may be part of the reason for fathers having similar dropout rates to the mothers (Klein, 2005).

Pillow (2006) argues that teen mothers are not receiving the education to which they are entitled. Title IX states that pregnant and mothering teens may not be removed from their home school and sent to an alternative school, or taken out of extracurricular activities, unless the teen volunteers to do so (Pillow, 2006). Despite the fact that Title IX explicitly states that teen mothers are entitled to the same or comparable education as their peers, pregnant and mothering teens do not receive an education that is equal to their peers (Pillow, 2006). In fact, many educators are not even aware of Title IX, which means that it is unlikely that teens are aware of their rights (Pillow, 2006). Even for those teens who do try to stay in their home school, certain accommodations are not made for them such as extended time for bathroom breaks, postpartum leave (schools often maintain attendance rules), and bigger desks, which in turn creates a hostile environment for pregnant teens (Pillow, 2006). Additionally, schools often do not maintain accurate and consistent records of the teen mothers: Some consider them enrolled in special education classes if they are in an alternative setting, classify them as disabled, or place them on medical leave (as if they have the flu), instead of following Title IX guidelines, which allows for

a period of postpartum leave (Pillow, 2006). In sum, schools and inflexible school policies often serve to create barriers to education for teen mothers (Pillow, 2006).

Psychosocial Problems

Children of teens are at a higher risk of being victims of child abuse than other children (Stevens-Simon, Nelligan, & Kelly, 2001). There are also other issues that will be further discussed in this section, such as increased incarceration among children of teen parents (Scher & Hoffman, 2008).

Children of teen parents are at increased risk of other negative life outcomes, such as poverty and incarceration. For example, children born to teen mothers are more likely to live in poverty than children born to adults, which means that these children have fewer resources (Grogger & Bronars, 1993). As compared to boys born to adult mothers, boys born to teen mothers have higher levels of drug use, gang membership, and are more likely to become fathers at a young age (Pogarsky, Thornberry & Lizotte, 2006). Boys born to teen mothers are also twice as likely to spend time in prison (Scher & Hoffman, 2008). Moreover data shows that if teens were to delay the timing of their first born until they were in their 20s, then the chances of their sons being incarcerated would be reduced, and in turn, it is estimated that the prison population would be reduced by four percent (National Campaign, 2011b). Teen girls born to teen mothers are more likely to have children at a younger age in comparison to their peers born to adult mothers (Pogarsky et al., 2006). Children of teens also have an increased risk of behavioral problems, such as truancy, engaging in fights at both school and work, and earlier sexual debut as compares with children of older parents (Levine et al., 2001).

Teen parents are also at a greater risk of maltreating their children than other parents (Stevens-Simon et al., 2001). Teen parents are overrepresented in child abuse and neglect cases,

and this is likely due to stress related to child-rearing for ill-prepared teens (Stevens-Simon et al., 2001). In a study that examined risk factors of child maltreatment, researchers found that the Family Stress Checklist is a reliable measure for predicting child maltreatment (Stevens-Simon et al., 2001). This latter research suggests that the stress of child-rearing when one is not ready, can be overwhelming, and can lead to a very preventable problem, child abuse and neglect (Stevens-Simon et al., 2001).

Theoretical Significance

The current study seeks to expand the current body of knowledge on teen pregnancy prevention research, and contribute to the current literature examining the relationships of religiosity and feminist ideology to teen pregnancy. Literature suggests that teen pregnancy contributes to a number of social problems. Therefore, if the incidence of teen pregnancy is reduced, then associated social problems can be reduced. The current study explored factors that could influence attitudes of social workers who could potentially advocate for teen pregnancy prevention. The population surveyed in this study may eventually work with at-risk teens, as well as advocate on their behalf for better prevention approaches (Benson, 2004). The current study analyzed the interrelationships among religiosity, feminist ideology, and attitudes toward teen pregnancy prevention. Religiosity was considered an influential variable due to its prevalence in the current body of teen pregnancy literature (Cooksey, Rindfuss, & Guilkey, 1996; Regnerus, 2005). Feminist ideology was assessed, because the teen pregnancy prevention programs rooted in feminist approaches differ from those preferred by religious groups, and because many scholars believe that a feminist approach to teen pregnancy prevention would be more effective (Bok, 1987; Pillow, 2003). The literature review will more fully describe how religiosity and feminist ideology relate to teen pregnancy.

Contributions to Current Research

The current study sampled a population that has not been tested in previous literature, Masters of Social Work (MSW) students, who are different from previous samples due to their overall education level, and possibly, previous experiences they may have had with pregnant or parenting teens and at-risk youth. This study examined the influence of religiosity and feminist ideology on social work students' attitudes towards teen pregnancy prevention to assess whether MSW students' attitudes are similar or different to those of samples surveyed in previous research. Furthermore, previous research has not examined religiosity and feminist ideology in relation to teen pregnancy prevention.

It is possible that social work students will encounter pregnant teens and teen parents in the field upon graduation, and the current study may yield information to indicate whether students may play a role in prevention of teen pregnancy and advocate for better teen pregnancy approaches upon graduation (Benson, 2004). Social workers often have to fit into the role as advocate for their clients, and may find themselves working with families and youth that are at-risk (Benson, 2004; National Association of Social Workers [NASW], 2008). Therefore, MSW students may find themselves in a role where advocating for an at-risk client may be called for. A previous study showed that the federally funded Adolescent Pregnancy Prevention program did not increase teens' knowledge of sexuality, but only impacted certain dating behaviors, such as teens pursuing long-term dating with one partner (Monahan, 2001). This latter finding suggests that teens may benefit from having advocates who can argue a need for more effective sex education that will equip them with the knowledge necessary to make healthier choices. Social workers could possibly help their clients (i.e. at-risk teens) to make healthy choices. The current study examined variables of interest in potential advocates for teens.

CHAPTER 2: REVIEW OF THE LITERATURE

The current study examined the interrelationships among religiosity, feminist ideology, and attitudes toward teen pregnancy prevention using a sample of MSW students. This review explores the current literature examining the relationship between religiosity and teen pregnancy, the role of feminist ideology in teen pregnancy prevention, current sex education approaches, and the role of school-based health centers. The review concludes with implications of social work in preventing teen pregnancy.

The Problem of Teen Pregnancy

Teen pregnancy is costly not only to the teen parents and their children, but also to society as a whole. Research shows that teen pregnancy costs taxpayers several billion dollars annually (National Campaign, 2011a). Teens and their children also have adverse educational and behavioral outcomes (e.g., dropping out of school, fighting, incarceration, and drug use) (Grogger & Bronars, 1993; Klein, 2005; Levine et al., 2001; National Campaign, 2011b; Pillow, 2006; Pogarsky et al., 2006). Teens and their children also are at an increased risk for health problems related to pregnancy and childbirth (Chedraui, 2008; Gilbert et al., 2004). Additionally, teen parents often experience stress related to unpreparedness for childrearing, which can lead to an increased risk for child maltreatment (Stevens-Simon, 2001). All of these documented social problems suggests that efforts to prevent teen pregnancy, such as providing better sex education to teens, may be prudent for decreasing risk among at-risk teens. This review will first look schools' role in teen pregnancy prevention, followed by religiosity, then feminist ideology, and lastly parents' roles.

Sex Education in Schools

The importance of sex education for preventing teen pregnancy cannot be overemphasized. Somers and Surmann (2005) have found that early and comprehensive sex education is correlated with less risky sexual behavior among teens. Specifically, those who receive sex education in school at a young age report having sex less frequently than those who received sex education post-puberty (Somers & Surmann, 2005). There are two major types of sex education currently used in schools: abstinence only and comprehensive sex education. This section describes both types in relation to teenage pregnancy prevention. Currently, states are not required to provide sex education to teens (Collins, Alagiri, Summers, & Morin, 2002). However, the federal government does decide which programs will receive federal funding, and after eight years of abstinence-only sex education being the only recipient of federal funds during the Bush administration, the Obama administration has made a change in policy only to provide funds to evidence-based sex education programs (Collins, et al., 2002; Guttmacher, 2009)

Abstinence-only sex education teaches students that the only sure way to avoid unplanned pregnancy and sexually transmitted diseases (STDs) is to abstain from sexual activity until marriage (Collins, et al., 2002). Teens are not educated about contraception and condoms, and discussions of abortion are avoided (Collins, et al., 2002). Students are taught refusal skills and discuss values, and they are also told that sex before marriage will likely result in negative consequences for themselves, their partners, and a baby if they were to get pregnant (Collins, et al., 2002).

Studies have shown that teens who have taken a pledge to be abstinent until marriage are just as likely to become sexually active as teens who have not received abstinence-only sex education, and are less likely to use protection than their peers who have received comprehensive

sex education (Thomas, 2009). This is likely a result of the teens not learning the effectiveness of condoms and contraception (Collins, et al., 2002).

The other type of sex education is comprehensive sex education, which can be described as “abstinence plus” (Collins et al., 2002, p.1), where abstinence is promoted, but students are also educated about contraception and condoms. Students may have discussions about such topics as STDs, HIV, and abortion (Collins et al., 2002). Comprehensive sex education recognizes that students may become sexually active at some point, and aims to equip teens with accurate knowledge about disease and pregnancy prevention options (Collins et al., 2002).

Currently, schools have the option of providing abstinence-only or comprehensive sex education, which is determined by policy. Some schools that teach abstinence only use programs such as The Postponing Sexual Involvement Program (PSIP) and the Youth Asset Development Program (YADP) (Yampolskaya, Brown & Vargo, 2004). Both of these programs are aimed at improving academic outcomes, assisting teens in making education and career goals, and educating at-risk youth about the consequences of sexual activity. The idea is that teens who have long-term plans will be less likely to engage in risky sexual behaviors. Yampolskaya et al. (2004) found that students who participated in these programs did have better academic outcomes, particularly with the YADP. However, these were preliminary data, and the researchers did note some limitations. For instance, Yampolskaya et al. (2004) did not find that these programs changed students’ attitudes toward teen parenting.

Monahan (2001) examined a federally-funded Adolescent Pregnancy Prevention program, which was abstinence-only based. Treatment and control groups were compared on their knowledge, dating behaviors, and attitudes (control groups did not receive the Adolescent Pregnancy Prevention program) (Monahan, 2001). No significant differences emerged regarding

knowledge about sex and reproduction, and dating behaviors (i.e., making out/kissing, sexual touching) (Monahan, 2001). However, participants in the treatment group were significantly more likely to report having a steady relationship, and were more likely to date at the completion of the intervention (Monahan, 2001). Furthermore, participants in the treatment group were significantly more likely to believe that sex before marriage and in their teen years was not okay, and they were more likely to report that their parents believed sex was wrong (Monahan, 2001). The results show an inconsistency between knowledge and certain dating behaviors among teens who receive this particular type of sex education, suggesting a need for prevention programs that yield greater consistency between attitudes and behaviors (Monahan, 2001).

Another program used by American schools, particularly in the Midwest, is a simulator approach called Baby Think It Over (BTIO) (Somers, Gleason, Johnson & Fahlman, 2001). The infant simulator is meant to imitate a real baby by crying at regular intervals, including at night, in order to help teens understand the responsibilities of being a parent (Somers et al., 2001). The study used pre- and posttests to examine high school students' sexual attitudes and behaviors, understanding of responsibilities of parenthood, and attitudes toward premarital sex and pregnancy (Somers et al., 2001). In addition, teachers were asked to report their perceptions of the BTIO program (Somers et al., 2001). Researchers found no significant differences in teens' perceptions from pretest to posttest after participating in BTIO (Somers et al., 2001). Teachers overall believed that BTIO helped in shaping some of the teens' attitudes, particularly their perception of being a parent (Somers et al., 2001). Researchers noted that schools have been using BTIO as a teen pregnancy prevention program despite the fact that no empirical evidence has supported its effectiveness in preventing teen pregnancy (Somers et al., 2001).

The programs that show the most promise in preventing teen pregnancy have a variety of approaches that include access to and education about contraception, sexual postponement whereby students delay sexual debut until a later age, birth control compliance, and access to school-linked community health clinics (Card, 1999). The need for a comprehensive approach that covers more aspects than just abstinence from sex until marriage is evident when the attitudes of teens toward postponement of sex are examined (Somers & Surmann, 2004a). For example, in a study that explored the perceptions of teens' decisions to have sex, a significant proportion reported that nothing could have postponed their initiation of sexual activity (Somers & Surmann, 2004a). Thus, if teens are going to have sex regardless of what they are taught, it is important that they are equipped with the knowledge necessary to make safe and healthy choices (Somers & Surmann, 2004a). Sex education in schools can be further enhanced by the establishment of school-based health centers.

School-Based Health Centers

A fairly recent development in providing health care services to children and teens is school-based health centers, which make health care accessible and affordable to children, while also keeping them in school (Manning, 2009). School-based health centers were created as a response to physical and mental health issues such as asthma, diabetes, teen pregnancy, STDs, suicide, depression, and ADHD (Manning, 2009). These centers provide services such as health and vision screenings, counseling, referrals, immunizations, sex education and eye exams (Manning, 2009). School-based health centers have been shown to increase health care access to minors (Manning, 2009).

School-based health clinics provide education and family planning among other services, according to Manning (2009), who asserts that clinics provide a variety of services to intervene

with mental health and medical conditions, including the prevention of teen pregnancy and STD's. Manning (2004) argues that despite the implementation of abstinence-only programs, rates of pregnancy and STD's among teens remain high. Weatherley and Semke (1991) cited positive results in some early school-based health clinics, including one school in St. Paul, Minnesota that saw a decrease in the fertility rate. However, legislation to establish school-based health clinics has failed to pass in some states. Some opponents believe that distributing contraception will lead to promiscuity among teens (Weatherly & Semke, 1991).

The road to establishing school-based health clinics has been one of advocacy. In Seattle, Washington, advocates were successful in instituting school-based health clinics (Weatherley & Semke, 1991). Advocates for school-based health centers should look at all of the benefits of having school-based health clinics, especially for underserved populations, which are already atrisk. School-based health centers can offer a holistic approach to healthcare for those who may not be receiving all the services they need (Manning, 2009). Social workers can play a role in establishing these clinics through organizing communities for change, advocating for funds, conducting parent outreach, and working in the centers as providers (Weatherley & Semke, 1991).

Next, the current study will review literature that examines religiosity and the role of religiosity in efforts to prevent teen pregnancy.

Religiosity and Teenage Pregnancy

Religiosity is defined by membership in an organized religion or an adherence to religious beliefs; whereas spirituality is defined as having a relationship with a higher power. Persons can describe themselves as being religious, spiritual, or both. Religiosity has a critical impact on teen pregnancy and how teens are educated about sex, because it appears to influence

the way parents communicate with their teens about sex (Regnerus, 2005). Those from conservative religions, particularly evangelical Christians, believe sex before marriage is morally wrong; and therefore, support abstinence-only sex education (Strayhorn & Strayhorn, 2009). Furthermore, studies have shown that teens who are taught sex education through an abstinence approach, such as those that encourage teens to take virginity pledges (pledges to remain abstinent from sex until marriage), report similar levels of sexual activity as teens that do not take virginity pledges (Thomas, 2009). The only sexual behavior that abstinence-only approaches to teen pregnancy prevention appear to influence is contraception use: Teens who report high levels of religiosity and those who have taken virginity pledges are less likely to use contraception than their peers (Cooksey, Rindfuss, & Guilkey, 1996; Thomas, 2009). This section of the review describes studies between the relationship of religiosity and teen pregnancy in further detail.

Religiosity also has an important impact on parents' communication about sex with their teens. In a study that examined communication patterns about sex and contraception, researchers found that parents who report higher religiosity talk to their teens about sex less frequently and are more apt to refrain from discussions about birth control (Regnerus, 2005). Specifically, mainline Protestants report talking the least about sex and report the greatest unease when talking about sex with their teens; while Catholics, evangelical Protestants, and Mormons tend to not discuss birth control with their teens (Regnerus, 2005). Furthermore, parents with higher religiosity and parents from conservative religions, such as evangelical Protestants and Mormons, are more likely to focus on the moral implications of sex as compared with less religious parents (Regnerus, 2005). When teens are educated about sex solely on the moral issues

of having sex before marriage, then it is likely that teens are not being properly equipped with the knowledge necessary to prevent unwanted pregnancy.

Religiosity also appears to influence teen sexual behavior and contraceptive use. A study that examined factors that influenced the initiation of teenage sexual behavior and contraceptive use found that teens from Catholic and fundamentalist Protestant families were less likely to use contraception at first intercourse (Cooksey, Rindfuss, & Guilkey, 1996). Patterns indicate that parents and religious groups tend to either influence age at first intercourse, or contraception use, and it is suggested that this is due to policies that emphasize either abstinence or contraception, instead of emphasizing comprehensive education about sex (Cooksey et al., 1996). A possible solution to this problem of either/or risky sexual behaviors (i.e., having sex at a young age, then not using contraception) is to use a more comprehensive approach that emphasizes both the importance of waiting as long as possible, but then using contraception when a teen decides to initiate intercourse (Cooksey et al., 1996). Cooksey et al. (1996) did find one exception to the rule: the mother's education. Specifically, the more educated the mother, the more likely the teen delayed initiation of intercourse and used contraception. It is possible that teens with more educated mothers are more educated themselves and view risky sexual behaviors as an obstacle to their life goals (Cooksey et al., 1996). Thus, this latter finding suggests that a feminist approach to teen pregnancy prevention may have particular relevance given the impact of higher education and female empowerment of the mother on their teen's sexual behaviors.

Feminist Ideology, Contraception and Teen Pregnancy Prevention

Feminist ideology is an aspect of feminism that focuses on issues of discrimination and collective action as they relate to women (Morgan, 1996). Feminist ideology reveals the core of feminist thinking (Morgan, 1996). The issue of teen pregnancy cannot be thoroughly assessed

without relating it to feminist issues. The right to plan a family has been a long road for women activists. Women's liberation as it relates to birth control started with Margaret Sanger, who argued that some women had to balance their own personal needs to control their bodies and their obligation to their husbands and children (Buerkle, 2008). Research has shown that women consistently report that unintended pregnancy has an adverse effect on their quality of life, which indicates a need for access to birth control (Schwarz, Smith, Steinauer, Reeves, & Caughey, 2008). Now that women have gained access to birth control, advocates have argued that teens should have similar access. According to Pillow (2003) the teen body has become another focal point of control of government regulations. However, when teens do have access to reproductive health care and are assured that their care is confidential, they tend to utilize services (Yanda, 2000). Research shows that as long as teens have the right to receive reproductive healthcare services confidentially, and are informed of these rights, they tend to make healthy and responsible choices (Yanda, 2000).

Bok (1987) argues that the current model of teenage pregnancy prevention views teen sexuality from a traditional and moralistic perspective rather than focusing on developing an approach that is effective. Current models tend to encourage abstinence from sex until marriage as the only way to prevent unwanted pregnancy (Bok, 1987). Abstinence-only programs are based on the moral ideology that teens should wait until marriage to initiate sex, and are taught the consequences of sex in an effort to scare them, which in turn fails to empower teens to make healthy choices (Bok, 1987). Furthermore, traditional views keep females in a submissive role, so that when she is pressured for sex, she will not feel empowered enough to insist on using protection, such as condoms (Bok, 1987). Indeed, current teenage parent programs focus on the teenage mother rather than making the father equally responsible for childrearing. According to

Bok (1987), the view that childrearing is for women, perpetuates patriarchal ideals in modern society. This also leaves the responsibility of pregnancy prevention on the female's shoulder, because females are the ones held responsible in the case of pregnancy, even though females are not empowered to insist on contraception (Bok, 1987). Thus, teenage pregnancy prevention programs that incorporate feminist approaches would likely be more effective in empowering adolescent females to protect themselves (Bok, 1987). A feminist approach to preventing teen pregnancy would include empowering young women to have sex only when wanted and to discuss contraception so women can protect their bodies (Bok, 1987).

Pillow (2003) argues that school-based programs assume a moralistic ideology (i.e., teens should remain abstinent until marriage), because teen pregnancy blurs the lines between adult and child. Thus, teen pregnancy prevention has become a policy of regulating bodies, morals, social welfare, contraception and abortion (Pillow, 2003). By controlling teens' access to the birth control pill, for example, state government is therefore able to impose the values of abstinence on teenagers as the only way to prevent pregnancy (Pillow, 2003). Men are largely the policy makers in all areas, including the regulation of abortion, contraception, and sex education, which not only politicizes family planning issues, but also keeps it out of the control of women (Pillow, 2003).

Feminist ideology can be utilized in the prevention of teenage pregnancy. In a study conducted by Ortiz (1984) the researcher measured the feminist values and hopelessness of college students and at-risk high school females. Ortiz (1984) found a correlation between scores measuring hopefulness and strong feminism. Ortiz (1984) argues that incorporating a feminist orientation into teenage pregnancy prevention programs can help teach young women to make better life choices, as well as give young women a sense of confidence and control in their lives.

There are seven proposed aspects to a feminist-oriented teenage pregnancy prevention program: role modeling, work and voluntarism, leadership experience, self-awareness training, problem-solving skills training, assertiveness training, and values clarification (Ortiz, 1984).

In a study that examined teen sexual behaviors, researchers found that teen girls who have educated mothers tend to delay sexual debut and are more likely to use contraception (Cooksey et al., 1996). This finding may indicate that girls who have aspirations for a bright future may feel they have more to lose by engaging in risky sexual behaviors, which is the basis for youth development programs (Card, 1999). It is possible that an approach that empowers teens to take control of their futures, combined with accurate information regarding sex, and prevention of unwanted pregnancy may be the key to reducing teen pregnancy.

Feminist theory can be used to strengthen sex education. Current models that focus on the negative consequences of sex (i.e., unwanted pregnancy and STDs), describe any sex that is outside of marriage as immoral, and thereby limit discussion about sexual behavior (Jackson & Weatherall, 2010). Abstinence-only models do not acknowledge that sex is desirable and pleasurable (Jackson & Weatherall, 2010). By educating teens from a feminist perspective, the idea that sex is pleasurable and that teens do, in fact, desire it, is acknowledged, thus allowing further discourse on sex that abstinence-only approaches do not permit, such as sexual health and sexual violence (Jackson & Weatherall, 2010). A feminist approach to sex education empowers teens to say no to unwanted advances, insists on the use of contraception, and encourages them to make choices that are right for themselves and maintain control of their bodies (Jackson & Weatherall, 2010). Participants in a study that compared feminist approaches to sex education and traditional sex education, described the sex education as eye-opening, as they were not

previously aware that having safe sex was their right, and that respecting others' wishes (to have sex or not have sex) was their responsibility (Jackson & Weatherall, 2010).

Parents' Role in Teen Pregnancy Prevention

Sex education in the home can be an excellent opportunity for teens and parents to communicate about sex, and can also give parents a chance to convey their values to their teens (Eisenberg, Sieving, Bearinger, Swain, & Resnick, 2006). A study that surveyed parents of teens asked participants about their beliefs regarding condom and birth control pill effectiveness and their teen's ability to use them properly (Eisenberg, et al., 2004). Eisenberg et al. (2004) found that parents tended to undervalue the effectiveness of condoms and birth control for pregnancy and STD prevention. However, if parents are not equipped with medically correct knowledge about condoms and birth control, they may be delivering inaccurate information to their children. Eisenberg et al. (2004) found, for example, that less than half of parents (40%) believed the condom was effective in preventing pregnancy, while only 52% believed that the pill was effective. About a quarter of parents thought that teens were able to use condoms correctly (26%), and only 40% believed that teens were able to use the pill correctly (Eisenberg et al., 2004).

This is in contrast to data reported by the Center for Young Women's Health (2010) showing that contraceptive (i.e. birth control pills) minimum effectiveness is 95% and condom minimum effectiveness is 86% with typical use (that allows for human error). The organizational website of the Center for Young Women's Health is operated by Children's Hospital Boston that specifically targets female teenagers. Despite the medical community's findings that demonstrate the effectiveness of contraceptives and condoms, parents tend to believe that contraceptives and condoms are not very effective (Center for Young Women's Health, 2010; Eisenberg, et al.,

2004). It also has been shown that the consistent and correct use of condoms can reduce the risk of infection (Centers for Disease Control [CDC], 2010). However, teens need to be taught to correctly and consistently use condoms (i.e., every time you, for the entire time) (CDC, 2010).

An additional survey conducted by Eisenberg et al. (2006) examined parents' communication patterns with their teens about sex. Eisenberg et al. (2006) found that a majority of parents had spoken to their teens about the negative consequences of sex (i.e., unwanted pregnancy and sexually transmitted diseases), but were less likely to discuss prevention of these consequences, such as access to condoms and birth control. Also, rather than taking a more preventive approach, researchers found that parents were 2.5 times more likely to talk to their teens about sex if they believed teens were already romantically involved, compared to those who believed their teens were not in romantic relationships. Despite findings of Somers and Eaves (2002) that early sex education is positively correlated with more communication from teens about sex, and not correlated with early initiation of sexual activity, parents appear apprehensive to bring up the topic of sex with their teens. It would seem that parents' decisions to educate their teens about sex is more so a reaction to their teens' romantic developments rather than as a more proactive, or preventative decision to educate their teens before teens become romantically involved (Eisenberg, et al., 2006)

In summary, parents often wait to educate their teen children until they become sexually active and at risk for STD's and pregnancy, as well as neglect to equip their teens with accurate preventive information, if parents give them preventive information at all (Eisenberg et al., 2004; 2006).

Limitations of Teenage Pregnancy Research

Despite the fact that social workers take an active role intervening with pregnant and parenting teens, their voices are not heard when it comes to preventing teen pregnancy (Benson, 2004). For example, Benson (2004) discusses the roles played by social workers when intervening with teenage parents in social welfare and child protection setting. Unfortunately, social workers have not taken a major role in the prevention of teen pregnancy education. Although some areas of the U.S. have been successful in advocating for school-based health centers and comprehensive sex education, not all states are taking this approach (Weatherly & Semke, 1991). Parents and religious groups assert pressure to focus on sex education that teaches teens to abstain from sexual activity and do not discuss contraceptive use (Cooksey, et al., 1996). Previous studies have examined perceptions of teens, parents and teachers but have not examined the attitudes and beliefs of MSW students or social workers (Regnerus, 2005; Somers, 2001). Previous studies also have not simultaneously the influence of religiosity and feminist perspectives on teen pregnancy prevention.

Summary and Implications for Social Work

Social workers assist pregnant and parenting teens in several ways (Benson, 2004). Social workers fulfill the following functions when intervening with teen parents: adoption, counseling for teens and their families (upon finding out the teen is pregnant to help the family cope, and also after a teen has decided on abortion), case management, and child maltreatment prevention/intervention (i.e., child welfare) (Benson, 2004). Thus, considerable resources target intervention, rather than emphasize prevention, which is a role that social workers can fulfill as school social workers, family therapists, and medical social workers (Benson, 2004).

Evidence suggests that parents delay communication about sex and do not convey accurate information to their teens about pregnancy prevention when they do talk to their teen children, if parents talk about prevention at all (Eisenberg, et al., 2004; 2006). Additionally, schools are limited by restrictive policies, and despite the positive impact of school-based health clinics on teen birth rates, there are not nearly enough clinics nationwide (Weatherley & Semke, 1991). Social workers can assist parents in educating their teens about sex. Social workers who practice family therapy can play a role in sex education by facilitating discussions about sex between parents and teens (Krafchick & Biringen, 2002). Somers and Surmann (2004b) have found that teens prefer to get their sexuality education from their parents, followed by school, and then peers. Therapists can help parents educate their teens by providing a basic knowledge of sex education, being aware of the family's values, normalizing parents' fears on this topic, coaching parents to approach problematic issues in a sensitive manner, and empowering clients to make healthy choices (Krafchick & Biringen, 2002). Schools can also play a role in helping parents to provide accurate and appropriate sex education to their teens through training (Somers & Surmann, 2004b). School social workers can facilitate this parent training.

Given social workers' influential role in health care services, it seems logical that they would play an integral part in advocating for reproductive rights (Alzate, 2009). Social workers help clients in schools and medical and mental health settings with a myriad of issues. Social workers are also called upon to serve as advocates for their clients, which may include advocating for reproductive rights for their clients (i.e., sex education and access to birth control) (Alzate, 2009). By empowering clients to make healthy choices for themselves by providing them with accurate knowledge about sex, social workers are also abiding by the Code of Ethics by advocating for those who cannot do it for themselves (teens who want accurate information

about sex) and by respecting self-determination (Alzate, 2009; NASW, 2008).

Feminist ideology (Ortiz, 1984) and programs that promote academic goals (Yampolskaya, et al., 2004) show a positive effect a wide range of outcomes among teens. Another aspect of feminism that appears to influence teens' sexual behaviors is the mother's education, which is negatively correlated with a teen's risky sexual behaviors (Cooksey et al., 1996). This is an example of how female empowerment (furthering education of females) can empower teens to make healthy choices by giving them something to which to aspire.

In conclusion, religiosity and feminist ideology appear to influence teen sexual behaviors. Social workers are involved in interventions with pregnant teens and teen parents already receiving social services, adoption, child welfare etc., and therefore have experience working with this at-risk population (Benson, 2004). Social workers could be a stronger voice in the prevention of teen pregnancy, especially those who work with youth and families. Social workers should not only play a larger role in promoting evidence-based teen pregnancy prevention programs in general, but also should advocate to policymakers for the establishment of school-based health centers in underserved population areas (Benson, 2004; Weatherley & Semke, 1991).

The current study examined religiosity and feminist ideology among social work students, and whether their moralistic views influenced what they believe to be the most effective approach to teen pregnancy prevention. The current study also examined the extent to which MSW students' views of teenage pregnancy prevention were associated with feminist ideological perspectives.

CHAPTER 3: CONCEPTUAL FRAMEWORK

Purpose

This cross-sectional, exploratory-descriptive study measured the interrelationships of religiosity, feminist ideology, and attitudes among Masters of Social Work students. The current study examined social work students' attitudes regarding abstinence-only sex education versus comprehensive sex education and teens' use of contraception. This study used a self-administered written instrument that asked questions about religious beliefs, importance of religion, religious service attendance, views of feminist ideology, abstinence-only and comprehensive sex education, and beliefs about contraception.

Research Questions

The current research was framed by the following questions:

1. Is there a relationship between level of religiosity and attitudes toward the two types of sex education (i.e., abstinence-only and comprehensive) among MSW students?
2. Is there a relationship between views of feminist ideology and attitudes toward abstinence-only vs. comprehensive sex education?
3. Are religiosity, feminist ideology, and beliefs about teenage contraceptive use interrelated?

Definitions of Key Terms

This section defines key terms used in research questions that analyze attitudes toward teen pregnancy prevention and contraception, religiosity and feminism. Specific survey items were described in more detail below in the methods section.

Religiosity

Religiosity is defined in this study as the self-reported religious beliefs, importance of religion, strength of spirituality, and frequency of religious service attendance of participants. For purposes of the current study, religiosity and spirituality are concerned with adherence to religious beliefs and a relationship with a higher power. Religiosity was measured with the Three-Factor Religiosity Scale (TRFS), which was adapted by Ai, Tice, Peterson and Huang (2005) from the original measure developed by Chatters, Levin, and Taylor (1992). Cronbach's alpha for the scale was .85 when used by Ai et al. (2005), and for the current study with MSW students, Cronbach's alpha was .87. These items were used to measure religious beliefs, importance of religion, and spirituality. The question regarding frequency of religious service attendance is a researcher-developed item.

Feminist Ideology

Feminist ideology is defined as the participant's views on social issues relating to women and is measured with items taken from Morgan's (1996) Liberal Feminist Attitude and Ideology Scale (LFAIS), a 70-item self-report instrument that measures respondents' views about gender roles, goals of feminism (i.e., global goals and specific political agendas), and feminist ideology. Cronbach's alpha for the LFAIS was .94 when used by Morgan (1996), and for the current study with MSW students, Cronbach's alpha was .90. Feminist ideology is assessed with items in three categories: discrimination and subordination (historical and current), collective action (strategies for change), and the sisterhood. For purposes of this study, the 20 items that measure views on discrimination, subordination, and collective action were used to assess participants' views on feminist ideology.

Sex Education

The survey asked participants about their views on the two predominant types of sex education: comprehensive and abstinence-only. Both types of sex education were defined using items derived from a study examining comprehensive and abstinence-only approaches (Collins, Alagiri, Summers, & Morin, 2002). Using a six-point Likert scale, participants were asked to rate their level of agreement on items asking about the effectiveness of each type of education to prevent teen pregnancy.

Teen Contraceptive Use

Teen contraceptive use was defined as a teen's ability to prevent unwanted pregnancy using condoms and contraceptives. Participants' beliefs about teen contraceptive use were measured with items assessing condom and contraceptive effectiveness and safety, with additional items assessing students' perceptions of the ability of teens to use condoms and contraception. Participants' beliefs about contraception are researcher-developed items adapted from a study that examined the medical accuracy of parents' beliefs about contraceptives (Eisenberg et al., 2004).

CHAPTER 4: METHODOLOGY

This cross-sectional, exploratory-descriptive study surveyed MSW students to examine the interrelationships among religiosity, feminist ideology, and beliefs about teen pregnancy prevention and contraception.

Research Design

The current correlational study used a survey method to collect data on variables measuring religiosity, feminism, and beliefs about teen pregnancy prevention approaches and contraception. Survey data were collected from a non-probability sample of 69 MSW students at a public university in the south. More specifically, the study used a convenience sample, because only MSW students at one institution were surveyed (Rubin & Babbie, 2005).

Methods and Procedures

For the purposes of the current study, the population surveyed consisted of all MSW students enrolled at one public university in the south. There are approximately 200 students in the MSW program, with 114 in the foundation year and 86 in the advanced year. Foundation-year students include those who have completed less than 30 credit hours whereas those in the advanced year have more than 30 credit hours. The final sample consisted of 69 MSW students from both the foundation and advanced years.

There are a few issues related to the external validity of this study. First, the southern region of the country in which the study was conducted is known for being more politically conservative than other regions of the United States (Healey, 2010). Thus, the results may only be generalizable to other MSW students in the southern United States. Students in this area of the country may be more conservative than students in other parts of the country. The sample is representative of other MSW students in graduate social work programs in the South who have

met similar admissions criteria. The study sample may also be representative of other MSW students with similar views on religiosity and feminist ideology.

All MSW students were asked to complete and return an anonymous written survey. Professors of different sections of core classes in both the foundation and advanced years distributed the survey at the beginning of class in order to ensure that all of the MSW students had an opportunity to participate. Surveys were also sent by email to 12 distance education students. There was a box by the student mailboxes in the social work lounge that was labeled with the study's title. Students who chose to participate were asked to leave the completed survey in the student lounge in a designated drop box. Directions for returning the questionnaire to the drop box were outlined on the survey.

Protection of Human Subjects

Data were collected for this study through an anonymous self-administered questionnaire. Participation in this study was completely voluntary, and there were no risks or benefits to the participants. There was no identifying information collected on the survey. Thus, this study met the criteria for exempt status from the Institutional Review Board.

Mode of Observation

The current study used a quantitative methodology. Data were gathered using a 36-item self-administered questionnaire that was scored by the researcher. The instrument included both existing measures used in previous research and researcher-developed items. The questionnaire included three sections measuring religiosity, feminist ideology, and beliefs about teenage pregnancy and contraception. The last four questions of the survey collected demographic and other information: age, year of study, gender, and race.

The first question in the religiosity section of the survey asked respondents to report their religious belief and included 14 options (e.g., Buddhist, Protestant, Unitarian, No preference, etc.) including one for “other” with a blank where participants specified their religious preference. The next three items measuring religiosity were taken from the TFRS (Chatters, et al., 1992). These questions asked about the importance of religion, degree of religiosity, and level of spiritual orientation on a 4-point scale. This scale is a reliable measure of religiosity that has been used to study reactions to the September 11th attacks (Ai, et al., 2005). The last item refers to church attendance and is a researcher-developed item with response options ranging from 1 (at least once a week) to 4 (do not attend), which was adapted from a study that examined the relationship of teen birth rate to religiosity in the U.S. (Strayhorn & Strayhorn, 2009). Cronbach’s alpha was computed to assess internal consistency of the scale ($\alpha = .87$).

The feminist ideology section of the instrument included items from the LFAIS, a measure with demonstrated reliability and validity (Morgan, 1996). Response options for each item ranged from 1 (Strongly Disagree) to 6 (Strongly Agree). The 20 LFAIS items used in the current study were derived from the 70-item scale. The current study used 10 discrimination and subordination (historical and current) items, and 10 collective action (strategies for change) items to measure the level of feminist ideology of participants. The instrument incorporated identical wording and the Likert scale used in the original LFAIS. Some of these items included the following: Women have been treated unfairly on the basis of their gender throughout most of human history; Men have too much influence in American politics compared to women; Women are already given equal opportunities with men in all important sectors of their lives; The government should definitely play a role in helping to improve women’s status in society; Most

group protests only serve to make the public see the protestors as fanatics. Cronbach's alpha was computed to assess the internal consistency of the LFAIS ($\alpha = .90$).

The third section of the instrument contained items measuring beliefs about teenage pregnancy prevention and contraception, and consisted of knowledge-based questions developed by the researcher. The first five items were true-false questions adapted from a study that examined parents' beliefs about contraception (Eisenberg, et al., 2004). The items measured participants' beliefs about contraceptive safety and effectiveness and the ability of teens to use contraceptives and condoms correctly. Some of the items included: Condoms are effective for pregnancy prevention; Oral contraceptives are safe to use; Teenagers can use oral contraceptives correctly. Finally, the instrument contained two researcher-developed questions that specifically asked participants about beliefs about comprehensive sex education and abstinence-only sex education. Both types of sex education were defined for the participant in the survey, and then participants rated their level of agreement as to which type of sex education they believed was most effective for preventing teen pregnancy using a scale of 1 (Strongly Disagree) to 6 (Strongly Agree).

Data Analysis

Univariate statistics were used to summarize and describe data. Bivariate statistics were used to analyze interrelationships among variables. The current study used Pearson's product-moment correlation coefficient (r) to examine the interrelationships of religiosity, feminist ideology, and attitudes toward teen pregnancy prevention (Rubin & Babbie, 2005). Attitudes toward teen pregnancy prevention were measured by analyzing beliefs about sex education and beliefs about contraception. Data were analyzed using the Statistical Package for the Social Sciences™ (SPSS). A power analysis was conducted for a medium effect size (.60) and a level

of significance of .05 with standard statistical power of .83-86 (Rubin & Babbie, 2005). A sample size of 80-100 was needed; however, only 69 surveys were completed. Due to this low sample size, results were interpreted with caution.

CHAPTER 5: RESULTS

The present cross-sectional descriptive study examined interrelationships among religiosity, feminist ideology, and attitudes toward teenage pregnancy prevention, as self-reported by MSW students. Attitudes toward teen pregnancy prevention were measured with survey items asking respondents' beliefs about sex education and knowledge of condoms and contraception. The sample for this study consisted of 69 participants, a response rate of 37.9%. In terms of statistical power for the bivariate analyses, according to Rubin and Babbie (2005), a sample size of 80-100 is recommended for a medium effect size (.60) at a level of significance of .05, with standard statistical power of .83-.86 (Rubin & Babbie, 2005). The present study, with an overall *N* of 69, is slightly less than the minimum recommended number of subjects. Thus, findings must be interpreted with caution.

Demographic and Other Characteristics

The sample was composed of predominantly Caucasian females. The sample included 58 females (84.1%), and 9 males (13.0%). Two participants (2.9%) did not identify their gender. The majority of participants were Caucasian ($n=51$, 73.9%), with the remainder reporting African-American ($n=14$, 20.3%) or other ethnicities ($n=4$, 5.6%). The ages of participants ranged from 21-50 years old. The mean age was 28.2 years old ($SD = 6.9$), the median was 26, and the mode was 24 years of age. Most participants ($n=55$, 79.7%) were in their advanced year of study, with the remainder of the participants in their foundation year ($n=14$, 20.3%). Approximately one-third (30.9%) of advanced-year students ($n = 17$) were in the advanced-standing program.

Attitudes toward Teenage Pregnancy Prevention

Beliefs about sex education were measured with two items that provided definitions for abstinence-only sex education and comprehensive sex education. Participants were asked to rate their level of agreement regarding the best type of sex education for preventing teen pregnancy. The responses were rated on a Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Table 1 shows the frequencies and percentages of response options reported by students. Overall, the participants disagreed that abstinence-only sex education was the best way to prevent teenage pregnancy ($M = 1.7$, $SD = 1.2$) (see table 1). The median and mode were both 1 (strongly disagree). Conversely, participants tended to agree that comprehensive sex education is the best way to prevent teen pregnancy ($M = 5.5$, $SD = .88$) (see Table 1). The median and mode on this item were 6.0 (strongly agree). The majority of participants either strongly agreed or agreed ($n = 63$, 91.3%) that comprehensive sex education was the best way to prevent teen pregnancy (see Table 1).

Beliefs about condoms and contraception were measured with five True/False knowledge-based items (Range = 0-5). In the current study participants were asked to mark True (1) or False (0) for five items that corresponded to their knowledge about contraception. Overall, participants appeared to have accurate knowledge about condoms and oral contraceptives. As seen in Table 2, the mean score measuring knowledge about condoms and contraception was 4.1 ($SD = 1.5$). Table 2 displays the frequencies and percentages of true and false responses for each item. The means and standard deviations for each item are as follows: Condoms are Effective ($M = .8$, $SD = .4$); Teens can use Condoms Correctly ($M = .8$, $SD = .4$); Oral Contraceptives are Effective ($M = .8$, $SD = .4$); Contraceptives are Safe ($M = .9$, $SD = .3$); and Teens can use Contraceptives Correctly ($M = .8$, $SD = .4$). Table 2 shows that the mode for each item was 1,

indicating that most respondents correctly marked the statement as true. The greatest proportion of participants (85.5%) correctly answered that oral contraceptives are safe, whereas the smallest proportion (75.4%) believed that teens could use condoms correctly (see Table 2).

Table 1
Level of Agreement for Types of Sex Education

Item/Responses	<i>n</i>	%
<u>Abstinence Only Sex Education</u>		
Strongly Disagree	42	60.9
Disagree	17	24.6
Disagree Slightly	5	7.2
Strongly Agree	3	1.4
Agree	1	1.4
Agree Slightly	1	4.3
<u>Comprehensive Sex Education</u>		
Strongly Agree	46	0.0
Agree	17	2.9
Agree Slightly	3	1.4
Disagree	2	4.3
Disagree Slightly	1	24.6
Strongly Disagree	0	66.7

Table 2
Overall Knowledge of Condoms and Contraception

Item	<i>n</i> (True/False)	% (True/False)	Mode
Condoms are Effective	56/12	81.2/17.4	1
Teens can use Condoms Correctly	52/16	75.4/23.2	1
Oral Contraceptives are Effective	55/12	79.7/17.4	1
Oral Contraceptives are Safe	59/9	85.5/13.0	1
Teens can use Contraceptives	54/14	78.3/20.3	1
Sum of Knowledge Totals	---	---	1

Religiosity of MSW Students

Participants' religious beliefs were measured with one item asking for their religious preference. The majority of participants reported being Protestant ($n = 24$, 34.8%), Roman Catholic ($n = 20$, 29.0%), or Non-Denominational/Christian ($n = 7$, 10.1%) as their religious or spiritual preference. Among the 69 participants 11 (15.7%) reported some other preference (Native American Religions and Spirituality, Unitarian, Atheist, Agnostic, Hindu, Buddhist, and Other), and 7 (10.1%) reported having no religious or spiritual preference.

Religiosity of MSW students was measured with the TFRS plus one researcher-developed item asking about the frequency of religious service attendance (Chatters et al., 1992). Participants rated their level of religiosity with four items on a Likert scale (1 to 4). Few participants reported low levels of religiosity. The mean score for the four religiosity items was 11.9 ($SD = 3.3$), indicating a somewhat high level of religiosity (Range = 1-16). The mean score on the item measuring the importance of religion was 3.2 ($SD = .92$). Respondents reported a mean of 2.7 ($SD = .95$) to indicate how religious they were. The same mean (2.7) was reported

by participants regarding how often they attended religious service. Participants reported a mean score of 3.3 ($SD = .84$) on the item asking about how strongly spiritually oriented they were. Thus, participants reported a fairly strong spiritual orientation, as well as indicated that religion was important in their lives. The Cronbach's alpha for the TFRS religiosity scale was adequate ($\alpha = .87$), indicating good internal consistency of responses.

Feminist Ideology of MSW Students

Feminist ideology was measured with 20 items from the LFAIS (Morgan, 1996). Items were rated with a Likert scale with response options ranging from 1 (strongly disagree) to 6 (strongly agree). Eight of the items were reverse scored and had to be recoded. The total score of the feminist ideology scale ranged from 1 to 120. Participants, overall, seemed to hold beliefs that were in agreement with feminist ideological views ($M = 88.6$, $SD = 13.0$) with scores ranging from 1 to 6. A couple of the items were rated by participants with an average score that was equal to or greater than 5, and these latter items were those with the highest means. These items included a question regarding the unfair treatment of women throughout history ($M = 5.3$, $SD = .5$) and another regarding the eventual fair treatment of women if everything is left alone ($M = 5.0$, $SD = .9$). The lowest scored item received a mean of 3.3 ($SD = 1.3$), which was an item that asked if women are treated as second class citizens. No item received a mean score that was less than 3, and most of the items received a mean score that ranged between 4.0 to 4.9, which indicates that the majority of participants at least somewhat agreed with feminist ideological principles. Cronbach's alpha for the LFAIS indicated very good internal consistency of items ($\alpha = .90$).

Religiosity, Feminist Ideology and Attitudes toward Teen Pregnancy Prevention

The current study examined the interrelationships among religiosity, feminist ideology, and attitudes toward teen pregnancy prevention. In the present study, significant intercorrelations emerged among religiosity, feminist ideology and beliefs about sex education (see Table 3). The level of religiosity of participants was significant and moderately correlated with a preference for abstinence-only sex education ($r = .384$) and negatively and moderately correlated with a preference for comprehensive sex education ($r = -.357$). Thus, higher levels of religiosity were associated with an increased preference for abstinence-only sex education and a decreased preference for comprehensive sex education. Religiosity and feminist ideology were negatively and significantly correlated ($r = -.356$). Preference for abstinence only and preference for comprehensive sex education was negatively and significantly correlated ($r = -.310$). Thus, as preference for abstinence only sex education increased, preference for comprehensive sex education decreased. Finally, there was also a positive and moderate, significant correlation between feminist ideology and comprehensive sex education ($r = .273$). Therefore, the higher the ratings on feminist ideology, the greater the preference for comprehensive sex education.

Demographic Differences and Summary

As recommended by Rubin and Babbie (2005) independent sample *T*-tests were performed to find out whether there were significant differences between African-American and Caucasian participants, and between advanced-year and foundation-year students regarding the major variables of interest (religiosity, feminist ideology, and beliefs). The present study showed significant differences in levels of religiosity between African-American and Caucasian participants. Prior to computing the *t*-test, race was dichotomized into two categories, namely, African-American and Caucasian, because those were the two ethnicities reported with the

Table 3
Correlation Matrix of Religiosity, Feminist Ideology and Attitudes

Scales	Level of Religiosity	Feminist Ideology	Abstinence Only	Comprehensive	Knowledge
1) Level of Religiosity	---	-.356*	.384*	-.357*	-.099
2) Feminist Ideology	---	---	-.015	.273*	.046
3) Abstinence Only	---	---	---	-.310*	-.016
4) Comprehensive	---	---	---	---	.134
5) Knowledge	---	---	---	---	---

* $p < .01$

greatest frequency. African-American participants reported a significantly higher level of religiosity ($M = 14.1$, $SD = 1.83$) than Caucasian participants ($M = 11.5$, $SD = 3.45$) $t(df) = .008$, $p < .01$. The standard deviation suggests less variability on the measure of religiosity among African-American participants than among Caucasians. No other significant differences on the major variables of interest emerged when comparing advanced-year and foundation-year students. Gender differences were not examined due to the low number of male participants.

In sum, the majority of participants reported that they were either Protestant (34.8%) or Roman Catholic (29.0%) Overall, respondents reported relatively high levels of religiosity ($M = 11.9$) and feminist ideology ($M = 88.6$). Participants indicated a preference for comprehensive sex education (91.3%), and were fairly knowledgeable about condoms and contraceptives ($M = 4.1$). Significant intercorrelations emerged between religiosity and sex education and between feminist ideology and sex education.

CHAPTER 6: DISCUSSION

The current cross-sectional, exploratory study examined views of 69 MSW students on religiosity, feminist ideology, and attitudes toward teen pregnancy prevention. Data were collected with a self-administered survey. The present study attempted to expand the current knowledge on teen pregnancy prevention research from the perspective of potential providers as well as identify variables that may influence attitudes toward prevention. This is the first known study to examine interrelationships among these variables with a sample of MSW students.

Sample Characteristics

The sample for the current study is different from previous studies in several ways. MSW students have a higher overall education level than samples used in previous studies. Also, the current sample may have had more professional experiences with pregnant and parenting teens and with at-risk youth than participants of previous studies. Finally, the current study had a high percentage of females (84.1%) in the sample, as compared with males (13.0%).

The purpose of the current study was to examine interrelationships among variables of interest. Results showed a moderate and positive correlation among religiosity and preference for abstinence-only sex education, and a moderate and negative correlation among religiosity and comprehensive sex education. As religiosity increased, support for abstinence-only sex education increased and support for comprehensive sex education decreased. This is similar to previous research which found that high religiosity of parents was associated with low communication about sex education with their teens (Regnerus, 2005). The current study showed a positive correlation between feminist ideology and comprehensive sex education. As agreement with feminist ideals increased, so did support for comprehensive sex education. This latter finding is

consistent with Pillow's (2003) recommendation for a more feminist approach to teen pregnancy prevention that empowers girls with teens' choices for protecting their bodies (Pillow, 2003).

Results from the current study showed a high level of knowledge about condoms and contraception ($M = 4.1$). The current study also yielded results different from those in previous studies. The level of knowledge among MSW students contrasts with that of research examining the medical accuracy of parents' knowledge, with the current study showing that MSW students have an overall greater knowledge of condoms and contraception (Eisenberg et al., 2004). Although these different studies cannot be compared, the current study suggests that MSW students may have more accurate knowledge of condoms and contraception than less educated samples (e.g. parents of teens).

No significant correlations emerged among knowledge of condoms and contraception and preference for abstinence-only sex education, which is somewhat dissimilar to findings in previous research showing that teens who received abstinence-only sex education were less likely to use protection once they became sexually active due to lack of knowledge about condoms and contraception (Cooksey et al., 1996). MSW students in the current study showed a sound working knowledge of issues around family planning, despite a preference for abstinence-only sex education among those participants who reported high religiosity.

There is some evidence from the current study that MSW students may be able to separate their personal beliefs from accurate knowledge needed for professional practice. The current study showed that African-American MSW students self-reported higher levels of religiosity than their Caucasian counterparts. There was also less variability in the level of religiosity reported by African-American students. However, it is unclear whether the religiosity of African-American MSW students actually influences how they practice. Although religiosity

may be associated with a preference for abstinence-only sex education, and African-American MSW students reported higher levels of religiosity, this does not necessarily mean that they will advocate for any particular type of sex education in practice. MSW students' practice behaviors are beyond the scope of the current study. Practice behaviors are defined as what the MSW students actually do in practice while working with clients (i.e., at their internships). The NASW code of ethics (2008) calls for social workers to practice with competence and with respect for the self-determination of clients. This means that regardless of personal beliefs and values, a social worker must respect the beliefs and choices of clients, as well as to stay abreast of with the most current knowledge available (i.e., best practice) in their field of practice. For the current study, this means that conclusions can be drawn about students' beliefs, but not practice behaviors.

The current study sampled a majority of females ($n = 58, 84\%$), a gender bias that may have contributed to the high levels of feminist ideology that were reported. Morgan's (1996) sample was primarily composed of college undergraduates and participants in a women's studies conference. A portion of the latter sample consisted of participants who were interested in women's issues. The responses on the LFAIS in the current study suggest that the majority of participants were aware of women's issues and largely supported a feminist perspective.

Limitations of the Current Study

As with all cross-sectional studies, there are some limitations that must be noted. One of these limitations is the social desirability bias (Rubin & Babbie, 2005). Data for this study were collected through a self-report survey of MSW students. Although, participation was voluntary and anonymous, participants may have answered the survey in a way that they believed was more desirable. This can mean the responses are less accurate (Rubin & Babbie, 2005).

Another limitation is the small sample size ($n = 69$) of the current study. Due to small sample size, the statistical power of the current study is low (Rubin & Babbie, 2005). This means that results from the survey must be interpreted with caution. The low statistical power of the current study influences the validity of the significant differences found in the data. The risk of making a Type II error is much higher when the power is low (Rubin & Babbie, 2005). A Type II error is a false negative, or failing to reject a null hypothesis. Thus, it is possible that the significant differences that emerged in the current study, were, in fact, the result of low power. Sample size could be increased in future studies by collecting surveys immediately rather than using a drop box, or by supplying a return date on the instrument.

An additional limitation is external validity. Data from the current study were collected from graduate social work students in a university in the South, which is in an area known for being more politically conservative than other states (Healey, 2010). Results from the current study may not be generalizable to MSW students in other regions of the country. Therefore, results may only be generalizable to other MSW students from regions known to also be conservative, such as other Southern states (Healey, 2010). Also, the low response rate makes the results from this study less generalizable to other populations.

There may also have been measurement issues with the instruments used to collect data. Some items may have been interpreted differently by different students. For example, one of the items regarding knowledge of condoms and contraception asked about the participants' knowledge of teens' ability to use condoms and contraception correctly. However, some who responded false to these items may have answered this way, because the question did not indicate whether or not teens have the ability to use condoms and contraception correctly with the proper education to teach them how to protect themselves correctly. Some may believe that teens cannot

use these condoms and contraception correctly, because they are not taught to do so. Other items, such as those comprising the TFRS can be very subjective in the way they are interpreted. Religion and spirituality can mean very different things to different people. For the current study, having a relationship with a higher power was the most important criterion; however, no definitions were provided on the survey. Wording of some of the items, as well as lack of definitions, may have influenced the way participants responded. Future studies that measure religiosity and spirituality should provide definitions of these concepts to improve measurement validity and reliability. Although, the current study yielded an alpha of .87; the scale was administered to a fairly religious sample. Other regions of the country may not find the same levels of religiosity.

In addition to the aforementioned limitations, another issue that must be considered is how the beliefs of MSW students affect practice. Although religiosity was moderately and positively correlated with a preference for abstinence-only sex education and feminist ideology was moderately and positively correlated with a preference for comprehensive sex education, this does not imply that social workers in the current study would advocate for any particular type of sex education due to their personal beliefs. Practice behaviors were beyond the scope of this research. Overall, the preference for comprehensive sex education and the knowledge of condoms and contraception was high among participants. In fact, there was no significant correlation between religiosity and knowledge. Despite participants' preferences for abstinence-only sex education and high levels of religiosity, MSW students displayed accurate knowledge about condoms and contraception. This is different from previous research suggesting that non-professionals may not make this distinction, because they do not have to (Eisenberg et al., 2004).

Also, one cannot assume that MSW students will advocate for evidence-based teen pregnancy prevention approaches just because of their beliefs and knowledge.

Strengths and Contributions to the Current Literature

Despite limitations of the current study, there are also some strengths. One of the strengths of the current study is that a different sample was surveyed: MSW students and social workers have not been sampled in previous studies of attitudes toward teen pregnancy prevention. The current study examined interrelationships among religiosity, feminist ideology, and attitudes toward teen pregnancy prevention, which has not been studied among MSW students, despite social workers' commitment to children and families and healthy psychosocial development.

Another strength of the current study is the combination of variables. Literature on teen pregnancy that has examined the interrelationships among religiosity and feminist ideology studied either one or the other (Pillow, 2003; Regnerus, 2005). The current study examined both religiosity and feminist ideology, as well as the attitudes toward teen pregnancy prevention. The current study sheds light on attitudes toward teen pregnancy prevention, as well as two different variables (i.e., religiosity and feminist ideology) that, in current literature, have shown to influence preferences for different teen pregnancy prevention approaches in different ways (Pillow, 2003; Regnerus, 2005).

Additionally, a third strength is the internal consistency achieved with major measures. In the current study the TRFS yielded an alpha of .87, which is considered to be adequate, and the LFAIS had an alpha score of .90, which is considered good (Rubin & Babbie, 2005). Both measures showed good internal consistency when used with the current study sample, suggesting that these latter measures are reliable when used to examine MSW students' religiosity and

feminist ideology, which is consistent with results obtained both by Ai et al (2005) and Morgan (1996), respectively.

Finally, the current study contributes to current literature by providing a description of the beliefs and knowledge reported by MSW students in a substantive area not previously studied with this sample. Many of the students surveyed will soon be practicing as social workers, and some have already had experience in the field of social work. Some of these MSW students have already, or may at some point, work with pregnant and parenting teens or at-risk youth. The knowledge of MSW students affects their work with these populations in that MSW students will be better equipped to practice competently. For example, a social worker who works in a school-based health center will need to have medically accurate knowledge of condoms and contraception. In the current study, knowledge about condoms and contraception was high among participants. It is important for MSW students to receive proper education and skills training to prepare them for best practice as social workers.

Conclusions

In sum, significant findings emerged among variables of interest (religiosity, feminist ideology, and attitudes toward teen pregnancy prevention). These findings were similar to those reported in current literature on teen pregnancy prevention (Pillow, 2003; Regnerus, 2005). There were also some dissimilar findings, such as the level of knowledge reported by MSW students, as compared with knowledge reported by previous samples, such as parents of teens (Eisenberg et al., 2004). In addition to major findings, an independent samples *T*-test showed that African-Americans reported higher levels of religiosity than Caucasians. There were some limitations noted, in particular, the low response rate, small sample, and measurement issues.

Finally, the current study contributes to current literature on knowledge and beliefs of MSW students regarding teenage pregnancy prevention.

The current study provides a foundation for future research on teen pregnancy prevention and social work. This study could be replicated with a larger sample, and could also be expanded to include undergraduate social work students. A nationwide survey of social work practitioners could be conducted as well in order to enhance generalizability of findings about attitudes and actual practice behaviors in the area of teen pregnancy prevention. Future research could examine the ethical issues in relation to actual practice behaviors, and whether beliefs influence how social workers practice, including the type of sex education taught. Finally, future research could examine whether social workers actually advocate for evidence-based practice in the provision of sex education from a policy perspective.

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VITA

Pilar Adrienne Thompson Borne was born in Tucson, Arizona, in 1981 to Kristine and Stiles Thompson. Pilar spent most of her childhood in Niceville, Florida, from the ages 4-16. Pilar had a son at the age of 16, which is a major, personal reason she has become interested in teenage pregnancy research. Pilar finished high school in Tucson, Arizona, and spent her freshman year of college at Arizona State University.

After moving to Baton Rouge, Louisiana, in 2001, Pilar got married and took time off from school to start a family. She had another son and a daughter. Pilar returned to school in 2006 and completed a Bachelor of Science in psychology at Louisiana State University in 2009. She then immediately returned to school at Louisiana State University to pursue a Master of Social Work, and will graduate in 2011. After graduation, Pilar will pursue her longtime dream of becoming a counselor. Pilar is interested in working with youth and families, as well as continuing her research interests.