

Crisis Pregnancy and Pregnancy Decision Making: An Outline of Influencing Factors

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RESEARCH

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1.0 Introduction

1.1 Aims of document

This document aims to review research literature in order to:

- outline and describe the factors that have been demonstrated to affect the level and incidence of crisis pregnancy
- examine the factors that affect a woman's decision when faced with a crisis pregnancy.

It is expected that solutions to the problem of crisis pregnancy will be suggested by each of the factors identified. It is important to note that this document does not aim to review all of the literature in the field of crisis pregnancy; rather it aims to describe the range of factors commonly identified in the literature and to illustrate these factors with examples from research findings.

1.2 Function of document

This document serves a number of functions. These include:

- To provide a working document as a basis for debate, consultation and action. This will be achieved by describing and structuring our knowledge in the area, and opening up the complexity of the field by specifically addressing how contributory factors interrelate in the lives of women and their partners.
- To generate a comprehensive representation of the causes of, and factors related to crisis pregnancy, so as to develop effective interventions that accurately reflect the reality of crisis pregnancy.
- To inform the development of a theoretical and conceptual framework, through consultation, from which crisis pregnancy can be addressed and understood more coherently. This will involve exploring our assumptions about sexual behaviour and pregnancy decision making.
- To explore the relative extent to which Irish data contributes to our evidence base and to identify where information gaps exist in the Irish context on both of the above aims. Gaps in our evidence base, or uncertainties as to how data from other countries translate into the Irish context will feed into the development of the Crisis Pregnancy Agency's research framework.

1.3 Structure of document

This document comprises two main sections:

- The first section attempts to outline key research findings that provide an understanding of the origins of the problem of crisis pregnancy. An understanding of the origins of the problem automatically lends itself to suggestions for prevention.
- The second section of this document deals with the issues women and those close to them confront when faced with the reality of a crisis pregnancy. This section aims to outline the main reasons why women respond differently to crisis pregnancies and how they can be better supported in their chosen course of action.

1.4 Methodological Approach

The research that provided a basis for this overview was collated using numerous data collection methods:

- Literature searches were conducted on electronic databases (e.g. PsychInfo) and university catalogues using terms such as 'crisis pregnancy', 'unplanned pregnancy' and 'unintended pregnancy'.
- In order to access Irish data (especially the grey (unpublished) literature) letters were sent to university departments, government departments, health boards, research institutes and libraries, requesting them to forward research contacts and publication details of any Irish research known to them. Out of 201 letters posted, a total of 53 responses were received. Fifteen contained details of further relevant research contacts and twenty contained details of relevant research papers, reports and other data sources.
- Bibliographies of collated literature were scanned for further references.

The following document is based on a review of these selected reports, papers, book chapters and unpublished documents. It is intended that this document will serve as a 'working' document, to be refined and embellished over time, as new data and research insights develop.

Before the findings are outlined, a brief summary of crisis pregnancy in Ireland will be presented, so as to root research findings in the Irish context.

1.5 Crisis pregnancy in Ireland: births, abortion, adoption and contraceptive practice

The Statutory Instrument under which the Crisis Pregnancy Agency was established defines 'crisis pregnancy' as a "pregnancy which is neither planned nor desired by the woman concerned, and which represents a personal crisis for her". This definition can, on occasion, include women for whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances. It is interesting to note that the literature on crisis pregnancy does not address this aspect of crisis pregnancy, and deals mainly with pregnancies interpreted as crises from the outset.

An estimate of the number of crisis and unplanned pregnancies is difficult to gauge without nationally representative survey data or data generated from maternity services. Indicators employed to gauge the incidence of crisis pregnancy are inaccurate and of questionable validity. Greene, Joy, Nugent and O'Mahoney (1989) surveyed 100 married and 100 unmarried women in Dublin attending their first antenatal visit. The authors attempted to examine the extent to which pregnancies were planned and unplanned; they also examined contraceptive use. Greene et al. (1989) found that 89% of single women did not plan their pregnancy and 20% of married women did not plan their pregnancy. There was no significant difference in employment or educational levels between planners and non-planners. The authors did not examine the extent to which unplanned pregnancies were experienced as crisis pregnancies.

It is more common for the number of births outside marriage to be employed as a crude measure of unplanned pregnancies. It is important to recognise that not all unplanned pregnancies are crises, neither are births to unmarried mothers necessarily unplanned or experienced as a crisis. Abortion data from the UK, indicating the number of abortions among women giving Irish addresses, is employed as an arguably more valid measure of crisis pregnancy. Knowledge of the reliability of Irish abortion figures (representing the numbers of women giving Irish addresses in UK abortion clinics) and how they are constructed is poor. Despite these limitations, both of these indicators suggest that the amount of women having unintended and crisis pregnancies is increasing.

1.5.1 Births

The number of births to unmarried mothers is indirectly proportionate to age, meaning that the greater proportion of non-marital births is to women under the age of 25. It is important to stress that births to women in this age group are not necessarily experienced as a crisis. Mahon, Conlon and Dillon (1998) provide an interesting example of these trends. In 1957 there were 1,033 births to women aged under twenty years, but only 26% of these were outside marriage. In 1995 there were 2,482 births to women under twenty years and 95% of these were outside marriage. While the actual number of births had more than doubled, the proportion of non-marital births had increased dramatically. In 2000, 31.2% (17,094) of all births (54,789) were outside marriage.

Fahey and Russell (2001) concluded that the importance of marriage in family formation in Ireland is less dominant and clear cut than it once was. Marriage rates in the Irish Republic have fallen and, as suggested above, much family formation takes place outside marriage. However, it is interesting that recent years have seen a surge in marriage rates with a 23% rise from 1997 to 2000.

1.5.2 Abortion

With respect to abortion data, the number of abortions has also been steadily increasing over time. In 1991 there were 4,154 abortions performed on women in UK clinics who supplied Irish addresses. In 2000 this figure was 6,391.

A consistent trend is that the greatest numbers of abortions occur for women between the ages of 20 and 24 years. In 2001, out of a total of 6,673 abortions 2,402 (36%) were to women within this age range.

The greatest proportion of abortions, with respect to the total number of pregnancies, occurs within the 20-24 age range and to women under twenty years of age. Approximately 22% of all pregnancies within these age ranges in 2000 ended in abortion. This contrasts with 11% of all pregnancies aborted in the 25-29 age range. It is important to point out that this percentage again jumps to 20% of all pregnancies aborted for women aged 45 and over in 2000. These are relatively stable patterns.

Small-scale studies exploring the characteristics of Irish women seeking abortion in the UK reveal fairly consistent patterns (see Dean, Walsh, O'Hare and McLoughlin 1985, Burke 1983 and Walsh 1979). Contrary to popular opinion and media stereotyping, abortion and crisis pregnancy are not experiences specific to unmarried teenagers. Age group and the predominance of urban origins (mainly Dublin and Dun Laoghaire

(see Dean et al. 1985)), suggest that it is young women in their twenties, of urban origin, who seek abortions in the UK. Analysis of geographical trends is required on recent abortion data in order to examine if trends found in the 1980s are stable.

Furthermore, the process and issues facing women when asked for a home address in UK clinics need to be examined with respect to how abortion figures are constructed. Jackson (1989) pointed out that the number of women seeking abortion who have already had a previous abortion increased from approximately 3% in 1980 (Burke 1983) to between 10% and 11% in 1983 (Dean et al. 1985). It is possible, however, that different sampling frames may account for this disparity.

1.5.3 Adoption

The number of Irish babies placed for adoption with non-family members has reduced dramatically over the last number of decades. The number of Irish babies adopted in 2001 was 81. This represents 0.45% of all births outside marriage. This figure contrasts sharply with data from the 1960s and 1970s. In 1967 the number of adoptions was 1,493, which represented 97% of all non-marital births. In 1977, 39% of babies born outside marriage were adopted. It is clear that adoption is no longer seen as an expected or real solution to crisis pregnancy, as it once was. The decline in the number of women having their babies adopted suggests that more and more unmarried women are choosing to keep their babies. However, as Jackson (1989) argued, this is not the case when one compares the ratio of abortion to unmarried births among single women. Jackson presents the ratio of unmarried births to abortions. In 1971 approximately three unmarried births occurred for every abortion. By the end of the decade, among unmarried women, for each birth there was one abortion. Therefore, these ratios suggest that while adoption has become an unpopular solution, abortion is now equally as common as having one's baby outside marriage for single women. The reasons behind a woman's decision to have an abortion or adoption are varied and complex, as are the socio-cultural changes that give rise to these trends. Section 3.0 addresses some of the factors related to these decisions.

1.5.4 Contraceptive behaviour

Since the 1970s, when the use of contraception was formally legalised in the state, there has been a considerable reduction in overall birth rates. This decline has been attributed to a decline in overall family size and the fact that women are deciding to have their babies later (see Courtney 1995). Comparison of contraceptive practice over time is hindered by a lack of data due to the fact that contraception was illegal until 1979. One of the first Irish surveys, before legalisation of contraception, asked women (married only) about their family planning practices. This was carried out in 1973 (Wilson-Davis 1974). Wilson-Davis found that a large proportion of married women were knowingly (54%) or unknowingly (16%) planning their families. Over three-quarters of the sample used natural family-planning methods. Among those using artificial methods, the pill was the most common. Family planning was found to be a function of occupational class with 'higher status groups planning more than the rest'. It was pointed out that 68% of white-collar workers were family planners versus 37% of the agricultural group. Family planners were also younger than non-family planners, and concentrated in the 25 – 34 age group. The majority of family planners admitted that their knowledge was lacking and that they would like more information.

A number of studies since have explored the contraceptive practices of women, married and single, in Ireland. A national survey of women's health in 1993 found that single sexually active women were more likely than married women to use contraception (Wiley and Merriman 1996). One third of married women did not use any form of contraception compared with only one in ten of single women. In addition to this national study there have been a number of small-scale studies examining use of contraception among women who have had unintended pregnancies. Generally, this work has documented low levels of contraceptive use. Mahon et al. (1998) found that 61% of 88 Irish women seeking abortion in the UK claimed to have used contraception.

It is important to recognise that social desirability may have affected women's responses whilst being interviewed. Social desirability, and not wanting to appear negligent or irresponsible, is always a factor that confounds such data, particularly in interviews. Francombe (1992) in his study of Irish women seeking abortion in the UK found that only 24% of women had been using some form of contraception at the time of conception and that married women were more likely to use contraception than single women. (Only 12% of single women were using contraception.) The main reason offered by women who were not using contraception was that intercourse had been unexpected. Among married women the most frequent reason given for non-use was 'side effects' (33%). 27% of the married sample also mentioned unexpected intercourse. Dean et al. (1985) found that 20% of a sample of Irish women seeking abortion had used contraception and only 63% had ever used contraception.

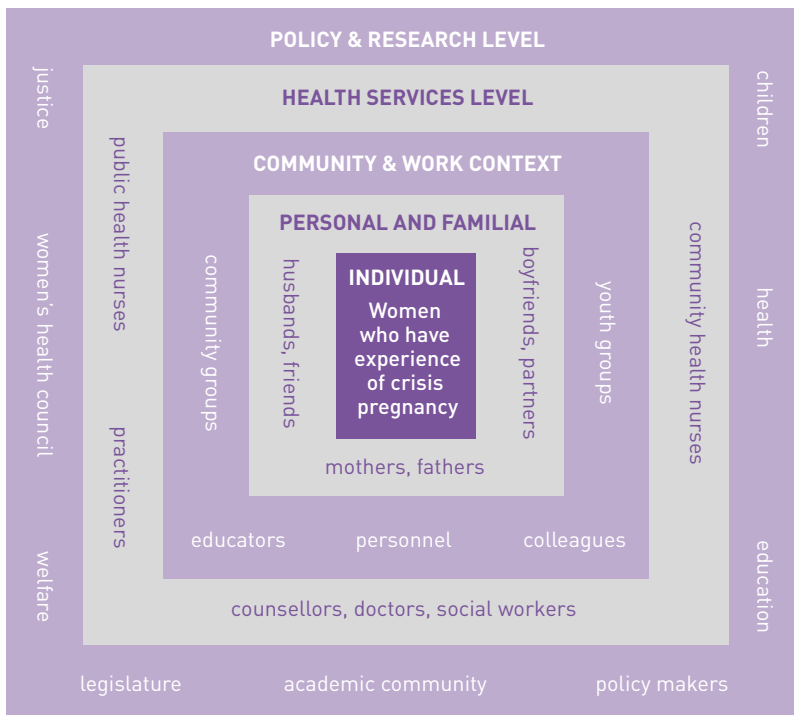
This pattern of low levels of contraceptive use has been replicated by other Irish research; see for example, Greene et al. (1989), Richardson (1991), Riddick (1993) and O'Shea (1990).

2.0 Crisis pregnancy: causes and influencing factors

The main question that has preoccupied researchers trying to understand and prevent crisis pregnancy has been: ‘why do couples have unprotected sex when they do not what to become pregnant?’. This is also a question that many policy makers have been attempting to answer in an effort to inform policy, reduce the rate of crisis pregnancies and provide the necessary supports for women in crisis.

What is clear from the literature is that a multiplicity of factors is related to unintended pregnancy. In order to distinguish between these factors, it is useful to categorise them according to their level of analysis: namely, the individual, the relationship, the contextual, the situational and the service level.

Figure 2.1 Levels of analysis of factors affecting crisis pregnancy



For example, psychological factors (e.g. attitudes, risk taking) that are independent of the situation have been purported to account for unplanned/unintended pregnancy. In addition, situation-specific factors such as the role of alcohol have also been purported to affect levels of unintended pregnancies. The social dimension is crucial to understanding sexual behaviour. This is evidenced in the contextual and relationship levels, where partner, peers, parents and people in general, play a critical role in determining what individuals think and do and how they attach meanings to behaviour. Therefore, relationship factors associated with the nature and type of sexual partner involved are important when trying to understand sexual behaviour and contraceptive decisions, as are contextual factors (e.g. parental influences, social and gender norms). Finally, service level and policy factors have also been found to be relevant when trying

to understand aspects of the wider context and its influence on sexual behaviour. A diagram representing these levels of influence is presented above.

It is important to recognise that the factors relating to unintended pregnancy, described above, are not mutually exclusive. They all relate to, and affect each other in different ways and to different degrees, depending on the circumstances. For example, policy-level factors, such as how social, personal and health education, (including relationship and sex education) is structured and resourced, have a direct effect on service-level factors (quality of education and who teaches it). This in turn may affect how a young person learns about what to expect to happen to them, physically and emotionally, when they are growing up. Aspects of alcohol advertising in the media may directly affect the associations people have with drinking alcohol, (e.g. positive rather than negative) which may play a role in endorsing and sanctioning alcohol consumption. Also, alcohol consumption results in loss of inhibitions which, in turn, can lead to crisis pregnancy. Alcohol consumption is also informed by cultural and societal norms, which interact with one another. The above diagram attempts to illustrate how these different levels of analysis may interrelate with respect to individual knowledge and attitudes which are thought to influence behaviour.

Before the factors operating within these levels are described in greater detail, it is important to outline a number of observations and qualifications with respect to the literature on crisis pregnancy.

a) Literature searches on electronic databases (e.g. PsychInfo) reveal that a recurrent theme in the field of crisis pregnancy is the effectiveness of contraceptive use, as opposed to any other aspect of sexual behaviour. Table 2.1 below serves to give an indication of the range of research questions and themes within the field of crisis pregnancy. The primary focus of this literature is on examining and attempting to explain the factors that predict effective use of contraception. Knowledge of these factors is crucial in order to understand and prevent unintended pregnancy. This assumption is backed up by research described in the last section demonstrating that many women with crisis pregnancies had not used any method of birth control at the time of conception. This research tends to be primarily conducted with teenagers or college students.

Table 2.1 Research areas covered in literature addressing crisis pregnancy

Research Area	Description
Contraception	Knowledge of contraception and attitudes towards it. Who uses contraception and what forms do they use? What predicts the use of contraception? Decision making. How best to teach and promote contraceptive use among sexually active people who don't want to become pregnant.
Teenage pregnancy	Factors that predict it. How best to prevent it.
Emergency Contraception	Its use, effectiveness and predictors of its use.
First intercourse	Predictors of this.
Teenage mothers	Needs of / supports for teenage mothers.
Pregnancy decision making	How women make decisions when faced with a crisis pregnancy.
Abortion	Predictors of abortion. Counselling and care post abortion.
Family planning services	Users and provision of family planning services.
Risk behaviour	Risk models explaining sexual risk-taking behaviour.
Pregnancy and contraception	Health implications of pregnancy and contraception.
Adult women and sex	Behaviour of non-adolescent samples.

b) As the importance of 'teenage pregnancy' as a social and political phenomenon has increased in recent years, so too has the volume of research detailing the causes of, and preventative solutions to teenage pregnancy. There are two main problems with literature in the field of crisis pregnancy.

Firstly, there is an assumption that crisis pregnancy is a teenage problem. As already described, Irish data reveals that crisis pregnancy and abortion are much more common among women between the ages of 20 and 25. Irish rates of teenage pregnancy have not increased significantly over the last twenty years. What has changed is the proportion of teenage births outside marriage. Various policy documents have identified the issue of teenage pregnancy as cause for concern (e.g. Developing a Policy for Women's Health [Department of Health] or The Voice of Women [Southern Health Board]). However, there is an obvious lack of research seeking to explain the factors relating to risky sexual behaviour of women other than teenagers.

Secondly, one factor that tends to be ignored in the literature on teenage pregnancy is motivation to become pregnant and have a baby. Most research on adolescents assumes that young women are not motivated to become mothers. Research on teenage pregnancy in the US, UK and in Ireland demonstrates that there may be powerful forces favouring pregnancy among some girls. These forces can operate on different levels. For example, Adler and Tschann (1996) found evidence to suggest that not all adolescents think the same way about the idea of becoming pregnant: some associated pregnancy with positive outcomes, and others did not. Research using small samples or case studies of young pregnant women demonstrates that pregnancy in adolescents may be motivated by the hope of achieving adult status, prestige or autonomy, or by a desire to demonstrate love for a partner. There may also be pressure on women from others, such as a partner who wants a baby.

Dempsey, Heslin and Bradley (2001) conducted the first Irish study designed to describe the spectrum of attitudes and experiences that make up teenage pregnancy. They found that reaction to the news of being pregnant was dependent on the status of the couple relationship and the relationship with parents. Age, goals and ambitions, whether the pregnancy was unwanted or wanted, the individual's sense of self-worth, and the practical implications of having a baby were also important in determining how the news was received. Some participants responded to the news positively and saw it as a positive direction in their lives. Finlay (1996) produced similar findings in his work with teenage parents in Northern Ireland: he found that adolescent mothers who had an unplanned pregnancy did not exclusively experience an unwanted baby. Factors relating to the age of the person will be further outlined in the following section.

c) Research in the area of crisis pregnancy and pregnancy decision making is mostly unconcerned with theory and, at best, could be described as mildly 'social psychological' in nature. No coherent theoretical framework has been employed consistently either to develop research designs or to interpret research findings. Additionally, a broad range of methodologies, analytical approaches, and sampling frames has been employed to examine different factors and their role in crisis or teenage pregnancy. For these reasons research findings are difficult to compare and often conflicting. It is the aim of this report to document what this research, in all its complexity, has to say about the origins of crisis pregnancy and women's pregnancy decisions. It is also the aim of this report to attempt to examine the kinds of theoretical frameworks that are best placed to enable understanding of reproductive decisions and behaviour. As this report serves as a working document, it is anticipated that the story that emerges will change and develop as new observations are made and data becomes available.

The rest of this section outlines the range of factors, at different levels of analysis, that affect sexual behaviour, contraception usage and pregnancy outcome.

2.1 Psychological factors

Psychological factors, specific to the individual, have been found in many studies to differentiate between an individual's use of contraception and pregnancy outcome. For example, an individual's attitude towards using contraception and their knowledge of how to use contraception affects actual use and efficacy of contraceptives. The range of psychological factors documented in the literature has been summarised in table 2.2. Age, gender and socioeconomic status (SES) have been found to differentiate between some psychological variables and will be referred to where evident. It is important to bear in mind that psychological factors cannot be considered in isolation. The interaction between the following factors and other levels of analysis will become clearer as the document progresses.

Table 2.2 Psychological factors associated with sexual behaviour and use of contraception

Demographic factors: age, gender, and SES
Knowledge of contraception/pregnancy and sexually transmitted infections (STIs)
Attitudes and intentions
Thought processes e.g. optimistic bias, denial of risk
Self-esteem, communication skills and condom negotiation

The following factors will be described in more detail in the next section: age and risk factors associated with teenage pregnancy; knowledge of contraception; attitudes and intentions; thought processes; self-esteem and condom negotiation.

2.1.1 Age-related risk factors associated with crisis pregnancy

As previously mentioned, there is a clear bias in the literature dealing with crisis pregnancy, in that it deals mainly with teenage pregnancy. The difficulty with this literature as a whole is that it does not use comparison groups (e.g. older women/men). It is therefore difficult to explore the extent to which findings from this body of work are specific to young women and men (under twenty years of age) and whether or not they can be extrapolated to older populations. However, it is clear that age is an important factor to consider when exploring the range of factors related to crisis pregnancy. The following section will outline some of the risk factors associated with crisis pregnancy among young women.

Research suggests that some sexually active teenagers are more at risk of pregnancy than others are. Risk factors include: social and economic risk factors, educational risk factors such as low achievement and low educational aspirations, risk-taking behaviour (alcohol and drug use), and specific social demographic characteristics found to be predictive of teenage pregnancy (sexual abuse, children of teenage mothers, children in care). These factors are outlined in table 2.3 below.

Table 2.3 Risk factors associated with teenage pregnancy

Psychological/demographic factors	Poverty and low SES Low self-esteem Early onset of first intercourse Low educational attainment and school non-attendance/alienation. Low knowledge levels.
Situational factors	Alcohol and drug use Access to contraception; cost, norms
Vulnerable or special groups	Low achievers and those with low educational aspirations. Children in care Sexually abused children Children of teenage mothers Those with mental health problems Those with a history of offending behaviour Siblings who had teenage pregnancies

Unprotected early sexual activity is often associated with low expectations, low educational attainment and low educational aspirations. This was outlined clearly in a British report by the Social Exclusion Unit (1999) and is related to a point made earlier about young women's motivation to become pregnant. A common finding in industrialised countries is that teenage pregnancy is more common among young people who have a disadvantaged childhood and whose educational and employment expectations are low. Low achievement can occur as a direct result of pregnancy, which may mean that a young woman is unable to finish education. However, growing evidence appears to suggest that many young women disengaged from education and were low achievers prior to pregnancy (Phoenix 1991, Selman, Speak, Richardson and Hosie 2001). For these women a risk of pregnancy does not pose a threat to their futures, as they are perceived to be limited from the start.

Another consideration specific to adolescents and risk of pregnancy, is cognitive developmental concerns with respect to whether young people are capable of making fully informed and rational decisions. Brooks-Gunn and Firstenberg (1989) identified social cognitive ability as a potential perspective for understanding adolescent sexual decision making. Several authors have identified aspects of adolescent reasoning (e.g. formal operational thinking) as relevant to decision making about contraception. For example, Richardson (1993, 2000) found that the ability of young Irish mothers to link sexual activity with the possibility of becoming pregnant was limited. Evidence has been

found to suggest that teenagers see themselves as immortal and immune to danger (Robinson 1988). US researchers Johnson and Greene (1993) found evidence to suggest that age and cognitive functioning (e.g. the ability to take more than one perspective) are related to better decision making about contraception. Clearly age, and its associated risks, is an important variable to consider when exploring the range of factors related to crisis pregnancy.

From the above table, it can be seen that there is a good degree of overlap between the range of factors that contribute to unplanned pregnancy for all women. It is important to state that factors related to unplanned adolescent pregnancy are also generalisable to older women. These factors include access to contraception, inadequate knowledge, obstacles to using contraception and a lack of communication or interpersonal skills needed to negotiate the use of contraceptives. Factors not specific to adolescents are discussed in the remaining sub-sections.

2.1.2 Knowledge

It is well documented that knowledge is an important factor in safe sexual practices. However, research has demonstrated that high knowledge levels do not reduce risk-taking behaviour. Knowledge is but one important factor in explaining sexual behaviour and risk of pregnancy. The following points aim to summarise some of the research findings, which examine the relationship between knowledge and unsafe sex and unintended pregnancy.

- Ireland has no nationally-representative data on sexual health knowledge levels. Several small-scale studies have documented that overall levels of knowledge are poor among women and men who have had unsafe sex, or who have experienced unplanned pregnancy or abortion. Fitzpatrick, Fitzpatrick and Turner (1997) surveyed 120 adolescent patients at an antenatal clinic in Dublin. They reported that only 39% knew correct times of maximum fertility and that in general knowledge of contraception was lacking in the group. This finding is complemented by data revealing a strong demand for information on contraception and sexuality among Irish men and women (see Smith 1996). Similar findings have been found in the UK.

For example, Houghton (1994) compared knowledge of contraception among a sample of abortion seekers with that of other pregnant and non-pregnant women in London. She found that contraceptive knowledge in the study population was less than adequate. Her findings were similar to other UK research findings (see also Duncan and Harper 1990, Bromham and Cartmill 1993, Brook 1991).

- In the US, a study by Morrison (1989) attempted to discriminate between effective contraceptive users and non-effective users of condoms among sexually active fifteen to nineteen-year-old women. Morrison (1989) found effective users of contraception were no better informed than non-effective users. Morrison (1989) found that ineffective contraceptive users have earlier first intercourse than effective users and actually had a greater knowledge of contraception. Such evidence strongly suggests that contraceptive knowledge is just one of several factors that affect the risk of unwanted pregnancy. The fact that a relatively high level of knowledge does not stop women from risking unwanted

pregnancy suggests that the relationship between risk factors is a complex one; a poor level of knowledge is unlikely to be an independent risk factor.

- Studies examining levels of knowledge tend to reveal that men's knowledge and awareness of contraception (and fertility and STIs) is poorer than women's of the same age. A survey of 1,654 pupils (sixteen to eighteen year olds) in the Midland Health Board region (Bonner 1996) revealed that only 25% of males (and 51% of females) knew the most likely time to become pregnant. Some studies reveal knowledge differences between people from different socioeconomic backgrounds. Houghton, however, found that the relationship between social class and level of contraceptive knowledge is not likely to be a causal relationship, but that ethnic or cultural background is the determinant of levels of contraceptive knowledge.
- Poor knowledge has been associated with poor sex education in school or lack of comprehensive sex education in school. Research findings have indicated that poor sex education can result in the following:
 - poor knowledge of fertility
 - poor knowledge of reproductive health
 - poor knowledge of contraception
 - poor knowledge of STIs
 - poor knowledge of services.
- Poor sex education has been found in some studies to be associated with earlier onset of first sexual intercourse. Research in Finland (Kontula and Rimpela 1988) found that students with higher level of general knowledge had a higher level of sexual knowledge. An increased level of educational attainment has also been significantly related to a higher age of first sexual intercourse (Kane and Wellings 1999) and more effective use of contraception (Morrison 1985). This data underlines or further reinforces the link between educational aspirations and attainment, knowledge and behaviour.

Literature reviews being commissioned by the Crisis Pregnancy Agency on the role of education and best preventative practice will facilitate elaboration of educational factors in the prevention of crisis pregnancy.

2.1.3 Attitudes and intention

Literature examining attitudinal factors and unsafe sex tends to indicate that attitudes play a part in predicting contraceptive behaviour. The attitudes that tend to be studied are: attitudes toward condom use (e.g. an aversion to condoms because they are seen to reduce sensation), attitudes toward the pill (e.g. a dislike of the pill because of the side effects) and attitudes toward sex. It is important to note that attitudes are strongly influenced by the social and cultural context. This includes peers, parents, significant others and the media.

Theorists examining the relationship between attitudes and unsafe sex traditionally adopt rational models, such as the Health Belief Model and the Theory of Reasoned Action. These approaches to understanding contraceptive behaviour assume that attitudes toward safe sexual practices are partly determined by a simple cost-benefit analysis of safe and less-safe behaviours. Other variables deemed to be important in

these models include behavioural intentions, perceived risk and vulnerability, social norms and self-efficacy. Intention to use contraception, in particular, has been cited as an important factor leading to safe sex behaviour (e.g. Baker, Morrison, Carter and Verdon 1996). Lack of an intention to use contraception can be attributed to a number of factors: for example, lack of knowledge, lack of availability, and the belief that normal behaviour involves unprotected sex. There is a lack of research in Ireland examining the interrelationships between these variables.

The following points illustrate some of the findings in this field:

Attitudes towards condoms: Richards and Van Der Pligt (1991) found that attitudes towards condom use among adolescents in the Netherlands played an important role in determining frequency of condom use. Also important were the type of relationship (monogamous or casual) and self-efficacy. The latter two variables are described in subsequent sections of this document. In the US Morrison (1989) found that knowing an individual's attitude towards contraception, intercourse and sex roles, (and their knowledge of contraception) increased the ability to predict contraceptive behaviour. Demographic factors such as SES, race and religiosity failed to contribute to the prediction. Young heterosexuals have also been found to have negative attitudes toward condoms, arguing that they reduce sensation and interrupt sex (Morrison 1985). Research in the UK (Gold, Karmiloff-Smith, Skinner and Morton 1992) found that this belief was very much stronger in males than in females.

Side effects: Mahon et al. (1998) found that women often rejected using the pill because of their negative attitudes towards its perceived side effects. The pill was perceived to cause negative side effects such as weight gain, crankiness and mood swings. Boyle (1991), when examining Northern Irish women's contraceptive practice, also found that perceived side effects were associated with young women's failure to continue with the prescription for the pill. Greene et al. (1989) found that 65% of their married sample using the pill had health concerns about it. It is likely that public health issues, such as the 1995 'pill scare', contribute to these fears. The pill scare originated when the British Committee on Safety of Medicines informed its doctors that the third-generation low-dose contraceptive pill was linked with an increased risk of death, due to deep vein blood clots.

Religiosity: Although recent research appears to have neglected the link between religiosity and attitudes toward contraception, there is evidence to suggest that religiosity and traditional sex-role attitudes are related to negative attitudes towards contraception. Fine-Davis (1983) found that religiosity was correlated with attitudes toward contraception in a survey carried out on 420 male and female Irish people in the late 1970s.

A construct related to attitudes, and also important in explaining contraceptive behaviour, is self-efficacy. In order to discuss, request or insist on protected sex, it is necessary for women (and men) to have the self-esteem, confidence, and skills to use condoms. This factor has been found to be particularly important for women, and more so young women, who do not have a monogamous relationship.

2.1.4 Self-efficacy, life skills and negotiating skills

Self-efficacy is concerned with people's beliefs that they can exercise control over their motivation and behaviour (see Bandura 1989). Self-efficacy is thought to be related to certain health behaviours. It is thought that self-efficacy is an important condition for behavioural change to occur; therefore it is an important factor in preventative planning. Self-efficacy concerns having skills and a belief in one's ability to exercise personal control over one's fertility and sexual behaviour. Self-efficacy has also been studied by researchers using different terminology. For example, self-efficacy is a similar construct to perceived behavioural control employed in models such as the Health Belief Model and locus of control, often employed when examining individual differences.

The relationship between self-efficacy, self-esteem and the ability to have the confidence and skills necessary to negotiate the use of condoms is an under-researched subject in the Irish context. Mahon et al. (1998) found that effective contraception was compromised when women feared objections from their partners or when they feared that insisting on the use of contraception would threaten the relationship. It is inferred from data such as this that self-efficacy plays a role in the ability to negotiate condom use. While studies like this, and practitioners working in the field, suggest that skills and self-efficacy are important, these constructs have not been directly studied. Research internationally has noted that young people who have higher educational achievements and aspirations also have higher self-esteem and a feeling of control in their lives, instead of simply, 'accepting fate' (Hosie 2002). Sex education programmes found to be most successful are those that tackle the issues of self-esteem and aspirations from an early age (Cheesbrough, Ingham and Massey 1999).

Some teenagers have poor negotiating skills and there can be embarrassment when talking about sex and contraception with partners. In order to propose the use of contraceptives, it is vital that young people can talk to their partners about sexual matters, without feeling embarrassed (Morrison 1985).

Research also suggests that the relationship between self-efficacy and the use of condoms may be gender specific. Richards and Van Der Pligt (1991) found that self-efficacy was an important factor in explaining girls' use of condoms, particularly girls without a monogamous relationship. The same was not true for boys: self-efficacy is not an important determinant for boys' use of condoms.

2.1.5 Thought processes

The possibility that some self justifications for having unprotected sex relate to thought process during sexual relations suggest that researchers need to address the mental state and cognitive processes that occur during such encounters. Feelings, thoughts and desires during sexual encounters are as important to address as those formed in the cold light of day when deciding to have unprotected sexual intercourse. The main thought processes affecting contraceptive behaviour identified in the literature are as follows:

- unrealistic optimism
- fertility denial
- destiny dependence.

Unrealistic optimism: Weinstein (1980, 1984) documented that most people believe they are less vulnerable than their peers to negative events and found this to be evidence of unrealistic optimism in risk perception. Perceptions of risk play a role in various behavioural models discussed earlier. There is evidence of unrealistic optimism in some individuals' risk perceptions of pregnancy. This has been documented by Irish researchers (e.g. Greene et al. 1989, Richardson 1991, Hyde 1996) and others (e.g. Gold et al. 1992). Hyde (1996) interviewed Irish mothers in a Dublin antenatal clinic and found that younger women were more likely to believe that an unplanned pregnancy would never happen to them. Hyde (1996) cited the work of Rynne and Lacey (1983) who found that 78% of 249 unmarried Irish women worried only a little or not at all that they might become pregnant – although most did not want to become pregnant. Unrealistic optimism was also found in some of the women interviewed by Mahon et al. (1998). These authors found that some women felt that the risk of them conceiving was diminished if they had previously had unprotected sex without becoming pregnant.

Fertility denial: It has been found that some women perceive themselves to be infertile. Hyde (1996) found in her interviews that fertility denial was more common among younger women with low SES backgrounds and low educational attainment. Greene et al. (1989) also found that some women fostered a psychological attitude of denial and wishful thinking that led them to feel that it would be impossible for them to become pregnant. Greene et al. (1989) found that a psychological attitude of denial was present among 41% of single women, as opposed to 4% of married women, who stated 'it [an unplanned pregnancy] would never happen to me'. Mahon et al. (1998) also found a strong sense of invincibility to pregnancy among unmarried study participants. Denial of fertility was also mentioned in the study by Dempsey et al. (2001) on pregnant teenagers in the south east of Ireland.

Destiny dependence: Hyde (1996) found that some women in her study were relatively unconcerned about what happened to them. She classified this thinking as 'destiny dependence'. Hyde found that these women were prepared to keep a baby if they became pregnant and did acknowledge that a pregnancy might arise in their case. However, the pregnancy was not consciously intended and these women tended to be young. Hyde also identified 'progressive remissness' as a factor in unintended pregnancies (see section 2.2). It may be that destiny dependence is related to what Alder and Tschann (1993) referred to as 'subconscious motivations' for pregnancy. These have been addressed in the literature on teenage pregnancy, where pregnancy is not perceived as an entirely negative outcome of sex. These subconscious motivations are clearly related to earlier discussions of teenage pregnancy and the reasons for having unprotected sex.

2.2 Relationship factors

It has been found that variations in women's contraceptive behaviour can be related to the nature and type of relationship they are in. Many of the factors described previously interact with the type of relationship or partner involved to affect contraceptive practice. The importance of this level of analysis suggests strongly that it is critical to consider the woman, the man and the interaction between the couple when trying to explain contraceptive behaviour. Findings in this field can be divided into papers that examine the effect of the type of relationship on behaviour (e.g. stable relationships versus casual relationships), and the effect of communicative factors on behaviour (e.g. negotiation, expectations, pressures). The following table sets out the kinds of factors, specific to the sexual relationship, which can affect contraceptive decisions.

Table 2.4 Relationship factors related to use of contraception

Negotiation, communication and power relations e.g. partner expectations
Length of the relationship and its relation to risk-taking behaviour
Affective factors - Wish for intimacy, love, arousal

a) A widespread finding here and abroad is that relationships appear to make risk taking more acceptable (e.g. Mahon et al. 1998, Hyde 1996). This has been identified in the literature examining couples' justifications for having unprotected sex (e.g. Hyde 1996) and also in survey data that reveals that within relationships condom use decreases over time. Richards and Van Der Pligt (1991) found that the most powerful predictor of contraceptive behaviour was the frequency of previous sexual behaviour. This is related to the type of relationship: the more frequently monogamous adolescents had sexual intercourse, the less likely they were found to be using condoms. Condom use was evaluated more negatively in stable relationships. This was true for both adolescent boys and girls.

Hyde (1996) provides a possible explanation for this behaviour pattern, although Hyde's findings were found for women in their early twenties. Hyde (1996) found that some of her participants could be categorised according to their risk-taking behaviour. She identified one particular behavioural pattern of relevance here, termed 'progressive remissness'. Progressive remissness refers to risk-taking behaviour while in a stable relationship. The women in Hyde's research did not want to get pregnant, but over time began to take increasing risks. These women tended to have completed their Leaving Certificate and had previously used the pill regularly. They described taking greater risks over the course of a relationship. Some women in this group stated that the relative infrequency of intercourse (e.g. boyfriend away) led them to stop taking the pill.

These findings, specific to stable relationships, are reinforced with findings that suggest that contraception is more likely to be used initially when the partner is a casual one, rather than a long-term partner. It would appear that individuals are more careful and concerned about contraception within casual relationships than in stable ones.

There is a contradiction in the literature, however, when one considers the finding that the level of communication between couples is a strong indicator of contraceptive use. If this finding is correct, one would assume that protected sex would be less likely with

casual partners. To some degree this conflict is demonstrated in the literature where contraception use during first sexual encounters is examined. Findings suggest that contraception is less likely to be used in first sex encounters, as the couple may not know one another well enough to communicate and discuss it. Other studies suggest the opposite. In the US, Lagana and Hayes (1993) reviewed health programmes for adolescents and noted that empirical studies found reliable use of contraception to be associated with strong commitment to one partner and not to promiscuity. Anomalies like these in research findings need to be addressed and resolved. It is also evident that concern about STIs, and how the level of concern may vary depending on the status of the relationship are important when interpreting this data.

b) The pill is widely perceived to be a contraceptive method only for women who are in a relationship. It has also been suggested that individuals having sex with regular partners may use condoms at the initial stages of a relationship but reduce condom usage as the relationship progresses, often replacing condom use with the pill for contraception. Greene et al. (1989) found that the type of relationship (married / unmarried) was related to the type of contraception used. Three fifths of the married sample had used the pill whereas only a little over a fifth of the single sample had used the pill. Condoms were much more popular with single women. Mahon et al. (1998) found that women stopped using the pill when a relationship ended, reinforcing the finding that being on the pill is associated with being in a stable relationship. Once more, fear of significant others finding out about use of the pill and its connotations of promiscuity made women cease to take it – unless they were in a longer-term relationship.

Gold et al. (1992) explored justifications that heterosexual students employed when they had unprotected sex and when they resisted a strong temptation to have unprotected sex. The authors found that students tended to use certain cues to infer that the partner was unlikely to be infected. Among respondents who recalled both encounters, the type of partner determined whether or not they resisted the urge to have unprotected sex: they were more likely to have unprotected sex with longer-term partners. When this variable was controlled – the following factors influenced how the students reacted to such encounters:

- desires
- knowledge of condom availability
- communication about condom use
- degree of boredom
- level of intoxication.

Gold et al. found that women in casual relationships were more likely than males to justify unsafe sexual behaviour by telling themselves that they would start using contraception 'soon'.

Partner support is thought to influence values and attitudes toward the use of contraception. Mahon et al. (1998) concluded that women whose partners were supportive and took equal responsibility for condom use had different attitudes about contraception to those whose partners who did not take responsibility. A principle cause of failure to use contraception was the failure of men to take responsibility for contraception. Mutual trust and communication were important in using condoms consistently.

2.3 Situational factors and service level factors

Various situational influencers have been purported to explain differences in contraceptive use. Situational factors include alcohol and substance abuse and general failures with method e.g. condoms that leak, antibiotics reducing pill effectiveness. Some of these can be attributed to lack of knowledge of how to use contraception safely and effectively. Situational factors also overlap with service level factors such as a lack of access to contraception due to cost, clients' age, confidentiality issues or location. These factors are listed in the table below:

Table 2.5 Situational and service level factors associated with contraceptive behaviour

Alcohol or drug influencers
Spontaneity of sex
Technical failure e.g. burst condom or failed pill
Service level: Lack of access to contraception e.g. ability to access, cost

2.3.1 Alcohol

Research suggests that alcohol is an important factor in sexual risk taking and contributes to the level of unplanned pregnancies. Alcohol is considered a situational factor in explaining unsafe sexual behaviours. It is important to recognise alcohol in the wider sociocultural context that promotes, encourages and glamorises its consumption. The relationship between alcohol and unsafe sex in the literature is not a clear-cut one. Bagnall, Plant and Warwick (1990) and Roberston and Plant (1988) found that drinking alcohol was associated with failure to use a condom. Leigh (1990) concluded differently. In the study of Gold et al. (1992), intoxication was associated with unsafe sex when the partner was a causal one rather than a stable one. This study concludes that alcohol promotes unsafe sex by impairing respondents' ability to think clearly about the threat of infection. McHale and Newell (1997) surveyed 2,754 pupils in County Galway and found that of those who had had sex (21%), 35% reported that drink was a contributory factor in their sexual debut. Dempsey et al. (2001) found that alcohol was implicated in teenage pregnancy among their sample.

2.3.2 Spontaneity of sex

Spontaneity has been mentioned as an explanation for unprotected sexual intercourse (e.g. Dempsey et al. 2001, Finlay 1995). Spontaneity has also been linked with affective factors, such as love, arousal, desire (Finlay 1996). Sexual intercourse is often spontaneous and sporadic. This is particularly so for teenage sex. Spontaneity reduces the probability that contraception will be planned and rational, thus increasing the risk of unprotected sex and pregnancy. Due to the fact that spontaneous sex limits the ability to plan, sensible evaluation of vulnerability to pregnancy is less likely. Research with adolescents suggests that first sexual intercourse is generally unplanned and this account for the lower levels of contraception used on such occasions.

2.3.3 *Technical failure*

Technical failure has also been purported to account for unplanned and crisis pregnancies. Greene et al. (1989) found that out of 117 women in a Dublin antenatal clinic, 26% reported failure with their method of contraception. Failure of contraception was related to marital status as 50% of single women reported contraceptive failure versus only 14% of married women. The authors concluded that there is widespread subjective belief that contraception fails (see also Hyde 1996). As previously mentioned, the possibility of social desirability and women not wanting to appear reckless or irresponsible by not using contraception, may bias this kind of data. Mahon et al. (1998) found that women who became pregnant as a result of contraceptive failure did so for the following reasons:

- could not access emergency contraception
- partner did not tell that condom burst
- the condom only burst once so felt the risk was small
- spermicide was used so felt the risk was small
- thought it was a safe time
- pill failure
- forgetting one or more pills
- stomach upsets
- antibiotics interact with pill.

It will be noted that many of the above reasons are related to other factors: service level factors (access to emergency contraception), relationship factors, such as the example where a woman was not informed by her partner that a condom had burst, and psychological factors, (e.g. when the woman convinced herself that it was a 'safe' time).

2.3.4 *Service level factors: accessibility of contraception*

While there is no nationally-representative data on attitudes and experiences of service provision, a number of small-scale Irish studies have examined these issues. Mahon et al. (1998) found that many women in their study had problems accessing contraception and emergency contraception (and information on abortion). Women recounted stories of doctors who acted as 'moral gatekeepers' by refusing to prescribe contraception because women were too young or in an effort to convey disapproval at sexual activity outside marriage. Other women did not know if their GP offered contraceptive services and had never asked. A study of women in Dublin who chose family planning centres for their contraceptive needs, indicated that more than half of the sample shared their GP with other family members and this may have militated against using their GP for contraceptive services (Smith 1996). Confidentiality was an important issue for these women and one that affected their willingness to access services. Some women in this sample also made reference to the cost of contraception, complaining that they found it a burden. The author concluded that "the weight of social attitudes toward sexuality may well militate against a section of young unmarried women in particular using their GP for contraception" (Smith 1996, p. 150). Dempsey et al. (2001) found in their study of teenage pregnancy that barriers to accessing contraceptive services were many, and included cost, relationship with GP, locality, fear of buying contraception, feeling embarrassed and tendency to procrastinate.

Access to doctors at suitable times was also an issue for working women as is access to a female practitioner (e.g. Smith and Bury 2000).

These findings are replicated internationally. In a review of international policies in relation to sexual health, Hosie (2002) listed the following service level factors as critical to young people's use of services: geographical location, services hidden from parental view, suitable opening times, confidentiality, informal and user-friendly services, professionals' attitudes, sex-speak and youthful linguistics, inclusive access and recognition of the needs of young men.

2.4 Contextual factors: parents, peers and gender and societal norms

The social context, including significant others (peers, partners, parents), the community context and wider societal influences (e.g. media) play an influential role in informing attitudes, expectations and behaviours. Models attempting to explain and predict behaviours and decisions incorporate social variables such as subjective norms in an attempt to reflect these influences. Research widely recognises that choices people make are not purely due to the individual's own attributes: family background and normative environment play an equally important role. An understanding of these contexts is fundamental in developing an understanding of contraceptive behaviour and sexual decision making.

Research findings have indicated that factors such as an individual's perception of peer norms and parental support affect both attitudes and actual contraceptive behaviour. A number of studies have demonstrated the positive influence of peers and parents, particularly the mother. In Ireland there appear to be a few small-scale studies that have examined the relative influence of these factors on individual attitudes, intentions, or behaviours.

2.4.1. Parental attitudes and communication

It has been documented that with younger women and adolescents, parents have a bearing on women's use of contraception and the type of contraception chosen. Parental norms often militate against the use of contraception. Mahon et al. (1998) found that the message many young women received from their parents was not to have sex until marriage. Like other authors, Mahon et al. (1998) found that women who were sexually active did not generally disclose their sexual activity to their parents due to anticipated disapproval. Women also expressed concern at using the pill for fear of their parents finding out.

Of course it is important to recognise that the converse of these findings is also true: parents can have a positive influence on children's attitudes and behaviour. Research in Ireland and internationally has demonstrated this. Ingham and Partridge (2002) found that parents with more egalitarian gender roles had daughters who were more likely to be assertive and more sensitive sons. Ingham and Partridge (2002) also found that a parenting style that accepted the reality of teenage sexuality, and that accepted that services existed for contraception was associated with safer sexual activity among young people, as indicated by later sexual initiation and higher reported use of contraception.

The concerns of young women regarding the reaction of significant others to their sexual and contraceptive choices is also seen in fear/concern at the GP's reaction and the reaction of prospective partners. These findings demonstrate that many women experience worry and concern over contraceptive decisions, since contraception implies sexual relations. Women feel that they will be judged negatively if they are known to be sexually active. It will be recalled that women were reluctant to use the pill, unless in a long- term relationship.

Francome (1992) surveyed 200 Irish women attending abortion clinics in the UK. He was interested in exploring the characteristics and experiences of Irish women seeking abortions in the UK. When asked whether their mother knew they had been sexually active, only 26% of single women said that their mother knew they had been sexually active. 30% stated that their sister knew they had sexual intercourse. Francome found that 15% of single women had discussed birth control with their mother. Mahon et al. (1998) commented that because of poor communication with parents and fear of disclosing sexual activity, many women interviewed relied primarily on informal sources of information when they became sexually active.

Data from the Health Behaviour of School Children (HBSC) survey in Northern Ireland suggested that poor family communication was associated with increased risk-taking behaviour. US longitudinal data of teenage health indicated that a high degree of family 'connectedness' through communication and shared activities was associated with delayed first intercourse. A report by Finlay (1995) for the Department of Health documented that Northern Irish teenagers experienced more difficulty in talking to their parents about sex than their peers in other European countries. Parents are the ones young people say they would most like to tell them about sex. UK research suggests that parents, especially fathers, do not feel equipped to fulfill this role (Social Exclusion Unit 1999).

Research in Australia and the US indicates that parents who do not participate in their children's sexual education contribute to their child's unwillingness to negotiate safer sex. Research has also shown that where there is a strained or discontinued relationship with parents there is greater sexual activity, greater non-use of contraception and higher levels of unplanned pregnancies.

2.4.2 Peers

Friends are also a very important source of support and information (Social Exclusion Unit 1999). There is little data in the Irish context that elaborates the influence of peers on knowledge, attitudes or behaviour.

2.4.3 Gender and societal norms

It is widely recognised that young people are less sheltered from the realities of the adult world than ever before (Social Exclusion Unit 1999). Shifts in societal norms have been attributed as a partial explanation for the earlier onset of sexual activity among teenagers. Sexual imagery is now commonplace, yet society disapproves of sex among young people. Moreover, entrenched gender norms continue to be propagated: women should not initiate sex, women who carry condoms are 'up for it' and women are purely sexual trophies for men (Social Exclusion Unit 1999). For example, Finlay (1996) and Mahon et al. (1998) found a perception, amongst teenagers in particular, that if girls

carry condoms they are promiscuous or 'looking for sex'. This is supported by research from other jurisdictions, which suggests that these gender and societal norms are not specific to Ireland. Abraham, Sheerin, Spear and Dominic (1992) found that a sample of Scottish girls were reluctant to carry condoms due to embarrassment and perceived connotations of promiscuity. Boyle (1991) reiterates this finding. A Northern Irish Department of Health report (2000) documented that males are under pressure to have sex from peers and the media.

Research in the UK suggests that the media is the main source of information on sex and relationships for boys (Todd, Currie and Smith 1999). For girls, the media came second, after friends. Raymond (2002) pointed out that the stereotypical, uni-dimensional antics of most of the 'lads mags' are particularly unhelpful for a fifteen-year-old boy. There is little other than anecdotal information looking at society and the role of the media in constructing and maintaining gender norms. There is very little analysis in the Irish context of the relative effects of the media (TV, magazines, music, web etc.) on young people's self-perceptions, expectations, attitudes and behaviours. These contexts are important to consider when attempting to map the range of factors contributing to crisis pregnancy.

The effect of the media and wider sociocultural context on parental and practitioner attitudes, expectations and behaviour is also important to consider.

2.5 Theoretical models

It has already been mentioned that a lot of the work in the area of crisis pregnancy lacks an integrated theoretical and conceptual framework. This makes interpretation and comparison of the literature awkward and unsatisfactory. Theories and models that have been employed lack validity, as they do not comprehensively address the totality of sexual decision making and often do not adequately explain the differences in people's sexual behaviour and decisions. Theoretical models and conceptual frameworks help to understand the problem, plan interventions and interpret evaluations more rigorously. Rational models, in particular, do not address behavioural decisions that are unplanned. They proscribe behaviour, and tend not to allow for the agency or autonomy of the individual to affect decisions. A developmental perspective, across a person's lifespan, is also lacking from the literature on sexual behaviour and sexual decisions. It is clear from the present review that age, sexual history and the length of the relationship play important roles in understanding contraceptive decision making. For example, the same event can look very different depending on the age and life situation of the person involved (Greene 2000).

It is arguable that more naturalistic models are required to analyse sexual decision making in real-life, dynamic and complex environments. This would involve delineating individuals' beliefs, attitudes, representations of themselves, sexual relations, how they expect scenarios to unfold and contextualising these variables within the broader social environment and age-related context. It is clear further work is required to feed into the development of a conceptual and theoretical framework.

3.0 Women and crisis pregnancy – decision making

This section of the document will attempt to outline the main factors characterising and informing a woman's decision when faced with a crisis pregnancy. Firstly, a woman's decision to have an abortion will be considered. This will be followed by a consideration of a woman's decision to have her baby adopted and finally, of the decision to keep the baby.

3.1 Decision to have an abortion

Research suggests that women do not necessarily conceptualise their pregnancy as a scenario involving three possible alternative outcomes. Irish research that has explored women's decisions to terminate their pregnancies suggests that they tend to make their decision immediately after discovering that they are pregnant and act on it very quickly (Mahon et al. 1998).

Boyle (2000) concluded that the large majority of women do not find the abortion decision difficult and that the decision to have an abortion is often made before the pregnancy is confirmed (see also Smetana and Adler 1979, Holmgren 1994). Miller (1992) found that 71% of women were 'very certain' about their decision and 90% either 'very' or 'mostly' certain.

A woman's decision to have an abortion is very much a contextual one. The analysis by Mahon et al. (1998) of 88 interviews of Irish women in UK abortion clinics suggested that the following reasons informed the decision to have an abortion: (These are listed in order of magnitude by the authors.)

- career and job-related concerns: women assessed the effect of having a child on their career paths, training and education.
- stigma of lone motherhood
- child's needs
- financially unready
- not ready for a child now
- could not cope
- too young
- my body, my right
- education and training
- never wanted a child
- stigma on parents
- no way I could have a child now
- too old.

It is clear that there is some degree of overlap in the above explanations; however, they are clearly grounded in women's experience of relationships, their assessments of capability and aspirations for the future.

Torres and Forrest (1988) surveyed almost 2000 women in the US. Their findings suggest that reasons for abortion decisions can be grouped into those that involve personal characteristics (age, not being ready for responsibility, health problems) and those that involve the woman's circumstances (relationship with partner, financial worries, desire

to continue education). Russo, Horn and Schwartz (1992) re-analysed Torres and Forrest's data and demonstrated that different groups of women tended to give different reasons for having an abortion. Adolescents were more likely to give reasons such as not being ready for raising a child. Women with children were less likely to give reasons such as education or career and more likely to cite responsibilities to significant others.

Mahon et al. (1998) discuss their findings about abortion decision making by relating them to the many roles women occupy. It is clear that age-related factors play a large part in accounting for differences in women's accounts of why they choose abortion.

Small-scale research suggests that over a third of women do not contact any doctor or agency in Ireland for information and/or counselling before they have an abortion. Barriers to contact outlined by Mahon et al. (1998) include cost, a waiting list, possible refusal of information and the different perceptions of pregnancy counselling agencies. There exists little in the way of quantitative data on women's attitudes toward the use of counselling supports, their expectations of supports and what their current support levels are.

Greene et al. (1989) found that 28 single women (out of 100) at a Dublin antenatal clinic had considered having an abortion. None of these women had planned their pregnancy. These women were not distinguished from other women (who were considering adoption or who were keeping their babies) on variables such as age, educational level, employment status or use of contraception, but did differ in three ways:

- more likely to report that they had not thought pregnancy would happen to them
- were more surprised by the pregnancy
- more likely to express being unhappy at finding themselves pregnant.

Greene et al. (1989) reported that eight of these women went on to choose adoption.

Francome's (1992) survey of 200 Irish women attending abortion clinics in the UK found that 77% of single women had told their boyfriend about the pregnancy. (90% of married women told their husbands compared with 53% of separated couples). Francome found that 10% of women had told their mother about the pregnancy and fewer than 4%, their fathers. There were sixteen (8%) separated women in this sample, 32 (16%) married and 152 (or 76%) single. The secrecy, silence and stigma surrounding a woman's decision to have an abortion are evident, and this is reflected in the relative dearth of literature exploring why women choose abortion, and their reactions to it. Fletcher (1995) examined the extent to which secrecy and silence was a feature of women's experience of abortion. Fletcher outlined that abortion is a personal, complex and difficult experience in any woman's life and that it is not possible to give a simple universal explanation of its many facets. She interviewed Irish women who had had abortions and found that women were selective about the aspects of the experience that they were willing to discuss. This was due to a number of factors, including a desire to protect themselves from the criticism of others, confusion over their own experiences, worry that their actions will be interpreted as wrongdoing and concern that others might be hurt. Fletcher described women as having irrational guilt that fed into the silence surrounding their experience. Irrational guilt was described as feeling sorry for having done something they believed to be right.

Women described finding themselves internalising the social construction of abortion in Ireland, which at worst views it as evil and at best traumatic. This feeds into the social taboo whereby women tend not to discuss their experience and normal interpersonal relations are distorted. These personal accounts help to give some insight into why women are reluctant to engage with family members, friends and professionals before and after they go have an abortion.

3.2 Decision to have an adoption

There is very little data in Ireland exploring women's (and men's) attitudes, beliefs and expectations about adoption and how this relates to crisis pregnancy decisions. It is unclear the extent to which Ireland's social history of adoption has contributed to the low proportions of babies adopted, and how this compares with other western countries.

Greene et al. (1989) found that 21 single women (out of 100) at a Dublin antenatal clinic had intended to give their baby up for adoption. This is similar to the 18.4% in the study of O'Hare, Dromey, O'Connor, Clarke and Kirwan (1987). It is interesting to note that these women did not differ to women keeping their babies in terms of age, employment status or educational level. Greene et al. (1989) found they differed in only two ways. These were:

- more likely to have reported being unhappy at finding themselves pregnant
- less likely ever to have used contraception.

The relationship between a woman's attitudes (e.g. religiosity, use of contraception) and adoption is unknown.

Qualitative Irish research and survey data from other countries have found that public attitudes toward adoption are negative.

Mahon et al. (1998) examined the decision of eleven women to have their baby adopted. They found that these women tended to weigh up the pros and cons, costs and benefits of lone motherhood compared with adoption throughout their pregnancy. These women experienced the same concerns as other women in the study. Concerns included who to tell and who to contact. What was common about these women was that they all got help from voluntary agencies and this enabled them to keep their pregnancy a secret. In doing so they protected themselves and their families from the perceived stigma of being pregnant. The report's authors (Mahon et al. 1998) documented that these women felt a great dilemma between contemplating giving responsibility for their baby to other people and feeling the growth of a baby inside them throughout the nine months of pregnancy. It is interesting that women in this study did not generally contemplate abortion and most had strong negative views toward abortion, indicating that attitudes play an important role in the adoption/abortion decision.

The women in the study of Mahon et al. (1998) felt unable to become social mothers with all the responsibility that this entails, yet they felt they could become birth mothers. These women felt that they would be stigmatised as single unmarried mothers: stigmatised by their community and also by family, peers and friends. They also expressed being aware that their parents would be stigmatised. Again, it appears that the attitudes and potential reactions of significant others and concerns about these play a part in women's decision making. The secrecy offered by agencies was part of avoiding

the stigma they were sure their pregnancy would bring. The need for secrecy was, in some cases, reinforced by significant others who colluded in the stigmatisation of unmarried mothers. Women found that adoption afforded them protection from the burden of pregnancy: a sense of control over their decision and the knowledge that if they follow through with adoption there is no need to tell anybody about their decision.

Another interesting common facet of these women's responses to being pregnant was that they tended to deny their pregnancy up to a late stage. This contrasted sharply with women who decided to have an abortion and tended to acknowledge their pregnancy immediately. There appears to be no research in Ireland on women who conceal their pregnancies or deny the pregnancy and the psychological implications of this.

In addition to the perceived stigma of lone parenthood, the following other reasons for rejecting lone motherhood were given by the eleven women in the study (Mahon et al. 1998):

- does not want to be a mother at any stage
- does not want a baby at this stage
- difficult for lone mothers to cope – end of social life
- economic and social ramifications of lone motherhood
- career and educational opportunities
- partner relationship
- effect of lone motherhood on familial relations
- financially unready, emotionally unready
- living arrangements and accommodation
- loss of independence and freedom – dependence on support of parents
- not fair on the baby – child-centred consequences, e.g. two parents better than one.

It is clear that attitudes toward lone mothers and being a lone mother played the most important role in these women's decision have their baby adopted. It is important to note these attitudes and perceptions and to recognise that there is some overlap between these concerns and the concerns raised by women who choose an abortion. In general, lone mothers are perceived to be socially and economically disadvantaged and to be 'trapped' into social and economic dependency. Lone motherhood to these women meant that they would be excluded from further employment and educational opportunities and were destined to be on welfare. Lone motherhood was also perceived as excluding women from forming and developing future romantic relationships. Some of these women perceived their future career plans and having a baby as incompatible, hence, adoption remained the only option.

There appears to be little research that tackles the economic considerations and realities for lone motherhood and the cost and benefits to women at different stages of their lives in having an unplanned baby on their own. This is an area for future research.

3.3 Decision to keep the baby

It is clear that the majority of women who experience a crisis pregnancy in Ireland decide to keep their baby. The following section aims to outline some of the factors thought to influence this decision.

Like the women who chose to have an abortion, the 34 women in the study by Mahon et al. (1998) who chose to keep their babies did so very quickly. When these women did consider the options open to them, they were more likely to consider and access information relating to abortion, rather than adoption. These women tended to feel obliged to carry the personal consequences of pregnancy, arguing that the pregnancy was not the child's fault. For women who had considered abortion, having the support of their partners and parents enabled them to contemplate motherhood instead.

While these women thought that the ideal context for having a child was in a traditional marriage, the prevailing view among this sample was that marriage was not an option and was not considered as a way of 'legitimising' the birth of the baby. Richardson (2000) reported a similar finding in her work with young mothers. The decision by these women to keep their baby was only the first step. After this women needed ongoing support in order to cope and adjust. It was noticeable that formal counselling and help for women in this predicament was much less a feature than it was for women who chose adoption and abortion.

The stigma of lone motherhood was still an issue for these women. Mahon et al. (1998) describe a transformation of identity for these women: their social identity was now stigmatised. Women were concerned about telling friends, people in the community and in the workplace. Telling significant others, and their reactions, were of major importance to women. In particular, the reaction of parents was very important as the parents represented key support systems for women who, in many cases, were dependent on their parents already. It is interesting that for the majority of women, parents were supportive of them at this time. They were supportive in areas that were of particular concern for women. These included:

- accommodation
- childcare
- finance.

Richardson (2000) interviewed 31 young mothers (under 25 years of age) and found that these women made little use of voluntary and statutory agencies, highlighting the important role of family in supporting these women. Lack of use of services was noted by Richardson to be related to lack of accessibility also. With respect to perceived stigma of being a lone parent, Richardson found that most of her sample did not feel stigmatised. This was partly due to the fact that many of their friends and/or siblings also had children outside marriage.

Poverty was also a real issue for the women in Richardson's study, who were attempting to manage on low levels of income. All of the women in this study were on One-Parent Family Payment, with no reliance on maintenance from the fathers of their children. The risk of poverty and welfare dependency among unmarried mothers are consistent findings in Ireland (McCashin 1993).

McCashin (1993) found that when income data for various households of different types were analysed to calculate risk of poverty, unmarried lone parents were the highest risk category.

It is important to note that pregnancy and lone motherhood did affect women's lives and aspirations, as they had to negotiate work during pregnancy, resolve childcare issues and decide on what to do about their educational plans (Mahon et al. 1998). Many of the women in the research of Mahon et al. (1998) had to give up work due to the incompatibility of pregnancy and work, illness or stigma. The women who stayed in work tended to be those with better jobs. Richardson (2000) found that just over half of the women in her study were in part-time work and the rest were unemployed. Most of this sample wished to work, but were prevented from doing so because of the lack of affordable childcare and the need to travel outside of the local area to obtain work.

In terms of lone mothers' social lives, women felt that their social lives were restricted because of pregnancy and its demands (Mahon et al. 1998).

What is clear from the work of Mahon et al. (1998) is that these women, who opted to keep their babies, were vulnerable socially, emotionally and financially. It is noteworthy that they tended to discuss their pregnancy with significant others (e.g. family/friends). It is likely that the support and reactions of significant others to the pregnancy was a key factor in their decision to keep the baby and how well they coped with as mothers.

4.0 Conclusions and recommendations

This section aims to list identifiable gaps in the literature on crisis pregnancy and decision making when faced with a crisis pregnancy. It will also outline key areas for action.

4.1 Research gaps

1. An up-to-date analysis of the geographical spread of women seeking abortion is required in order to examine if trends found in the 1980s are stable over time. A fuller picture is required of what abortion data represents, in terms of its reliability and how abortion figures are constructed.
2. Ireland has no nationally-representative data on sexual health knowledge, attitudes and behaviour. This detracts from our ability to construct a full picture of the interrelationship between these variables.
3. Theory-driven research attempting to understand the links between attitudes, intentions, relationships etc. is lacking in Irish literature and is much more common in the UK and US.
4. The relationship between self-efficacy, self-esteem and the ability to have the confidence and skills necessary to negotiate the use of condoms is an under-researched subject in the Irish context. While practitioners working in the field infer that skills and self-efficacy are important, these constructs have not been directly studied.
5. There is a distinct lack of focus on the experiences, problems and issues facing men, from a psychological, relationship, contextual and service level perspective,

for example, the role of men in initiating preventative behaviour. This clear gap in the literature needs to be addressed at all levels and gender comparisons need to be considered in the design of research projects and interventions.

6. Research in Ireland on teenage pregnancy has not directly confronted the role of influencing factors such as desire for a baby, desire to achieve adult status and how this is related to social and economic variables and the life aspirations of women.
7. Research examining contraceptive practices and factors relating to crisis pregnancy in Ireland has been mostly qualitative, using selected samples. This work tends not to be theoretically driven, nor does it explicitly incorporate different levels of analysis, or employ a developmental perspective. It may be that this kind of data would be better able to provide a comprehensive picture of the relative weight of important influencing factors.
8. There is very little research examining the morning-after pill in Ireland, including its legality, women's use of it, what the barriers to use are and the motivating factors for its use.
9. There is a lack of representative data on sex education and sexual practices of young people in Ireland and on the relative importance of peers, parents, community and the role of the media in their lives. There is little data in the Irish context that elaborates the influence of peers on knowledge, attitudes or behaviour.
10. The role of the media and conflicting messages that young people receive about sex appears to be a relatively under-researched field. Research into media influence also needs to address the importance of the messages disseminated by the media in constructing, informing and developing gender norms and normative sexual expectations over time.
11. The role of the media and significant others in informing gender norms among non-adolescent men and women is also worthy of exploration.
12. No quantitative data appears to exist examining risk taking among Irish men and women and how this differs depending on psychological and relationship factors in particular.
13. Research often treats the risk of pregnancy and risk of STIs as discrete and distinct research topics. Qualitative research suggests that individuals having sex do not. It is important to address this finding when deciding upon research questions and planning research designs.
14. Quantitative data outlining the relationship between alcohol and unprotected sex needs to be gathered.
15. There appears to be little in the way of cost-benefit analyses of the economic implications for women when choosing whether to keep a baby (e.g. reality of costs of childcare). There appears to be little analysis of the economic and political cost for government when women are denied access to education and to work due to the perceived 'liability' of being a single parent.

16. There is very little Irish data exploring public attitudes to adoption and the role of socio-historical factors in women's decisions not to have an adoption. There is also very little current research examining the psychological effects of adoption and the supports that women require when they choose to have their baby adopted.
17. There is a lack of quantitative data exploring the supports that women rely on when faced with crisis pregnancy and the supports that they would find helpful.
18. Women's experience of supports and in particular crisis pregnancy supports is in the main unexplored.

4.2 Implications for action

1. Sex education, at the individual, family and policy level requires strategic planning. This action will be facilitated by reviews of best practice in sexual health education programmes.
2. The critical role of parents in sex education and pregnancy prevention needs to be acknowledged and directly incorporated into preventative strategies. This needs to be complemented by an understanding of the support needs of parents in relation to facilitating healthy sexual behaviours.
3. The role of the media, and how it can be employed to positively affect and communicate healthy sexual messages to young people, needs to be explored.
4. Attitudes and thought processes that contribute to sexual risk taking (e.g. fertility denial) need to be challenged and contextualised in terms of people's experiences for maximum effect.
5. Situational factors that give rise to unsafe sex and risk taking need to be highlighted and challenged. This is especially relevant with respect to the role of alcohol and contraceptive failure.
6. The sex educational needs of men should be addressed, especially with respect to sexual stereotypes and masculinity. It is clear that truly effectual interventions will have to directly involve men, with the aim of empowering them to avail of services that meet their needs and promote healthy sexual behaviours.
7. Service level factors need to be holistically addressed with respect to meeting the needs of various clients, facilitating access and promoting inter-agency collaboration to provide the best services for women and men.
8. Widespread myths need to be identified and directly challenged. This is a key factor affecting behavioural norms and women's pregnancy decision making.
9. Theoretical strides need to be made in order to facilitate strategic planning and rigorous evaluation.

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