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THE RELATIONSHIP OF AGE, RELIGIOSITY, AND DEPRESSION ON RISK RELATED BEHAVIORS AMONG AFRICAN AMERICAN MOTHERS

By

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ABSTRACT

THE RELATIONSHIP OF AGE,
RELIGIOSITY, AND DEPRESSION ON
RISK RELATED BEHAVIORS AMONG
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The purpose of this study was to compare the relationship of age, religiosity, and depression on risk related behaviors among African American mothers. An aspect of risk behaviors that has gained increased attention is sexual risk behavior. The rise of sexually transmitted diseases (STDs), human immunovirus (HIV), and acquired immunodeficiency syndrome (AIDS) are rising in the African American female population. However, missing in the literature are studies that correlate the risk related behaviors, religiosity, and depression in adolescent and adult African American mothers.

An integrated framework derived from the Health Belief Model and the Social Control Theory was used to guide the study. It is believed that adult mothers being more mature, are less likely to engage in risk related behaviors than are adolescent mothers. In a retrospective, exploratory study, using secondary analysis of data, a data set of 127, (78 adolescent African American mothers - ages 12-17) and (49 adult African American mothers ages 18 and older) was analyzed. This data set was obtained from the Ethnic Families Research Project (EFRP) of H.P. McAdoo, PhD conducted in 1994-1997. Three

areas were examined: First, age, as it relates to risky behaviors, is explored using five risk-related indicators: a) the inconsistent or lack of use of birth control; b) the non use of condoms or abstinence (as compared to all of those not using birth control other than condoms and all of those who are not using birth control); c) experienced an unwanted pregnancy and birth; d) experienced an unwanted miscarriage or abortion; and e) the use of illicit drugs. Second, the relationship of depression to risky sexual behaviors is examined through the use of the five risk-related indicators and responses from the Beck Depression Index. Lastly, the relationship of religiosity to risky sexual behaviors is explored using the five risk-related indicators.

The independent variables for this study were: age, religiosity, and depression. Dependent variables consisted of five risk-related indicators: a) the inconsistent or lack of use of birth control; b) the non use of condoms or abstinence as compared to all of those not using birth control other than condoms and all of those who are not using birth control; c) experienced an unwanted pregnancy and birth; d) experienced an unwanted miscarriage or abortion; and e) the use of drugs.

Findings revealed that there was no significant differences in the age of the mothers, level of religion, depression, and risky sexual behaviors. The practical and policy implications of this study were also examined.

In honor of and dedicated to, my mother, Nelia Hamlin Lewis...a truly virtuous woman.
In loving memory of my father, Napoleon Lewis, Sr. and my brother
Napoleon Lewis, Jr. You are forever in my heart.

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OVERVIEW OF STUDY

Introduction

The purpose of this study was to examine the influence of age, religiosity, and depression on risk related behaviors, of African American mothers. In recent years, there has been an increase interest in the study of risk related behaviors particularly with regard to sexually transmitted diseases (STDs). High risk sexual behaviors especially with the increased incidences of multiple partners and unprotected sexual intercourse has dramatically increased the prevalence of STDs.

The increasing percentage of adolescents having sex at earlier ages has a collective influence on number of sex partners the person has. The earlier that sexual activity is begun, the longer the interval of exposure to different sex partners. Adolescence represents a time of sexual inquisitiveness and experimentation. The 15-19 year age interval appears to be the highest risk interval for exposure to multiple sex partners (CDC, 1990). Greater than twenty-five percent of women who began sexual activity prior to or by age 15 had 10 or more lifetime partners, compared to less than six percent of those beginning sexual activity at 20 years. It is important to question whether risk related behaviors continue as mothers grow older and mature.

Religiosity is a significant factor in determining risk because of its importance in the lives of African Americans. It has been reported that African American mothers rely on a spiritual association and the church as a source of strength and guidance for their families. It is believed that the more "religiously" involved one is, the less likely one is to engage in risky behaviors.

Depression as a factor in determining risk behaviors is linked to the vulnerability of the person experiencing at the time of the behavior. Persons with low levels of depression are presumed less likely to engage in risky behaviors because they are perceived as less vulnerable than persons with high levels of depression and vulnerability.

Practical implications for the study pertain to the reported increased incidence of STDs and AIDS in adolescent populations with high risk behaviors. Nursing implications include the policies and treatment regarding health and reproductive education for adolescent and adult African American mothers. Theoretical implications for this study are explored in a later section.

Significance of the Study

There is a considerable amount of existing literature comparing adolescents with other adolescents regarding risks (Jessor, 1991) and risk related behaviors and outcomes (Cates, 1991; Feldman, et al., 1995). Literature exists comparing attitudes and beliefs (including religious beliefs) of adolescent and adult mothers (Baranowski, Schimoeller, & Higgins, 1990, 1991). There is also a myriad of studies on post partum depression (Logsdon, McBride, & Birkimer, 1994; Auerbach & Jacobi, 1990). However, there is a

paucity of literature addressing the influence of age, religiosity, and depression on risk related behaviors in African American mothers. This study examined and the relationship of age, religiosity, and depression on risk related behaviors among this population of African American women.

Significance to Nursing

Risk related behaviors lead to a host of problems for adolescents and adults. African American adolescent females and mothers are particularly vulnerable to the consequences of engaging in these types of behaviors. When adolescent choices include engaging in sexual activity, the adolescent is at risk for various health problems. The nurse can work effectively with the sexually experienced adolescent to achieve optimal health outcomes. According to Wong and Perry (1998) this can be accomplished by using the nursing process.

Nurses must be knowledgeable of the developmental attributes of adolescents, as well as attributes of women in risk related situations. They must also be cognizant of the unique characteristics inherent in the African American culture (values, kinship network, family, etc.). Nurses must be knowledgeable of their responsibilities which encompass all aspects of sexually transmitted disease education, confidentiality, prevention and treatment. When educating these women and adolescents about sex education, information about these diseases, symptoms, and treatment needs to be included. Most persons in the vulnerable adolescent population are uninformed or misinformed about the severity of these diseases.

The major effort of nurse counseling should be toward prevention. This would include the avoidance of many of these risky behaviors. The school nurse may be involved in developing preventive programs and interventions for adolescents at risky for risk related behaviors- including depression, for adolescent mothers and their significant others, and the children of these teen mothers as well.

The nurse must be aware of the influence of religion and culture with regard to health care and perceived health outcomes. Culturally competent care is a must with clients of diverse cultures and beliefs. Perceptions of what is risky and what is not may be contingent on beliefs inherent in religions and cultures. These possibilities must be properly assessed by the nurse.

Assessment for depression in the client is a must for the nurse. Both subjective and objective data may be obtained to complete this assessment. Depression may be a contributing factor in adherence to prevention programs involving education on risk related behaviors. Proper assessment for depression is essential so that appropriate treatment is prescribed for the client.

Theoretical Framework

There are several models and theories that have been used to examine risk behaviors. For the purpose of this study, using strengths and attributes of the Health Belief Model developed by Marshall Becker (1974) and the Social Control Theory (Hirschi, 1969), an integrated framework was developed to help compare and explain the relationship of age, religiosity, and depression on risk related behaviors. From these two

major models, an integrated ecological framework was developed. A brief explanation of the models are included . Collectively meshed, using the strengths of these models, an integrated ecological framework was developed that is applicable for the study of the relationship of age, religiosity, and depression on risk related behaviors among African American mothers.

In the Social Control Theory, the human context is examined through four elemental bonds to one's society, using these bonds as motivators for participation in behaviors. Although similar to the Social Control Theory, the Health Belief Model examines the perceptions of individuals as motivators for engaging in certain behaviors. In both models motivation is a factor, however, while the Social Control Theory also examines what motivates one not to engage in a said behavior, the Health Belief Model only considers the perceptions of individual regarding engaging in a behavior. Both motivation for and perceptions of risk related behaviors are significant to the study, therefore, both models combined, were used.

Social Control Theory

The Social Control Theory examines what factors prevent individuals from participating in nonnormative behavior and explicitly ignores variations in frustration or motivation to deviate or change (Hirschi, 1969). This theory assumes that there is always "adequate motivation for any individual to deviate and that the great diversity in the motivations of persons resists useful classification" (Hirschi, 1969, p. 862). Many forms of deviance, such as drinking, truant behaviors, and sexual activity are believed to be

attractive and appealing to the vast majority of adolescents (as well as adults). Therefore, the social control theory argues that variations in motivation levels are not necessary to the explanation of deviance. Control theorists do not want to know what motivates participation in risk behaviors, instead, what factors prevent the engaging of these types of behaviors (Hirschi, 1969; Moore, Sims, & Betsey, 1986).

To test this social control framework, one must examine the effects of four elemental bonds to one's society - attachment, commitment, involvement, and belief (Hirschi, 1969). Attachment refers to the internalization of norms, caring, respect, affection, and sensitivity to the beliefs of others. Attachments are to family, teachers, friends, and are positively correlated to decreased deviance. "Commitment refers to an individuals investment in conformity" (Hirschi, 1969, p. 862). Persons committed to jobs, completing high school or college are likely to examine the costs and benefits of engaging in risk behaviors. Involvement denotes that persons who are involved in conventional activities within the family or community, are to busy to participate in deviant or nonconventional risk behaviors. Belief is how strongly one believes in the conventional order of society (Hirshci, 1969).

The Health Belief Model

The Health Belief Model (HBM) provides a theoretical approach to the issue of promoting positive health practices. This model investigates the individual perceptions as motivators of health related behaviors - including depression. These motivators include perceived susceptibility, defined as "individual's perceived vulnerability or

personal risk to the health threat" (Brown, O'Clemente, & Reynolds, 1991, p.63). Also, perceived severity defined as the perceived implications of the health threat (Becker, 1974). The individual must weigh the perceived benefits, which are the believed effectiveness of the strategies to prevent the illness, against the negative consequences of taking prescribed health actions (Brown, O'Clemente, & Reynolds, 1991).

A weakness of this model is that culture is not included as in influence of health perceptive motivators. In Spector (1995) cultural concepts relating to women's health is explored with regard to health-promoting behaviors. Concepts of heritage consistency, traditional beliefs, and traditional health-promoting behaviors based on one's culture is discussed. Those concepts are lacking in the HBM.

Integrated Ecological Framework

The intent of the integrated ecological framework builds from the Social Control Theory and the Health Belief Model and aid in explaining the relationship of age, religiosity, and depression on sexual risk behaviors in the study population. Adult and adolescent African American mothers are engaging in risk related behaviors.

From the Social Control Theory, age is examined with regard to it's influence on risk related behaviors. Maturity is believed to be a factor in the engaging of risk related behaviors. Religiosity is also examined through the use of the Social Control Theory. Religiosity is based on commitment, attachment, and belief, which coincide with some measure of appraisal or thought when participating is risk related behaviors. From the Health Belief Model, depression is studied. Depression is part of the perception or

"perceived susceptibility" and "perceived threat" of engaging in risk related behaviors. The level of depression determines the perception of the person. The integrated model will allow for the meshing and examination of the variables age, religiosity, and depression and their relationship to risk related behaviors in a population of African American mothers.

Explanation of Framework Design. Both adolescent and adult African American mothers are motivated to engage in risk related behaviors which can lead to states of depression. These mothers base their motivations and perceptions on levels of attachment, commitment, beliefs and involvement in society, family, and community. These factors (attachment, commitment, beliefs (including religious beliefs), and involvement) contribute to their level of religiosity (importance of religion, and meaning of religion to mother) and this in turn relates to motivation and types of behaviors the mothers will participate in. Levels of religiosity (low) are also factors contributing to depression.

This framework reflects the influence of age, religiosity, and depression of the individual and the individual's perception of risk related behavior - its cost and benefit. Motivators for the engagement in risk related behaviors are also examined using an integrated ecological framework (Figure 1.1).

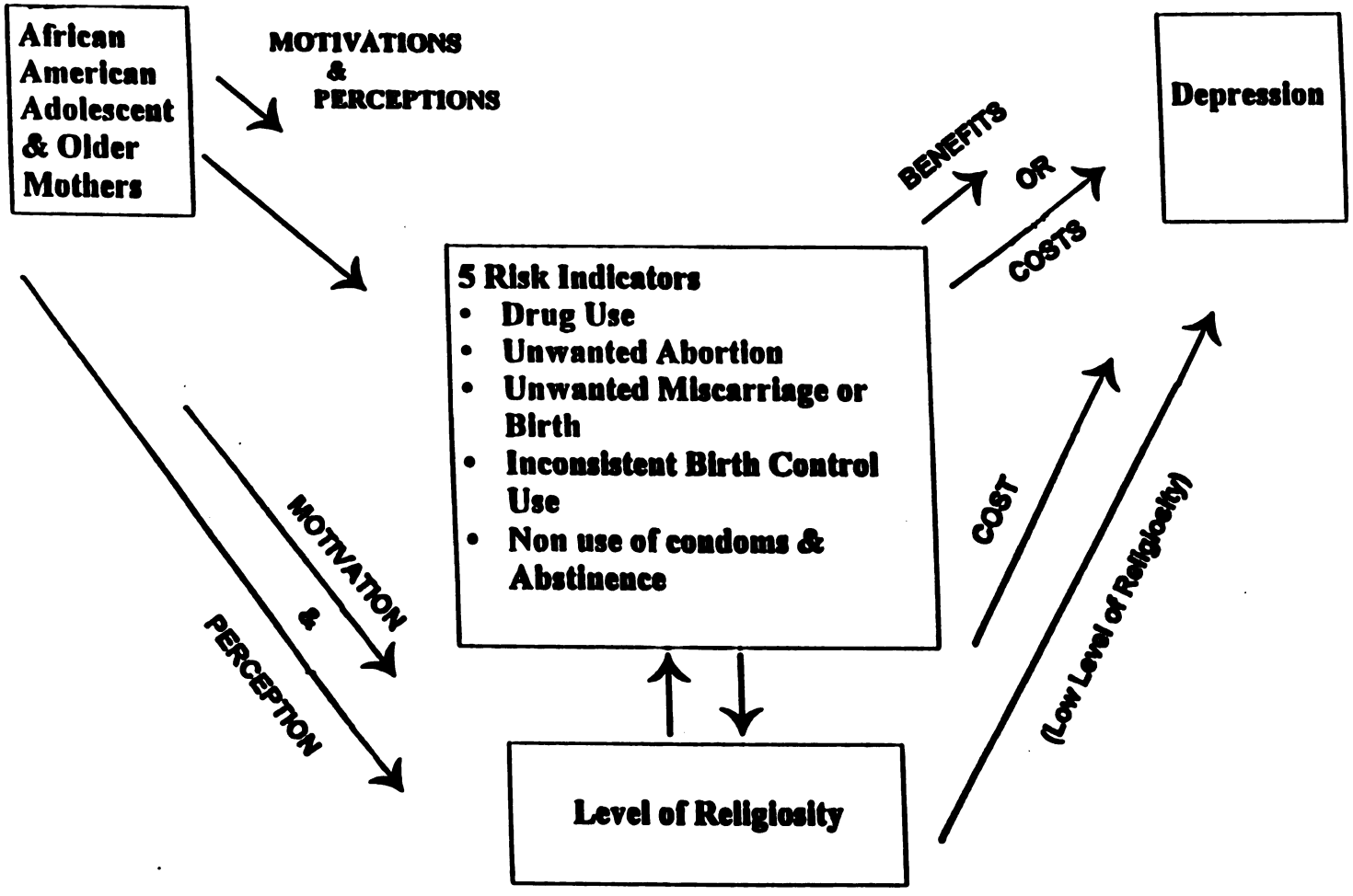

Figure 1.1 INTEGRATED ECOLOGICAL FRAMEWORK

The purpose of this research was to examine the relationship of age, religiosity, and depression on risk related behaviors in adolescent and older African American mothers. Definitions (conceptual and operational) inherent in this study are listed below.

Definitions

Conceptual Definitions:

Age:	The length of time a person has lived.
Religiosity:	The beliefs of a person, generally centered on a supernatural power or being. Degree of belief pertains to significance of belief.
Depression:	A psychological decline of deep dejection.
Risk Related Behaviors:	Engaging in chance or hazardous endeavors which negatively affect the reproductive health of the mother and/or her offspring.
Beck Depression Index:	Index used to measure levels of depression.

Operational Definitions:

Age:	For the purpose of this study, age is defined by age of mother at birth of her first child and corresponding categories adolescent mother, age 17 and under, and adult mother, age 18 and older.
Religiosity:	For the purpose of this study, religiosity is defined by the scores to responses to questions pertaining to

	the significance of religion: How religious are you? (Not religious, Somewhat religious, and Very religious). and How important is religion to you? (Not important, Somewhat important, and Very Important).
Depression:	For the purpose of this study, depression is defined as the score of responses to questions from the Beck Depression Index. The scores are categorized into levels of depression: Low 0-20, Moderated 21-39, and Severe 40-100.
Risk Related Behaviors:	For the purpose of this study, risk related behaviors are operationalized as the risk behavior indicators: Birth control method used or not used, unwanted miscarriage, unwanted abortion, unwanted pregnancy, unwanted birth, drug use, inconsistent condom use, and utilization or non utilization of abstinence as a birth control method.
Depression:	The Beck Depression Index is defined as the scores of the responses of the mothers for measuring levels of depression. Scores of 0-20 indicates low levels of depression; 21-39 indicates moderate

levels of depression; and 40-100 indicates high levels of depression.

Chapter 2

REVIEW OF LITERATURE

For the purpose of this study, the literature review was discussed in two sections. The first section overviews the literature on the growth and development of females, and the meaning of motherhood in African American women. The next section pertains to risk related behaviors in women, and the influence of age, religiosity, depression and risky related behaviors. A summary concludes this chapter.

Adolescent Growth and Development Characteristics

In most girls the initial indication of puberty is the appearance of breast buds, an event known as thelarche. This generally occurs between the ages of 9 and 13.5 years. Thelarche is then followed by the growth of pubic hair, known as adrenarche (Wong & Perry, 1998).

The initial appearance of menstruation, or menarche, usually occurs about 2 years after the first prepubescent changes, 3 months after attainment of peak height velocity, and 3 months after attainment of peak weight velocity. The average age of menarche in the United States is 12.8 years, and ovulation and regular menstruation usually occur up to approximately 14 months later (Wong & Perry, 1998).

At age 15 to 17 years, growth decelerating occurs in girls. They have reached 95% of their adult height and secondary sex characteristics are well advanced. Cognitively, adolescents age 12-14 years have limited abstract thought, and normality is compared with their peers; while adolescents 15 to 17 begin to develop a greater capacity for abstract thinking. These teens also tend to enjoy intellectual powers - and often think in idealistic terms. In the late adolescent/young adult stage, abstract thought is established and long range options are perceived. Problems are viewed comprehensively and intellectual and functional identity is established (Wong & Perry, 1998).

Sexuality development in adolescents ages 12 to 14 years tends to be a "self-exploring" and "self-evaluation" phase. They usually have limited dating experiences with limited intimacy. As teens mature (ages 15 to 17) multiple (plural) relationships occur. This is the usual period of "sex appeal" exploration and the feelings of "being in love" are realized. Tentative relationships are also established. At ages 18 and older, stable relationships and attachments to one another occur. Dating as a male and female pair is the norm. Intimacy at this stage involves commitment rather than exploration and romanticism (Wong & Perry, 1998).

Characteristics of Adult Women

In the mid 1990's, the average American woman is 34 years of age and is more likely to be college educated than the average American man. American women outlive their male counterparts by approximately seven years. Despite these advantages,

American women are disproportionately represented among the poor, single, heads of households, and the chronically ill and disabled (Allen & Phillips, 1997).

Today's average woman is approximately 34 years old. By the middle of the next century, however, the average American woman could be approximately 45 years of age. The average age hides much of the diversity and disparity among American women. Among 100 women today, 84 are Caucasian, 13 are African American, 3 are other races, and 8 are of Hispanic origin. By the middle of the next century, projections indicate that among 100 women, 75 will be Caucasian, 16 will be African American, 9 will be other races, and 17 will be of Hispanic culture (Allen & Phillips, 1997).

Educational status is positively correlated with health status regardless of gender. Over the past 20 years, there has been a marked increased in the number of women college graduates. Asian American women are reportedly most likely to be college educated (27%), Caucasian women (13%), and African American women (8%) (Taeubner, 1991).

Employment status of women vary with regard to race. Female African American teenagers are reportedly less likely to be in the labor force than Caucasian teenagers. In a 1987 report, 39.6% of female African American teenagers were in the work force compared to 56.5% of Caucasian teenagers. However, adult African American women (ages 20 and older) tended more likely to be employed (60%) than adult Caucasian women (55.6%) (Taeubner, 1991).

Earnings for women have consistently been lower than that of men (the same age and comparable education). In a study conducted in 1986, men with a college education

aged 25-34 years averaged $28,000, while women of the same education and age group averaged $22,000. Education positively correlates with earnings. Women tended to have lower educational levels than men. In 1987, a study revealed than 13.4% of all women were below the poverty line, compared with 9.1% of all men (Taeubner, 1991).

Over the past 20 years, marital status for women has declined. In comparison to 1970 statistics when 11% of women reported never married, in 1993, 30% of women aged 25 to 29 reported never married. (Taeubner, 1991).

Childbearing for adult women differ by races, particularly for women age 25 and younger. African American women under age 25, tend to have a higher fertility rate than Caucasian women of the same age. After age 35, there is much less difference reported between the two groups of races (Taeubner, 1991).

Health status and life expectancy of women varies between the races with Caucasian women (79.3 years) and African American women (73.6 years). Women of both races (African American and Caucasian) suffer from conditions found in both races: cardiovascular disease, cerebrovascular disease, and cancer. However, more African American women tend to die from these conditions due to lack prevention and treatment measures which are more commonly accessible to and adhered to by Caucasian women (Mastroianni, Faden, & Federman, 1994; CDC, 1993).

Adolescent and Adult Mothers

One common standard for becoming a woman that is accepted by a majority of people in the community was the time when girls gave birth to their first child. This

"milestone" was identified as the demarcation line that separated girls from women. The child-bearing experience enhances maturity.

Differences in older and younger mothers with regard to parenting are noted in a study by Chase-Lansdale, Brooks-Gunn, and Zamsky (1994). In this study, it was found that multi-generational families most likely to provide positive parenting examples were those where older mothers did not live with the grandmothers. "Whereas, in families with very young mothers co-residing with grandmothers showed higher quality of parenting than did non-co-residing ones" (p.127).

To reinforce what has been taught schools pertaining to sex education and sex information has been cited as an issue of concern (Hockenberry-Eaton, Richman, Dilorio, Rivero, & Maibach, 1996). In their study, the impact of personal and family characteristics on adolescent's HIV risk and risk reduction is discussed. Findings revealed that mothers were not able to define sexual development terms to adequately teach their children about sex. Adolescents tend to lack accurate knowledge regarding reproductive physiology, especially in the timing of fertility awareness about birth control pills may be greater today than it was a decade ago, ignorance remains about most other forms and methods of birth control (Panzarine & Gould, 1988). Green, Johnson, and Kaplan (1992) examined the relationship of cognitive capacity, cognitive egocentrism, and experience factors to decision-making in contraceptive usage. In this study, it is proposed that as one ages, cognitive capacity increases. This theory, however, conflicts with the study conducted by Hockenberry-Eaton, et al. (1996), where mothers lacked the

knowledge to adequately educate their children regarding sexual development and sexual education.

In efforts to work to try and understand adolescent risk, Jessor (1991) sketched a conceptual framework which examines lifestyle risks from socio/developmental and psychological perspectives. Joffe and Radius (1992) used a self-efficacy theory to explain adolescent condom use. As one becomes older, one is more able to use self-efficacy regarding risk related behaviors.

Wayland and Rawlins (1997) discussed teens general lack of knowledge with regard to childbearing and information about their children's normal growth and development and safety issues. Adolescents are less likely to have information on normal growth and development because of their cognitive development and level of readiness for parenthood.

The Meaning of Motherhood in African American Women

Historically, childbearing has been revered as the most significant role in a female's life. Procreative powers, possessed by women and girls have important value in the African American culture. Children are greatly valued and a strong emphasis is placed on one's being able to give birth (Ladner, 1971). Therefore, the true confirmation of womanhood is one's ability to bring forth life.

The ability to bear children also represents (for girls) a maturity that they feel

cannot be gained any other way. Rainwater (1965) asserts that "it would seem that for girls, pregnancy is the real measure of maturity, the dividing line between adolescence and womanhood" (p. 216 in Ladner, 1971).

Harrison (1977) reports that African American women have always valued the role of mother. Motherhood is an important dimension of their sex-role identity. It has also been reported that African American women have been known to give the mother role priority over the wife and worker roles (Blood & Wolfe, 1971; Harrison & Minor, 1978).

Age Related Literature on Risk Related Behaviors in African Americans

Specific information on risk related behaviors in younger and older mother needs further exploration. The following section will speak to literature related to age and risk related behaviors in African Americans.

Currently, there has been an increased focus on age specific risk related behaviors. Especially with the increased onset of STDs in the adolescent population. African American adolescents are likely to be at an elevated risk for STDs give the disproportionately high incidence of AIDS and HIV infection among African Americans and other minorities (Lawrence, Brasfield, Jefferson, Allyene, & Shirley, 1994).

One of the oldest and most widely accepted beliefs regarding sexual risk behaviors is that adolescents are high risk takers. In a longitudinal study conducted by Feldman, Rosenthal, Brown, and Canning (1995) that focused on the relationship between peer relationships in sixth grade and the number of sexual partners in the tenth

grade. Low self-restraint led to increased misconduct which led to increased opportunities for sexual intercourse with multiple partners. Likewise, in a study conducted on a convenience sample of 250 African American males ages 12 to 70, the mean age was 24 years, the mean age at first intercourse was 13.4 years. Only one-fourth of the sample used a method of birth control at first intercourse. After first coitus, only 34.3% reported using any form of contraception with regularity. One hundred percent of this sample reported receiving information about sex and 83.3% stated they had received medium to large amounts of information on birth control (Tucker, 1991).

In 1988, African American women ages 15-19 years continued to have the highest rate of sexual activity. Fifty-eight percent of these sexually active females reported having sex with two or more partners. Younger African American teens are at risk for early parenthood (Pitman, Wilson, Adams-Taylor, & Randolph, 1992). Nearly 6 of 10 births to teens younger than age 15 were to African American teens. Fifty-two percent of children under age 14 who have AIDS are African American (CDC, 1990).

Early sexual activity and risk related behaviors. Young adolescent girls who participate in early sexual activity are at a greater risk of becoming pregnant than are older counterparts. Young adolescents are less knowledgeable about reproduction and contraception use (Marsiglio & Mott, 1986). These teens may not have the cognitive ability to perceive that they are at risk of becoming pregnant if they are sexually active. Because they are younger and have less information, they are not always aware of the repercussions of their actions, and they are less likely to use contraceptives to prevent pregnancy and or STDs (Zelnik & Shah, 1985).

Many studies have been done comparing mother/teen dyads and risk behaviors. In these studies teens were pregnant and non-pregnant (Rogers & Lee, 1992). Family structure has been examined using two-parent family households and black and white teens, male and female teens who where virgins and non-virgins (Young, Jensen, Olsen, & Cundick, 1991). This report indicated that white females, with two-parent households, tended to remain virgins, however, once the white adolescent female became sexually active, she had more sexual encounters than the black adolescent female. The number of parents n the household was not a positive indicator for the black adolescent female in maintaining virginity. Social support and teen parenting has been studied (Lawrence, Brasfield, Jefferson, Allyene, & Shirley, 1994). Findings here noted that adolescents with fewer social supports were more likely to engage in casual sex and have higher levels of STDs.

Resnick and Burt (1996) report that a number of behavioral traits most consistently identified in the literature as being indicative of serious problems of risk in adolescents include: early sexual behavior, school truancy, running away from home, early use of tobacco, alcohol, and other drugs as well as delinquent peers.

Risk Related Behaviors

Inconsistent use or lack of birth control. Hormonal contraceptives are indicated for pregnancy prevention or birth control. The mechanism of action in ovulation is inhibited by suppression follicle-stimulating hormone (FSH) and luteinizing hormone (LH). These contraceptives may alter cervical mucus and endometrial

environment, preventing penetration by sperm and implantation of egg. Biphasic Oral contraceptives inhibit ovulation by suppressing the FSH and LH. It may also alter cervical mucus and the endometrial environment, prevention of penetration by sperm and implantation of the egg. In addition, there is a smaller dosage of progestin in phase I which allows for proliferation of the endometrium. Larger amounts of progestin are noted in phase II which allows for secretory development. Triphasic Oral contraceptives again, inhibits the suppression of FSH and LH. The cervical mucus and endometrial environment which prevents the penetration of sperm and implantation of the egg. There are varying doses of estrogen/progestin and may more closely mimic natural hormonal fluctuations. Progestin-Only contraceptives and Contraceptive Implants mechanism of action is not clearly known. These contraceptives may alter cervical mucus and endometrial environment, preventing penetration by sperm and implantation of the egg. Ovulation may also be suppressed. Medroxyprogesterone Injection inhibits gonadotropin secretion, follicle maturation, and ovulation. It also produces endometrial thinning (Deglin & Vallerand, 1995).

Contraindications and precautions for these medicinal contraceptives include thromboembolic disorders, cardiovascular disease, and cerebrovascular disease. Caution is to be taken in clients with a history of cigarette smoking and also in clients with the presence of other cardiovascular risk factors and a history of diabetes mellitus, bleeding disorders or headaches. Adverse reactions and side effects noted with the use of contraceptive hormones include: migraine headaches; depression; contact lens intolerance; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral

hemorrhage; thrombophlebitis; thromboembolic phenomenon; Raynaud's disease; hypertension; edema; nausea; vomiting; rash; bloating; dysmenorrhea; and weight changes (Deglin & Vallerand, 1995).

Elective Abortions

Elective abortion is the intentional interruption of a viable pregnancy. The indication for an elective abortion is by request of the mother but not for reasons of maternal risk or fetal disease (Wong & Perry, 1998).

Many women report that there is more than one factor contributing to the decision to abort (Thompson & Thompson, 1990). Most of the women in the United States who have had abortions are white and younger than age 24 (CDC, 1994). One-fourth of all abortions are obtained by married women (Wallach & Zacur, 1995).

Non-Use of Contraceptives

The highest risk for adolescents begins with sexual intercourse, without the use of contraception at the initial intercourse. This action sets the adolescent up for a possible unintended pregnancy, sexually transmitted diseases, and other possible reproductive infections (Dryfoos, 1990).

Once adolescents become sexually active, the usage of contraceptives becomes important. The inconsistent use of condoms and other forms of birth control have resulted in over one million pregnant teens and increasing incidences of STDs (Cates, 1991). The need for behavioral change of risk related practices has been of the highest

priority since the onset of the AIDS epidemic. The major focus of education has been emphasis on condom use (Kramer, 1991) . Increasing the use of condoms by adolescents is an important public health goal. Although this protective behavior is beginning to be adopted by increasing numbers of sexually active adolescents, many of them still do not use them, and consistently using condoms remains infrequent (Sonnestein, Pleck, & Ku, 1989; Hingson, Strunin, & Berlin, 1988, 1990; Shafer & Boyer, 1991; Weisman, Plichta, & Natheson, 1991).

Disease. There have been a great number of studies related to risk related behavior and its outcomes. One result of risk related behavior is STDs including HIV and AIDS. An alarming number of the studies relate to the prevalence and incidences of sexually transmitted diseases (STDs) and AIDS which is now in epidemic proportion in some African third world countries. However, few if any of these studies compare risk related behavior of older and younger African American mothers.

One of the most serious consequences of STDs, particularly syphilis, is the increased likelihood of HIV infection (Office of Technology Assessment, 1991). AIDS is now the leading killer of adults aged 24-44, many of who were infected as adolescents (CDC, 1996). The number of AIDS cases is growing faster among African American women than any major race-gender group.

STDs are a major health concern of the 1990's as the incidences of these diseases increases (Ament & Whalen, 1996). High risk sexual behaviors such as multiple partners and unprotected sexual intercourse has dramatically increased the prevalence of STDs in the United States (Cates, 1991). Nearly 75% of college students have reported that they

have engaged in unprotected sexual activity with multiple partners. Rates of reported AIDS cases are seven times higher among African-Americans, and three times higher among Hispanics than for whites. AIDS is now the leading cause of death among all Americans aged 25-44, accounting for 19% of the deaths in this age group (CDC, 1996). Half of all AIDS cases among women are African American women, and is the third leading cause of death for women aged 15 to 44 (Jenkins, 1992; CDC, 1996). For the researcher, these statistics are alarming. Risk related behavior is proving to be a fatal encounter of many African American women. As these African American mothers age, they are engaging in risk related behaviors? What is accounting for the incidences of STDs, HIV infections, and AIDS for mothers greater than 18 years of age? Is there a difference in the average age of younger African American mothers who engage in risk related behaviors versus those who do not? The purpose of this study is to compare the risk related behaviors, religiosity, and depression in younger and older African American mothers.

The likelihood of engaging in risk related behaviors is based on differences in age, culture, and decision-making (Pittman, Wilson, Adams-Taylor, & Randolph, 1992). Additionally it is believed that attitudes and cultural values related to identity, self-image, gender/role socialization, and contraception have a role in the increased widespread of HIV/AIDS in African American youth (Pittman, et al., 1992).

Diseases related to risk related behavior, AIDS and STDs, are growing at astonishing rates. Females, particularly African American females are those reported to be most affected by this epidemic. African American females are at a greater risk for

early initiation of intercourse, inconsistent contraceptive use, which leads to unplanned pregnancy or worse - HIV infection and AIDS.

Drug Use

Alcohol. In the United States, it is estimated that 50% to 80% of all pregnant women use alcohol. Data are difficult to obtain because alcohol is so rapidly absorbed in the small intestine and is metabolized in the liver. A major concern of health care providers is the under reporting of alcohol use in pregnancy. It is estimated that 1% to 55% of pregnant women meet diagnostic criterial for alcoholism. Predisposing factors for alcohol abuse in pregnancy include the following: women who smoke, who are unmarried, less educated, and younger than age 25. Alcohol abuse during pregnancy is the leading cause of fetal retardation in the U.S. (National Organization on Fetal Alcoholism, 1995).

Marijuana. Marijuana smoke has the characteristics of tobacco smoke and has similar dangers (Cook, et al., 1990). Marijuana easily crosses the placenta. Both cigarettes and marijuana increases carbon monoxide levels in the mother's blood, and this reduces oxygen to the fetus.

Research findings report some inconsistencies with regard to marijuana. It is been reported that marijuana use may cause spontaneous abortions and stillbirths. Effects on the neonate varies and may include altered sleep and arousal patterns and tremulousness. Women who abuse marijuana are more likely to bear children with features similar to Fetal Alcohol Syndrome. These findings support the theory that marijuana may have a

synergic effect on alcohol and other substances (Cook, et al., 1990). Marijuana rapidly passes into breast milk.

Cocaine. The increase use of cocaine and even more addictive "crack" among childbearing women has been great in the past few years (Glantz & Woods, 1993; Vaughn, 1993). Cocaine is used in all cultures, however, its low cost and availability makes it the drug of choice among the economically disadvantaged.

In the U.S., it is estimated that 10% to 15% of all pregnant women use cocaine (Glantz & Woods, 1993; Lynch & McKeon, 1990). Cocaine affects fetal movement and development , cause premature birth, and cocaine addiction in the neonate.

Heroin. The incidence of heroin use in pregnancy is unknown, however, persons with a heroin dependency may use multiple drugs. Opiods, such as heroin are the most commonly abused by those in their late teens and early twenties. Studies report that approximately 0.7% of the adult population uses heroin (American Psychiatric Association, 1994).

Medical complications of heroin use include an increased risk for bloodborne pathogens such as HIV or hepatitis B. Narcotics may depress fetal movement. The most common effect is interference with fetal growth and increased incidence of prematurity (Ney, 1990).

Methamphetamine. Approximately 2% of the adult population experience methamphetamine abuse at some time during their lives. It is most commonly abused in the 18 to 30 year-old age group. Most of the complications of methamphetamines are

similar to those of cocaine. However, fewer maternal-neonate complications are noted with these drugs.

Methamphetamine-exposed pregnant women have higher rates of preterm births and more neonates with intrauterine growth restriction and smaller head circumferences. Neonatal behavioral patterns are characterized by abnormal sleep patterns, poor feeding, tremors, and hypertonia (Cook, et al., 1990).

Religiosity-Historical Perspective and Influence

From an historical perspective, the African American church, as it is known today, was evolving into its own pattern long before official efforts were made to Christianize the New World African. In the seventeenth century, slaves were considered infidels; and because of this belief, the slaves were allowed to have "secret religious meetings" to promote their practices of beliefs held dear (Carter, Walker, & Jones, 1991).

"Slaves, not masters, took the initiative to translate their African beliefs into English and into inescapably Christian terms. They also sorted through the Christian bible and selected ideas useful to them in the new slave experience. By the time the masters were willing to concede souls to slaves, satisfied that Christian faith could be used to enforce obedience and increase market value, the slaves had long since established their underground version of the true faith; and they were well along in their own 'individual institution', or underground church" (Carter, et al., 1991, p. 196).

Foremost in the unrecorded religious beliefs of the African slaves in the later seventeenth and early in the eighteenth century were the absolute belief in the Supreme

God and the absolute acceptance of Jesus as the Son of God. They believed that God's grace was sufficient and it could save a sinner from destruction. The concept of hell was embraced and often used by white preachers as a form of fiery symbolism to control slaves (Carter, et al., 1991).

The Praise House. The Praise House was the hut or building used by slaves for their nightly meetings of prayer and song. At times, these meetings were held in secret, in open fields, and at other times, they were held with permission from the master. These meetings served as a safe place for the slave to vent their emotions and feelings about their life's condition under an attitude free of a restrictive boss. It was in the Praise House that the slave got religion and his soul was converted (Carter, et al., 1991). In Carter, et al., it is further stated that: "These meetings celebrated life under the harshest human conditions, and affirmed the slave's personhood in a world where he was sold as a piece of property. Everyone in this setting was somebody. He could sing, dance, pray, or shout with fervor as life permitted" (p. 8).

In the African American church, the vision of a nobler life is lifted up. It views life as a perennial struggle by people in pilgrimage. Because the African American church is nondependent on the greater society, it is free to be prophetic. There are distinct differences between the white church and the African American church:

African American Church	White Church
Church of the oppressed	Church of the oppressor
Theology of survival	Theology of success
Theology of Immanence	Theology of Transcendence
Prophetic/ Free Pulpit	Priestly/Restricted Pulpit
Spontaneity in worship	Rigidity in worship
Social ferment	Status quo oriented
Activistic Affliction	Apathy
Substance	Shadow
Heterogeneous	Homogeneous

(Carter, et al., 1991, pp. 96-97).

Religion and risk behaviors. Historically, the African American church and faith have remained strong and powerful in the lives of African American people. In the church, kinship structures have been a key in holding and keeping the family together. It represents a sanctuary for the family which stresses family values and responsibility, and there is still a continued tendency for the church to provide direction and psychological support for dealing with the stressors of everyday existence. The church, and religion have been an essential staple for the African American in society, particularly, the African American mother.

The many functions of the African American church were described by Benjamin Mays and Joseph Nicholson: "Despite its problems and failures, there was a certain 'genius' of the soul of the black church that gives it life and vitality, that makes it stand

out significantly above its buildings, creeds, rituals, and doctrines; something like that makes the institution unique" (Billingsley, 1992, p. 354).

At the apex of this "genius" was the notion of complete ownership and control by the African American people. It (the church) represented freedom, independence, and respect for its leadership, as well as opportunity for self-esteem, self-development, leadership, and relaxation. It also serves as a community center as well as a recreational center which encourages education, business development, and democratic fellowship (Billingsley, 1992). Further, Blackwell (1991) reports that the black church is a basis for citizenship training and community social action; it provides educative and social roles; it is an agency for the development of black business; it is an instrument for black leadership; and an index of social class. The church is critical, especially for African American families undergoing transformation crises such as poverty and inadequate health care that plague society today.

A study reported at the 1991 meeting of the Association of Black Sociologists revealed that the strongly held belief in God, apart from religious participation, had a positive effect on the outcome of pregnancies in low- and moderate-income of African American unmarried women. Women with strongest beliefs were more likely to have healthy babies. Families and individuals actively involved in a religious life also tend to have more positive life outcomes than those who are not actively involved. In addition, McAdoo (1983) reports in a study conducted on women and stress that, women under the most stress tended to be the most religious. These women attended church more frequently and tended to have more of a religious orientation.

In the National Survey of Black Americans (1980), 86% of the African American females considered themselves religious, 72% considered religion to be very important when they were young and 80% considered the church as very important to them now. Eighty-four percent of the women report that they pray daily.

Moore (1977) found in a self-rating inventory and religiosity index study which correlated these two categories, that in the male students there was significant correlation between self-rating and religiosity and with the females there was no correlation. McAdoo (1995) reports in a study conducted on stress in single African American mothers, that religion provides emotional support, however, women who are not religious, tended to have lower stress levels. In a study of 251 college students asked to describe their own degree of religiousness, this self report study revealed that 75% of the students believed they were more religious now than they had ever been, and this correlated positively with GPAs above the sample mean (Zorn, 1989). Based on the literature reviewed, one would anticipate that older women are more religious than younger women. There is a scarce amount of literature pertaining to adolescent African American females regarding religiosity and its influence on motherhood status and depression.

Depression

Depression is one of the most prevalent disorders and has been recognized since the time of the early Egyptians. It may be a cause of risk related behavior or depression may be the result of risk related behavior. Regardless, depression is a common thread

inherent in postpartum women of all races and ethnicity. It is also exhibited in females throughout the lifespan and may be exhibited in a host of ways Anxiety is one of the primary features of depression in adolescents (Goldman, 1988).

Depression and Risk Behavior. In a study conducted by Culp, Clyman, and Culp (1995), it is reported that adolescents who have symptoms of depressed mood and who believe they must care for their own problems are over represented among teenagers who think of attempting suicide. In another study conducted on 455 adolescents to determine the relationship between depression and parental happiness, social support, intimate relationships, self-esteem, and risk-taking behaviors, findings revealed that adolescents with depressed moods were less intimate with both parents, felt less social support and had lower self esteem than peers. Adolescents who perceived their mother or father as unhappy also reported less intimacy with both parents and less social support (Lasko, Field, Gonzalez, Harding, Yando, & Bendell, 1996).

The incidence of postpartum depression without psychotic features is 10% to 15% in all childbearing women. Predisposing factors of postpartum depression may be hormone-related or infant related. Environmental and family stress issues may also be connected to postpartum depression (Gotlib, 1991). In general, women who experience depression often have fewer personal support systems, more stressful life events, and fewer personal resources to combat these events. Women with feelings of postpartum closeness to their husbands or partners report fewer cases of depressive signs and symptoms (Logsdon, McBride, & Birkimer, 1994).

Predictive factors for postpartum depression that may assist the nurse in assessing potential problems include a previous history of mood disorder, meager or absent social support, and stressful life events (e.g., single parent, divorce, or recent death of parent or child (Auerbach & Jacobi, 1990; Stein, et al., 1989)).

Clinical manifestations of postpartum depression are severe anxiety, panic attacks, spontaneous crying long after the usual one to four days of postpartum blues. Alterations in maternal-infant attachment may result from postpartum depression and infant separation from the mother (American Psychiatric Association, 1994).

There is substantial literature on the relationship between maternal depression and child adjustment (Downey & Coyne, 1990). Mothers diagnosed with major depressive disorder have been found to have children with higher rates of psychiatric disorders in general (Orvaschel, Walsh-Allis, & Ye, 1988); cognitive deficits (Kaplan, Beardslee, & Keller, 1987); and a full range of adjustment problems (Downey & Coyne, 1990). Even less severe forms of maternal depression have been associated with difficulties in child function. Thus, parental depression, whether defined as a disorder or simply as a mood predicts child adjustment.

A study, reported by O'Hara, Neuraber, and Zekoski (1984), found maternal depression to range from 25-30% during the first three months after delivery. Even mild depression may effect a new mother's relationship with her child. For example, in one study, postpartum depressed mothers demonstrated less rocking, gaze, and positive regard toward the infants than did nondepressed mothers (Livingood, Dean, & Smith, 1983). Others have reported less frequent positive and more frequent negative states among

depressed mother-infant dyads (Cohn, Campbell, Matias, & Hopkins, 1990; Field, 1992; Healy, Goldstein & Guthertz, 1990).

Finally, in a study conducted by Hubbs-Tait and Garmon (1995), moral reasoning and risk related behaviors were found to be inversely correlated as was the relationship between AIDS knowledge and sexual behaviors. AIDS knowledge and risk related behaviors are inversely correlated for higher-level moral reasoners and not for lower level reasoners. There tends to be more literature on self-esteem, early motherhood, locus of control and violence in African American adolescents. These issues are considered contributing factors to depression, however, there is a lack of information on depression itself in this particular population of women.

Summary

The theoretical framework for this study is an integrated ecological framework using strengths of the Social Control Theory and the Health Belief Model. From this perspective, this framework served as a guide for this study of age, religiosity, and depression on risk related behaviors in African American mothers.

Age is a significant variable in the study which discerns older and younger mothers and their level of engagement in risky behaviors. Adolescent females, expectantly, will be the greater risk takers with regard to sexual behavior. Reportedly, African American adolescent females engage in sexual behaviors earlier than other adolescents. With the increase incidences of AIDS and unplanned pregnancies, adolescent African American women tend to be the most critically affected. Abortions

(elective) are also used as a form of birth control in some instances. The most widely represented group of women engaging in abortions are single and under the age of 24 .

African American adult women and Caucasian women vary in areas of employment, fertility, and life expectancy. It has been reported that adult Caucasian women have lower employment status, lower fertility level at earlier ages, and longer life expectancies than adult African American women. Caucasian women are more educated, and Asian women surpass them with regard to college and advanced degree obtainment. However, all women, are at greater risk for being at the poverty level or below the poverty level regardless of race.

Lack of knowledge regarding sexual risk behavior is believed to be related to increased risk taking. In fact, because of a lack of knowledge and maturity (including physical maturity), risks are engaged in without knowing that they are indeed risky behaviors. An example of this is consistent condom usage. The pill or foam or Norplant may protect the adolescent from and unwanted pregnancy, however, it will not protect them from sexually transmitted diseases, only adding condoms or abstinence will prevent this.

Drug use while pregnant has implications for both the health of the mother and the fetus. Children born to mothers who are abusers and users of alcohol, marijuana, cocaine, amphetamines, and heroin have negative health outcomes with regard to physical and cognitive development.

The influence of religion on risky behaviors is particularly important with regard to African Americans. For the African American, the church and religion have long

served as the backbone and roots of cultural and moral development. This influence dates back to the African ancestry, and still serves as an influence in the lives of many African Americans.

Depression is noted as a variable of influence or it may serve as a result for risk related behavior. Depression more specifically, post partum depression, affects mothers of all cultures, however, little research has been noted on depression and it's influence on age with regard to risk related behaviors in African American mothers. This study will examine the influence of age on risk related behaviors in adolescent and adult African American mothers.

Research Questions

Based on a review of the aforementioned literature the following research questions are posed:

Question 1: Does religion and depression influence engagement in risk related behaviors in African American women?

Question 2: Are adolescent African American mothers less likely to use condoms than adult African American mothers?

Question 3: Are adolescent African American mothers less likely to use birth control methods than adult African American mothers?

Question 4: Are adolescent African American mothers less likely to abstain from sexual activity than adult mothers?

Question 5: Are adolescent African American mothers more likely to experience more unwanted pregnancies and births than adult African American mothers?

Question 6: Are adolescent African American mothers more likely to have undesired miscarriages and abortions than adult African American mothers?

Question 7: Are adolescent African American mothers more likely to use drugs than adult African American mothers?

Question 8: Are adolescent African American mothers more likely to have higher levels of depression than adult African American mothers?

Question 9: Do adolescent African American mothers have lower degrees of religiosity than adult African American mothers?

Hypotheses

From the aforementioned research questions, the following hypotheses were proposed:

Hypothesis 1: Religion and depression positively influence engagement of risk related behaviors in African American mothers.

Hypothesis 2: Adolescent African American mothers are less likely to use condoms than older African American mothers.

Hypothesis 3: Adolescent African American mothers are less likely to use birth control methods than are older African American mothers.

Hypothesis 4: Adolescent African American mothers are less likely to abstain from sexual activity than are older mothers.

Hypothesis 5: Adolescent African American mothers are more likely to experience more unwanted pregnancies and births than are older African American mothers.

Hypothesis 6: Adolescent African American mothers are more likely to have more undesired miscarriages and abortions than older African American mothers.

Hypothesis 7: Adolescent African American mothers are more likely to use drugs than are older African American mothers.

Hypothesis 8: Adolescent African American mothers are more likely to have higher levels of depression than older African American mothers.

Hypothesis 9: Adolescent African American mothers have a lower degrees of religiosity than older African American mothers.

Chapter 3

METHODS

This section of the study includes the sample, a description of the sample, variable specification, information on and data analysis and limitations of secondary analysis.

Sample and Materials

The sample for this study was obtained from the Ethnic Families Project data set which was collected in 1996 by H.P. McAdoo, PhD entitled: The Family Dynamics of African American and Mexican American Children With Learning Disabilities. This Midwestern regional sample consisted of the 127 African American mothers. Subjects were a convenience sample selected based on the acknowledgment that they were African American, female, and mothers.

Mothers ranged in age from 20 to 60. The mean age of the mothers at the birth of their first child was 19 years. Sixty-three percent (63%) of the mothers gave birth when they were between the ages of 13 and 19 years while 37% were between 20 and 38 years of age.

Fifty-three percent (53%) of the women had never been married, while 47% were married at one time in their life or lived as a "common law couple". The mean

educational level for this population of mothers was 12.44 years. The income levels were very low, with average income of less than $12,000 annually. The mean number of children living in the household was three (Table 1).

Variable Specification

Measurement of the Variables. The variables in this study were selected from self-report measures obtained from the original 1994-1996 interview schedules. The individual items were selected for the collective list of questions in the Health Status section; Life Events Section; Feelings Section; and the Stress Section using the BDI. The responses were recoded into appropriate categories for analysis.

Independent Variables. As stated earlier, age was operationalized as the age of the mother at the birth of her first child. Age was then further broken down into two categories. These categories were recoded into dichotomous variables for analysis using the two categories (groups) 0 (group 1) were younger mothers (ages 13-17), and 1 (group 2) were older mothers (ages 18 and older).

Religiosity was defined as the degree to which religion influences ones life. It was measured by using the Likert-like scale (1-3) responses to: How religious are you? 1) Not religious; 2) Somewhat religious; and 3) Very religious. How important is religion to you? was also used to measure religiosity. The responses to this question were: 1) Not religious; 2) Somewhat religious; and 3) Very religious. These responses were recoded for analysis.

Table 1 - Demographics of African American Mothers

Variables	Adolescent Mothers	Adult Mothers
Age at First Birth	53	71
Income	<$12,000	<$12,000
Educational Level	12 years	12 years
Number of Children	Mean = 3	Mean = 3
Mother's Religion		
Catholic	1	3
Protestant	1	5
Baptist	35	32
Jewish	0	1
Methodist	0	4
Other	8	19
No Religion	5	1

For the purpose of this study, depression is defined by the Beck Depression Inventory (BDI) indicated by scores reported in study which depict level of depression reflected in responses. The BDI, developed in 1967, is the most frequently cited self-report measure of depression. It contains 21 items (13 in the short version) which encompasses four major components of depression: affective; cognitive; behavioral; and physiological. This tool is applicable in measuring the intensity of depressive symptoms as well as a screening tool for determining the presence or absence of depression (Robinson, Shaver, & Wrightman, 1991). Depression was operatonalized by the scores from the BDI. Scores between the ranges of 0-20 represented mild levels of depression; scores of 21-39 were considered moderate levels of depression; and scores of 40-100 represented severe levels of depression.

Dependent variables. The dependent variable for this study was: Risk related behaviors which were defined by the following five risk indicators: 1) condom use or abstinence; 2) birth control usage; 3) unwanted abortion or miscarriage; 4) unwanted pregnancy or birth; and 5) drug use.

Condom use or abstinence was operationalized as birth control used compared to all of those using birth control other than condoms and all of those who are not using birth control. Birth control usage was defined as the non use or inconsistent use of any birth control method. Experienced an unwanted pregnancy was an unplanned pregnancy, followed by the birth of an undesired child. Experienced an unwanted miscarriage or abortion was defined as a mother who had been pregnant and either lost her child or was

coerced into having an abortion. Use of drugs was operationalized as maternal use of alcohol or other non-prescribed chemical substances within the last month.

The following questions representing the five risk-related indicators from the study were derived from the Health Status, Life Events, Religion, and Depression sections of the Family Environment Survey:

1) Are you using any birth control methods now such as:

a) Pills ___ b) Diaphragm ___ c) IUD ___ d) Condoms ___

e) Foam ___ f) Abstinence ___ g) Norplant ___ h) Depo Provera ___

I) Tubal ligation/vasectomy ___ j) Other: (specify) _____

2) Have you used drugs not for a medical reason (in the last month)?

3) Do you have problems getting pregnant?.

Instrumentation and Measures

The principle instrument of the original study was a semi-structured interview schedule (McAdoo & Villaruel, 1996). This instrument (Ethnic Families Research Project Instrument) consisted of two questionnaires (including the Families Environmental Scale survey) with multiple sections including: general demographic information, health status section, life events section, stress scale indicator and feelings, child's health and education, and depression section.

Data Analysis

Variables related to risks from responses to surveys from these mothers were analyzed. Age, as a variable, examined adolescent African American mothers and adult African American mothers with regard to risk related behaviors. Religiosity and depression were also addressed in both adolescent and adult African American mothers and further examined with regard to risk related behaviors.

Descriptive statistics were presented on the sample. The statistics used to test the hypotheses were Chi-square (Cross- tabs). Fisher's Exact Test (One-Tail) was used primarily due to the direction of the hypotheses. Adolescent African American mothers are less likely to use birth control, more likely to use drugs, and have a greater likelihood of being depressed than are adult African American mothers. Fisher's Exact Test has level of significance $p<.05$. This test was used to test hypotheses: 1, 2, 3, 4, 5, and 6. Chi-square ($p<.05$ level of significance) test was used to test hypotheses: 6 and 7. Chi-square is a nonparametiric test of statistical significance used to assess the relationship between risk related behaviors and all independent variables.

Limitations of Secondary Analysis

A key issue associated with the use of secondary analysis of data involves the question of validity (Babbie, 1983). The concern being that researchers who collect original data for one particular purpose may not include specific questions that will measure what another researcher is particularly interested in studying. However, questions of the original study may come close to measuring what he or she is interested

in or related questions from the study can often be used. The question becomes: "Do these questions provide a valid measure of the variables to be analyzed?"

This study examined the relationship of age, religion, and depression on risk related behaviors among African American mothers. This retrospective, exploratory study did pose a few problems in the original data, the researchers did not compare the aforementioned variables for adolescent and adult mothers to risk related behaviors; nor did they examine the relationships of religion and depression with regard to risk related behaviors among African Americans. Interpretation and presentation of the data was contingent upon the original researchers' display of the data; accurate and consistent description of the sample; methodology, results, and accurate, appropriate statistical measures (Stewart, 1987). Secondary analysis and retrospective studies tend to limit the researcher to data that cannot be easily manipulated and/or compared over a period of time.

Summary

In summary, this study examined 127 African American mothers. The relationship of age, religion, and depression on risk related behaviors was studied in this population. The population is a sample from a larger sample of African American and Mexican American families. The original study The Ethnic Family Research Project, was conducted by H.P. McAdoo, PhD, and F. Villaruel, PhD (1994-1996). Interviews were conducted using interview schedules. Each semi-structured interview lasted

approximately three hours. The mothers were given $25 for participation. Interviews were held in the homes of the families or in a community agency.

Limitations of secondary analysis of data include the concern that questions may not reflect what the current researcher is seeking from the data. Validity of original study is also considered a limitation when using this type of analysis.

Chapter 4

RESULTS

A descriptive breakdown utilizing percentages, means, and frequencies of mothers' risk factors, levels of depression, and levels of depression, and hypotheses testing were discussed in this section. The results and a summary of the hypothesis testing are also included in this section.

Influence of Religion and Depression

Hypotheses 1: Religion and depression positively influence the engagement of risk related behaviors in African American mothers.

It had been hypothesized that religion and depression positively influenced the engagement of risk related behaviors in African American mothers. Using Fisher's Exact Two Tail Test, findings revealed that severe levels of depression and unwanted pregnancies and births were significantly correlated, $p = .04$, $n=121$. Findings also noted that the inconsistent use of abstinence and or condoms as a form of birth control was significantly correlated with severe depression, $p=.021$, $n=120$. Results also indicated that use of or inconsistent use of an IUD significantly correlated with severe depression, $p=.002$, $n=119$ (Table 2).

Table 2 - Correlations of Religiosity, Depression, and Risk Related Behaviors in African American Mothers

Variable	N	Value	Significance
Risk Related Behaviors and Religiosity			
Drug Use	127	.1137	.203
Depoprovera	122	.2134	.018*
Pills	123	-.0209	.819
IUD	122	.0554	.545
Condoms	122	.0194	.832
Foam	123	.0096	.916
Abstinence	123	.1140	.209
Norplant	122	-.0621	.497
Unwanted Abortion or Miscarriage	124	.0826	.362
Unwanted Pregnancy or Birth	124	.1020	.260

Table 2 (cont'd)

Variable	N	Value	Significance
Risk Related Behaviors and Depression			
Drug Use	122	-.0152	.868
IUD	119	.2805	.002**
Abstinence	120	.2099	.021*
Unwanted Pregnancy or Birth	121	-.1872	.040*
Pills	120	.0306	.740
Condoms	119	-.1285	.164
Foam	120	.0104	.911
Norplant	119	-.0034	.971
Depoprovera	119	.0738	.425
Unwanted Abortion or Miscarriage	121	-.1151	.209

*p<.05 **p<.01

Use of certain types of birth control was also significantly correlated with level of religiosity. The more religious one reported to be, the more likely they were to use Depoprovera as a form of birth control p=.018, n=122. This hypothesis was accepted.

Condom Use

Hypotheses 2: Adolescent African American mothers are less likely to use condoms than older African American mothers.

It has been hypothesized that adolescent African American mothers are less likely to use condoms than adult African American mothers. Findings reveal that there was no significant difference noted. Adolescent African American mothers are just as likely to use or not use condoms as adult African American mothers. Fourteen percent (8) adolescent mothers reported "Yes" to using condoms, while, 10% (10) adult mothers responded "Yes" to condom use. The level of significance was .43. This hypothesis was not supported. (See Table 3.)

Birth Control Methods

Hypothesis 3: Adolescent African American mothers are less likely to use birth control methods than are adult African American mothers.

There was no significant difference noted the use of birth control pills, foam, IUD, and Norplant. With the use of Depoprovera, adult African American mothers were more likely to use as a birth control method, however, findings were not statistically significant with the exception of other methods of birth control. Other methods of birth control not

noted in the questionnaire, were found to be used more by adolescent African American mothers. This hypothesis is not supported. (See Table 3.)

Birth control methods were tested using Fisher's Exact Test (one-tail) and Pearson's. The methods used were not consistent among both adolescent and adult

Table 3 - Chi-Square of Birth Control Methods Used By African American Mothers

Birth Control Method	Adolescent f	Adult f	% Yes	% No	%Total
Pills	5	4	7.4	92.6	100%
IUD**	0	2	1.7	98.3	100%
Condoms	8	10	15.0	85.0	100%
Foam	2	2	3.3	96.7	100%
Abstinence	4	6	8.3	91.7	100%
Norplant	2	2	3.3	96.7	100%
Depoprovera	1	7	6.7	93.3	100%
Other Methods	1	2	2.5	97.5	100%
Significance (p=.35 and above) ns					

*p<.05 **Only adult mothers utilized this form of birth control.

n = 121

mothers. Birth control pills were reportedly used more by adolescent mothers with 14% (5) "Yes" responses and 86% (44) "No" responses. Adult mothers reported 5.5% (4) "Yes" and 94.5% (68) "No" responses. The level of significance for the Fisher's Exact Test (one-tail) was $p<.05$. The level of significance for birth control pills usage by these mothers was .27, which is not statistically significant.

IUD use was tested using Fisher's Exact Test (one-tail) $p<.05$. Adolescent mothers reported no utilization of this form of birth control. The total n for adolescent mothers responding to this question was forty-nine, each responded "No" to the use of IUD as a method of birth control. Only 2.3% (2) adult mothers responded "Yes" to the use of IUD as a birth control method, while 97.7% (69) reported "No". The level of significance for this response was .35 for the adult mothers only. This was not statistically significant although more adult mothers used this form of birth control.

Foam as a method of birth control was tested using Fisher's Exact Test (one-tail) $p\leq .05$. Adolescent mothers and adult mothers both had 2 .3% (2) respondents to "Yes" as using foam as a method of birth control. Adolescent mothers who reported "No" totaled 97.7% (48) and 97.7% (70) adult mothers reported "No" to this birth control method as well. The level of significance was .53 which is not statistically significant.

Depoprovera use was tested using Fisher's Exact Test (one-tail) $p\leq .05$. Adolescent mothers had 2% (1)"Yes" response to this birth control method and 98% (47) "No" responses. Adult mothers reported 9.7% (7) "Yes" responses and 91.3% (65) "No" responses. The level of significance for this method was .10, which is not statistically significant in spite of number of older mothers using this form of birth control.

Norplant was tested using Fisher's Exact Test (One-tail) $p<.05$. Both adolescent and adult mothers had 4.1% (2)"Yes" responses. Adolescent mothers had 95.9% (46) "No" responses and older mothers yielded 95.9 (70)"No" responses to using Norplant as a method of birth control. The level of significance was .53 which is not statistically significant.

Other methods of birth control was tested using Fisher's Exact Test (one-tail) $p\leq .05$. Adolescent mothers were the only "Yes" respondents to this method of birth control with 8.7% (4) and 91.3% (42) "No"responses. Adult mothers (with n= 71) all reported "No" to other methods of birth control. The level of significance for this method of birth control was .02 which is statistically significant, however, n is too small for actual significance to be warranted.

Hypothesis 4: Adolescent African American mothers are less likely to abstain from sexual activity than adult African American mothers.

It was hypothesized that adolescent African American mothers would be less likely to use abstinence as a birth control method than would adult African American mothers. Findings reported that 8.1% (4) adolescent mothers responded "Yes" to abstinence and 91.9% (45) responded "No". Adult mothers responded with 8.4% (6) "Yes" and 91.6% "No". The findings were not statistically significant. Level of significance .42. This hypothesis was not supported. (See Table 3.)

Unwanted Pregnancies, Births, and Abortions

Hypothesis 5: Adolescent African American mothers are more likely to experience unwanted pregnancies and births than are adult African American mothers. This hypothesis was not supported. Using Fisher's Exact Test (one-tail) there was no significant level of difference noted in the findings p = .48 .

Unwanted pregnancies, births, and abortions were tested using Fisher's Exact Test (one-tail) $p<.05$. Adolescent and adult mothers alike reported 3 "Yes" responses to having had unwanted pregnancies and births. Forty-seven (47) adolescent mothers reported "no" as did sixty-eight (68) adult mothers. The level of significance for this factor was .48 which is not statistically significant. (See Table 4.)

Hypothesis 6: Adolescent African American mothers are more likely to have undesired miscarriages and abortions than adult African American mothers.

Unwanted abortions and miscarriages was tested using Fisher's Exact Test (one-tail) $p\leq .05$. Both adolescent and adult mothers reported 3.3 % (2) "Yes" responses to this question. Forty-eight (96.7%) adolescent mothers responded and 96.7% (69) adult mothers responded "No". The level of significance was .55, which is not statistically significant. (See Table 5.) This hypotheses was not supported.

Table 4 - Chi-Square of Unwanted Pregnancy and Birth in African American Mothers

Variable	f		
Unwanted Pregnancy & Birth	Yes	No	Total
Adolescent Mothers	3.0	47.0	50
Adult Mothers	3.0	68.0	71
Total	6	115	121
Total %	5.0	95.0	100.0

*$p<.05$ $n = 121$

Table 5 - Chi-Square of Unwanted Abortions and Miscarriages in African American Mothers

Variable	f		
Unwanted Abortions & Miscarriages	Yes	No	Total
Adolescent Mothers	2.0	48.0	50
Adult Mothers	2.0	69.0	71
Total	4	117	121
Total %	5.0%	95.0%	100%
Significance (p=.53) ns			

*p<.05 n = 121

Drug Use

Hypothesis 7: Adolescent African American mothers are more likely to use drugs than are adult African American mothers.

Adolescent mothers reported 11.3% (6) "Yes" responses, and 88.7 (47) "No" responses. Adult mothers responses were 21.9% (16) "Yes" and 78.1% (57) "No". Findings indicated that there was no level of significance noted p=.09. (See Table 6.) This hypothesis was not supported.

Depression

Hypothesis 8: Adolescent African American mothers are more likely to be depressed than adult African American mothers.

Levels of depression was tested using Pearson's Test where $p \leq .05$. Depression level was determined using the BDI. Scores for the BDI were interpreted by the use of total scores derived from the Family Ethnic Studies questionnaire section on depression and feelings. Since the lowest score for each question was zero, the lowest possible score is zero. The higher the score, the more severe the depression. Ranges for levels of depression were reported as follows: Mild Depression - 0-20; Moderated Depression - 21-39; and Severe Depression - 40-100.

Adolescent mothers reported as follows: Mild Depression - 76.4% (39); Moderate Depression - 15.7% (8); and Severe Depression - 7.9% (4). Adult mothers reported: Mild Depression - 80.2% (58); Moderate Depression - 10.7% (5); and Severe Depression - 9.1% (7). The level of significance was .32 which is not statistically

Table 6 - Chi-Square of Drug Use in African American Mothers

Variable	Adolescent Mothers f	%	Adult Mothers f	%
Drug Use				
Yes	6	9.3	47	21.9
No	16	88.7	57	78.1
Total	22	100.0	104	100.0
Significance (p=.09) ns				

*p<.05 n = 126

significant, although, adult mothers reported more severe levels of depression. (See Table 7.) This hypothesis was not supported.

Religiosity

Hypothesis 9: Adolescent African American mothers have a lower degree of religiosity than adult African American mothers.

Levels of religiosity were tested using Pearson's Test $p<.05$. The questions How religious are you? and How important is religion to you? were tested. Responses were categorized as: not religious; somewhat religious; very religious; and I don't know. Adolescent mothers reported: not religious - 7.5% (4); somewhat religious - 64.1% (33); very religious - 28.4% (14), and don't know - 0. Adult mothers reported: not religious - 10.9% (8); somewhat religious - 46.5% (34); very religious - 42.3% (30); and don't know - 1.3% (1). The level of significance was .22, which is not statistically significant. (See Tables 8 and 9.) This hypothesis was not supported.

Using Pearson's Test $p\leq .05$, there was no significance noted in the findings. It was noted that there tended to be a trend in the results reflecting religion being more important in the adult African American mothers, however, the findings were not statistically significant $p = .22$. This hypothesis was not supported.

Table 7 - Chi-Square of Level of Depression in African American Mothers

Variable	Adolescent Mothers		Adult Mothers		Total
Depression Level	f	%	f	%	f
Mild Depression	39	72.5	58	83.0	97
Moderate Depression	8	15.6	5	7.0	13
Severe Depression	4	7.9	7	10.0	11
Totals	51	100.0	70	100.0	121
Significance (p=.32) ns					

*p<.05 n = 121

Summary

The tests used for analysis of data were Fisher's Exact Test (one-tail) and Pearson's Test. With regard to methods of birth control, no significant level of difference was noted between adolescent and adult mothers with the exception of "other methods of birth control" utilized by adolescent mothers. Depression and religiosity both reported trends in favor of adult mothers being more depressed and more religious. However findings were not statistically significant. These may be due to low number of participants.

Table 8 - Chi-Square of Importance of Religion in African American Mothers

Variable	Not Important	Somewhat Important	Very Important	
Religion	f	f	f	%
Adolescents	1	21	29	41.1
Adults	2	18	53	58.9
Total	3	39	82	100.0
Total %	2.4	31.5	66.1	100.0
Significance (p=.22) ns				

*p<.05 n = 124

Table 9 - Chi-Square of Level of Religiosity in African American Mothers

Variable	Not Religious		Somewhat		Very		DK	
How religious are you?	f	%	f	%	f	%	f	%
Adolescent Mothers	4	3.1	33	26.2	14	5.0	0	0
Adult Mothers	8	6.6	34	27.8	30	30.5	1	8
Total	12	9.7	67	54.0	44	35.5	1	8
Total % = 100.0								
Significance (p=.22) ns								

*p≤ .05 n = 124

Chapter 5

SUMMARY AND CONCLUSIONS

This study examined the effects of age, religion, and depression on risk related behaviors in a group of African American mothers. It was hypothesized that adolescent African American mothers were more likely to engage in risk related behaviors than were adult African American mothers; and mothers with lower levels of religiosity would be more likely to participate in risk related activity. Lastly, it was believed that mothers with high levels of depression were more likely to partake in risk related behaviors.

When run as a group, there was a significant correlation noted between level of religiosity and depression on risk related behaviors. It was noted that as a group, the African American mothers who were suffering from severe depression, tended to be inconsistent with birth control methods particularly abstinence. Level of religiosity ("very important") revealed that mothers who viewed religion as very important tended to use Depoprovera consistently as a birth control method. Positive correlation existed between Depoprovera and the significance of religiosity to the mother.

Possible explanations for these findings include the fact that mothers who are more depressed or who suffer from severe depression, tend to be less motivated to consistently use birth control methods. Depression affects all women and presents itself in a multitude of manners. Lack of appropriate decision-making by the mother is a strong

likelihood when levels are severe. When levels of depression are minimized, or when mothers are able to positively recognize and affirm that they are depressed, and seek appropriate therapy, effective management of a severe depressed state can be obtained.

African Americans women reportedly, are less likely to seek assistance when they are depressed. Historically, African American mothers have borne the brunt of society. They have been subjugated to severe levels of scorn and oppression. Long periods of this type of treatment and "way of life" is essentially "second nature" to many African American mothers. Depression may almost be an expectation for African American women.

Depression, in the form of feelings of oppression, and low, altered self-esteem, make recognition of depression difficult to recognize in the African American mother, thereby making it difficult to treat. Nursing implications for African American mothers and women who are depressed would include: seeking out positive attributes of themselves, positive activities, reporting feelings of depression - anorexia, fatigue, listlessness, malaise, anger, anxiety, and mood swings to their physician or nurse practitioner. If the client has been diagnosed with depression, encourage them to follow the therapeutic regimen outlined by their health care provider for treatment. The nurse may be accessible to or provide a 24-hour crisis hotline number for the depressed client in case of a crisis or emergency.

For many African Americans, particularly young adult and adolescents, religion has rejuvenated itself for the 21st century. Historically, the church and its precepts, have served as an undergirding for the foundation of the African American mother and her

family. African American mothers have relied on the church as a method of support and guidance in the rearing of children, and the establishment of values and norms. Over the last two decades, the significance of the historical, traditional African American church has waned. Young adults and adolescent African Americans have pulled away from the traditional "fire and brimstone", "hell and damnation for sins". These attributes prevailed historically in the traditional African American Pentecostal, Baptist, and some Methodist churches. This type of traditional worship does not hold the interest of the younger adult and adolescent.

A new, up and coming trend of sorts in the area of religion and religious music are the young African American artists who have blended the rhythm of R&B with the lyrics of gospel music to create a sound and message that appeals to young adults, adolescents, and many older adults. Artists such as "Take 6", Kirk Franklin, and the Winans are upbeat gospel groups who mix the sound of R&B with the message and lyrics of gospel music. Kirk Franklin includes "gospel rap" in his musical repertoire, making worship and praise for young adults and adolescents, in particular, popular and exciting. The lyrics are positive and uplifting, and present God and Jesus as tangible deity, worthy of everyone's praise. It was stated earlier, that when one is involved in the church, or actively practicing one's faith, they are less likely to engage in risk related behaviors, and have more positive life outcomes.

Music is a tremendous motivator. Just as gospel music steers adolescents in a positive path, "Gangsta Rap" or "Hardcore" rap tends to lead adolescents down a risky path. Rap artists such as the late Tupac Shakur, and the late Notorious B.I.G., Lil' Kim,

and Snoop Doggy-Dog fill the airwaves and Music Television Videos with lyrics of explicit sex acts, violence, and belittling women (referring to them as "bitches and whores"). Graphic videos and concerts portray the artists in suggestive poses and acts. This music revolution has captured the minds and the spirits of adolescents across culture, gender, and socio-economic lines. Music such as "Gangsta Rap" has been linked with violent, brutal crimes, and as an instigator and motivator for stimulating sex and or acting out sexual fantasies in adolescents.

When analyzed by groups as adolescent and adult mothers, results indicated no significant differences between adolescent and adult mothers with regard to engaging in risk related behaviors. Findings also indicated that degrees of religion and levels of depression have no effect on participating in risk related behaviors.

What needs do be done then, is an examination of these results for the purpose of research and practice. I will discuss implications for research first, then discuss implications for practice.

Implications for Research

In the past, literature pertaining to younger mothers, especially adolescent mothers have been plentiful. Very little research had been done on comparing adolescent and adult mothers with regard to religiosity, depression, and it's effects on risk related behavior. This study sheds light on both populations and finds that there is no significant difference in the two. Where should research focus? Further exploration using the other variables inherent in the Social Control and Health Belief models could be a start.

In this research, only three areas were examined using these frameworks. Age and religion were examined using the Social Control Theory. Depression was examined as it relates to the Health Belief Model. A suggestion would be to examine other factors possibly related to risk related behaviors.

Findings were interesting in that, it was an assumption that age was an influence on engaging in risk related behaviors, as it had been reflected in the literature. There may be a need to rethink this belief. This finding may lend itself to the development of a new theory which the researcher will not embark on at this time. However, the notion of when is age a factor or important? When is age not a factor?

Implications for Practice

Implications for nursing practice are three-fold. First, based on the findings, the nurse must address the readiness level of all clients. In the past, when caring for mothers, especially with regard to education, nursing has focused on being assured that the younger/adolescent mother have a clear understanding of what is being taught.

As stated earlier in the literature, repeated STDs predispose women to higher incidences of cervical cancer. Cervical cancer is particularly prevalent in young African American women and is generally diagnosed in very late stages. The unfortunate reality of cervical cancer is, when it is diagnosed via a positive pap smear, the cancer is in an advanced stage, and often times more challenging to treat, manage, or cure. Cervical cancer is a serious complication directly linked to engaging in unprotected sex, with

multiple partners, and repeated STDs. Education with regard to this disease and others (like HIV) is imperative.

Remedial education and often re-educating young mothers was a basic expectation of the nurse. Nursing must now be prepared to take the same precaution and educational approach with adult mothers to be assured that they too, understand what is being taught with regard to reproductive health education.

Secondly, although, religion and depression were not significant, culturally specific norms are to be recognized and considered when caring for clients of diverse cultures and backgrounds. There is a need for age, religiosity, depression and culturally competent care (Andrews & Boyle, 1995).

Lastly, there is a need for follow-up on teaching regarding reproductive health in younger and older mothers. The rates of sexually transmitted disease in the United States is a alarming. As a profession, nurses must stand watch as protectors and providers of quality and prudent health education. Nurses must be knowledgeable and maintain an objective, non-judgmental point of view when working with adolescents. Society and the public must be involved in positively educating adolescent and adult women toward a healthy, holistic lifestyle. A method of follow-up and continued education needs to be in place to assure optimal health for these mothers.

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