

1998

# Teen Pregnancy: What Brings Teens To Family Planning Clinics For Pregnancy Tests

Norma Reynolds Allen

Follow this and additional works at: <http://digitalcommons.library.umaine.edu/etd>

 Part of the [Family, Life Course, and Society Commons](#), [Social Welfare Commons](#), and the [Women's Studies Commons](#)

---

## Recommended Citation

Allen, Norma Reynolds, "Teen Pregnancy: What Brings Teens To Family Planning Clinics For Pregnancy Tests" (1998). *Electronic Theses and Dissertations*. 669.

<http://digitalcommons.library.umaine.edu/etd/669>

This Open-Access Thesis is brought to you for free and open access by DigitalCommons@UMaine. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of DigitalCommons@UMaine.

TEEN PREGNANCY: WHAT BRINGS TEENS TO  
FAMILY PLANNING CLINICS FOR PREGNANCY TESTS

By

Norma Reynolds Allen  
B.S, University of Maine, 1991

A THESIS

Submitted in Partial Fulfillment of the  
Requirements for the Degree of  
Master of Science  
(in Human Development)

The Graduate School  
University of Maine

August, 1998

Advisory Committee:

Sandra L. Caron, Associate Professor of Family Relations/Human  
Sexuality, Advisor

Marc Baranowski, Associate Professor of Human Development

Barbara Howard, Instructor in Human Development

TEEN PREGNANCY: WHAT BRINGS TEENS TO  
FAMILY PLANNING CLINICS FOR PREGNANCY TESTS

By Norma Reynolds Allen

Thesis Advisor: Dr. Sandra L. Caron

An Abstract of the Thesis Presented  
in Partial Fulfillment of the Requirements for the  
Degree of Master of Science  
(in Human Development)

August, 1998

This purpose of this study was to explore the factors that bring teenage girls to family planning clinics for pregnancy tests. This study focused on those teens requesting pregnancy tests to investigate the circumstances surrounding their concern that they may be pregnant. A total of 116 teenage girls, between the ages of 13 and 19 completed the 21 item questionnaire.

While the results of this study did support previous research showing that teens are using birth control, results found correct and consistent use to be a problem. While most teenage girls reported that they use condoms (73%), over half did not use them every time.

The number one reason given for why a teenage girl was not using a method of birth control or not using it every time was, “I didn’t plan to have sex.”

This study found that 60% of these teenagers had had a previous pregnancy test; in fact over half had been to a family planning clinic. While some researchers have suggested that a negative pregnancy test visit is a great time for counseling and education, these results would suggest that this has not been the case for these teens.

When asked about partner involvement, the results supported previous work which found that teens plan to involve their partner in their pregnancy decision. However, it is not clear what the reality will be for these girls since previous research indicates that teen mothers are relying on welfare - not their partner - to support their children.

Overall, the results of this study suggest that the rates of risky sexual behavior among these teens is high. Implications for family planning workers and others working with this population are discussed.

## Acknowledgements

My academic pursuits at the University of Maine remind me of one of my children's favorite movies, "The Wizard of Oz." Dorothy's journey on the yellow-brick road took many twists and turns. My personal journey, achieving my Master's degree, has also taken many twists and turns. Like Dorothy, the obstacles I have faced have been many, and those obstacles have at times seemed insurmountable. Dorothy's companions were unfaltering in their efforts to help her achieve her goal, to find her way back to Kansas.

My companions in my journey, Barbara Howard, Dr. Marc Baranowski and Dr. Sandra Caron, have been as steadfast in their efforts to help me accomplish my goal, my Master's degree in Human Development. I would like to acknowledge their contribution of time, energy and knowledge. I would particularly like to acknowledge Dr. Caron for having faith in me when I didn't and for giving so generously of her time for the pursuit of my goal.

Last, but most particularly, I would like to thank my family. Without their love, support and encouragement I would never have been able to accomplish my goal.

## Table of Contents

Acknowledgements .....	ii
List of Tables.....	v
Chapter 1: Review of the Literature.....	1
Overview of Teen Pregnancy.....	1
Teenage Sexual Activity and Contraceptive Use.....	2
Sexuality Education.....	4
Subsequent Pregnancy and Childbearing among Teens.....	6
Theories of Teen Pregnancy .....	9
Research on Teens with Positive Pregnancy Test Results.....	12
The Purpose of this Study .....	18
Research Questions .....	18
Chapter 2: Methodology.....	20
Subjects.....	20
Procedure .....	20
Questionnaire .....	21
Data Analysis.....	21
Chapter 3: Results .....	22

Demographic Information .....	22
Research Question 1.....	24
Research Question 2.....	24
Research Question 3.....	28
Research Question 4.....	28
Research Question 5.....	29
Chapter 4: Discussion.....	31
Limitations.....	33
Implications.....	33
References.....	36
Appendices	
A: Informed Consent Document.....	40
B: Teen Pregnancy Survey.....	41
Biography of The Author.....	44

## List of Tables

Table 1: Descriptive analysis for the total sample.....	23
Table 2: Responses to questions 7-21 for the total sample.....	25

## Chapter 1

### Review of Literature

#### Overview of Teen Pregnancy

Teen pregnancy is a subject that has been defined as a problem in the United States for more than two decades. We know that certain factors have effected the teenage pregnancy rates. There has been a decline in the number of teenage marriages, an increase in the onset of early puberty, looser rules and norms that govern sexual behaviors, and a change in youth culture itself. Television, literature, books, music and videos all confirm these changes (The Alan Guttmacher Institute, 1994).

The teenage sexual activity rates in the United States are consistent with those of other developed countries, yet teen pregnancy rates in the United States are much higher. In fact, the United States has the highest adolescent pregnancy rates of any industrialized country in the world (Senderowitz & Paxman, 1985). The rates are twice as high as England and Wales, France and

Canada; and nine times as high as in the Netherlands and Japan (The Alan Guttmacher Institute, 1994).

One million teenage women, 12% of all women aged 15-19 (117 per 1000) and 21% of those who have had sexual intercourse (207 per 1000) become pregnant each year. Eighty-five percent of teenage pregnancies are unplanned, accounting for one quarter of all unplanned pregnancies each year. Among sexually experienced teenagers, about 9% of 14-year-olds, 18% of 15-17-year-olds and 22% of 18-19-year-olds become pregnant yearly. One-half of the more than 1 million teenage pregnancies each year end in birth (most of which is unplanned); about one-third in abortion and the rest in miscarriage (The Alan Guttmacher Institute, 1994).

The high rates of teenage pregnancy in the United States has prompted research into many areas. Some of those researched are teenage sexual activity and contraceptive use, sexuality education, closely-spaced subsequent pregnancy and childbearing among teens, theories of teenage pregnancy, and research on teenagers with positive pregnancy test results.

## Teenage Sexual Activity and Contraceptive Use

The Alan Guttmacher Institute (1994), reports that 56% of women and 73% of men had sexual intercourse before age 18. In 1993, 54% of Maine high school students reported having had sexual intercourse (Maine State DHS, 1995). This rate (54%) is also reported nationally by high school students. In Maine, out-of-school youth reported a much higher rate of sexual activity. Of the 200 youth surveyed, 91% reported having had sexual intercourse. Twenty-five percent of high school students and seventy percent of out-of-school youths reported experiencing sexual activity by age 14. Sexual activity increased with each grade level. By their senior year 77% of males and 71% of females reported having had sexual intercourse (Maine State DHS, 1995).

It appears that these sexually active teenagers have knowledge of contraceptive methods. During the 1980's two-thirds of teenagers reported using a contraceptive method the first time they had sexual intercourse. Teenage women's use of a birth control method at first intercourse rose from 48% to 65% during the 1980's. This increase

was almost entirely because of the increase in use (from 23% to 48%) of condoms (Henshaw & Forrest, 1993).

Data from Penquis Health Services/Family Planning in 1996, a women's health care provider serving Penobscot and Piscataquis counties in Maine, noted that birth control pills were used by 66% of their teen clients. The two most used methods after that were condoms and Depo Provera, at about equal rates (Penquis Health Services, 1996).

Nationally, 1.7 million teenagers are reported to be using the pill as their method of birth control. One quarter of these teens also report using condoms. Between 72% and 84% of teenage women and their partners use a contraceptive method on an ongoing basis (The Alan Guttmacher Institute, 1994).

Caldas (1993) indicated that most American teens were knowledgeable enough about reproduction to prevent pregnancy if they so desired. (Zelnick, Kantner, and Ford 1985), found that a large majority of sexually active girls were knowledgeable of effective contraceptive methods. Caldas also noted that only 12% of American

adolescents were completely ignorant of effective birth control methods. This raises the question of the role of sex education.

### Sexuality Education

Some of the focus of research has been on the effectiveness of sex education in schools. Many of these programs have been aimed at reducing teen pregnancy rates. A 1995 study examined the effectiveness of some programs. Barth, Fetro, Leland & Volkan (1992) state that sex education, in some form, is provided by nearly 90% of large school districts. They also noted that the average time spent on sex education is 6-10 hours annually in junior and senior high school. Forty percent of the programs at schools are aimed at reducing unwanted pregnancy, primarily by encouraging abstinence.

Frost and Forrest (1995), looked at five prevention programs. The five programs emphasized abstinence or delay of sexual intercourse, training in decision making and negotiation skills, and education on sexuality and contraception. Four of the five programs directly or indirectly provided access to contraceptive services.

One of the programs that was aimed at eighth graders noted that at the onset of the program, 25% of the students were already sexually experienced. This supported the view of more than half of the teachers, that by the end of seventh grade students should have received instruction about sexual decision-making, abstinence, STD's, birth control and homosexuality. Their view was also supported by national data from The Alan Guttmacher Institute (1994) that showed that 9% of 12-year-olds and 16% of 13-year-olds had had intercourse.

After reviewing the programs, the researchers indicated that these programs were able to instill in young people the philosophy that although abstinence is best, contraceptive protection is next best. They also noted that four of the programs demonstrated an ability to delay the onset of sexual activity among participants. Three of the five programs significantly increased the proportion of sexually active teenagers using contraceptives (Frost & Forrest, 1995). The researchers note that further research needs to be conducted to determine how other factors effect teen pregnancy rates. Areas suggested for research were how poverty and media messages about sexuality and relationships affect teen sexual and childbearing

behavior. This could give us a better indication of what can be done to address influences that encourage early sexual activity, pregnancy and childbearing.

### Subsequent Pregnancy and Childbearing Among Teens

Of all births to women in the United State, 12% are to teenagers (The Alan Guttmacher Institute, 1994). Most teen mothers come from socially and economically deprived backgrounds. These factors combined with early childbearing put the young women at a greater risk of problems in the area of education, physical and mental health, and economic well being (Davis, 1996). These are problems that not only effect the young woman, but effect her child and society as a whole.

Two-thirds of all adolescent births and 90% of all Black adolescent births in the United States are out of wedlock (Trussell, 1988). The result is many teens as single-parents, the majority of whom are poor and headed by females (Gold, Kenney, & Singh,

1987). Teenagers who give birth are more likely to rely on public assistance to pay for having and raising a child.

Welfare costs for mother and child average just over \$4,200 per year. Over 60 percent of those currently receiving Aid to Dependent Children are or were teen parents. There are 25 to 30 million teenage parents in the United States (Barr & Parrett, 1995).

Kalmuss & Namerow (1994) studied subsequent childbearing among teenagers. They cited it as another problem we are facing in this country, with approximately one-quarter of teenage mothers having a second child within 24 months of their first. The prevalence of closely spaced second birth is greatest (31%) among young women who gave birth for the first time before she was seventeen.

Their research confirms what others have found: teenage mothers who have a closely spaced second child are more likely to have poorer educational and economic outcomes than young mothers who delay subsequent childbearing. This is significant in that it defines the social and economic context in which the children are raised. This was significant in research by Maynard & Rangarajan (1994) that found that nearly 70% of their sample had

mothers who themselves had been teenage parents; 42% grew up in a single-parent household and 63% were raised in a family that had received welfare either occasionally or all of the time.

Kalmuss & Namerow (1994) were interested in whether the background characteristics affected the spacing of repeat births among teenage women. Prior research had shown that younger mothers were more apt to have a second closely spaced pregnancy. It also showed that the education level of the teen mother had an effect on the contraceptive choices she made. Their research supported the findings of other researchers: teens who began childbearing at an early age were more likely to have a subsequent closely spaced pregnancy. Women who had their first child at 16 or younger were strikingly more likely to have had a second baby within 24 months. Their findings regarding education also strengthened claims made by others that teenagers with more educated parents were less likely than others to have a rapid second pregnancy. Women who continue their education after childbirth were also less likely to have a closely spaced second pregnancy. The involvement in school and the

orientation to the future serves as a deterrent to a subsequent closely spaced birth.

Teenage parents with two children will be on welfare for a minimum of ten years. Children of teenage parents tend to be premature and small. These infants often have a variety of health problems. Infants born of teen parents are 45% more likely to require neonatal intensive care. The average cost: \$32,000. Each severely handicapped child requires an average of \$400,000 in additional public assistance for medical conditions until the age of 21. The long-term costs to taxpayers is overwhelming when we consider the fact that there are 25 to 30 million teenage parents in the United States today. Of course, not all teenage parents are welfare consumers, but teen parents are more likely to require help. Teen parents are caught in a cycle of poverty, illiteracy and welfare needs that are transferred from one generation to the next. These demands have escalated year after year (Center for Population Options, 1987).

With Welfare Reform we are faced with new challenges in moving welfare recipients to self-sufficiency. The Welfare Reform that is now taking place will limit the time that services will be

provided for mothers and children (Henderson & Hastedt, 1996). The training and education available in this state for women collecting Aid to Dependent Children is very limited. The Welfare Reform will make the problems that pregnant and parenting teens now face even more difficult. Therefore it is more important than ever to discover why teenagers are at risk of unintended pregnancies and develop effective programs that will decrease the risky behaviors that put teens at risk. Barr & Parrett (1995) state that teenagers who have a child tend to have a second child unless there is some sort of intervention.

### Theories of Teenage Pregnancy

Caldas (1993) examined the most prominent theoretical explanations for the high rate of teen pregnancy and childbearing in the United States. Each hypothesis was examined by Caldas.

*Reproductive-Ignorance hypothesis: The teen pregnancy rate is a result of ignorance regarding conception and contraception.*

Caldas found no evidence to support this theory, in fact his as well as prior research shows that American teens have enough

knowledge of conception and contraception to prevent pregnancy.

Paikoff (1990) found for the most part, teens held accurate beliefs about situations in which pregnancy is or is not possible.

*Psychological Needs hypothesis: The pregnancy/childbirth fulfills a subconscious need of the teen.*

Caldas finds evidence that shows that teens do become pregnant to meet a subconscious need. Childbirth may be a way for many of the nation's poor, who have not achieved in other areas, to elevate self-esteem. Conversely, young women with higher educational goals are more likely to use birth control methods consistently and correctly, thus with lower pregnancy rates. Jones et al. (1985) surveyed people from six countries and asked what were the characteristics of young women most likely to have a child. Respondents from all six countries most commonly answered, "adolescents who have been deprived, emotionally as well as economically, and who unrealistically seek gratification and fulfillment in a child of their own." Barnett, Papini & Gbur (1991) reported adolescents who report low self-esteem and/or weak ego strength have been found to be at the greatest risk for pregnancy.

*Welfare hypothesis: The pregnancy and childbirth is a result of the poor teens desire to receive welfare.*

The evidence was inconclusive in this area. This is not to say that welfare payments are not a factor in some adolescents decision to bear children. The author suggests this as an area for further study.

*Parental Role Model/Supervision hypothesis: Parental behavior and lack of supervision is a cause of teen pregnancy and childbearing in single parent families.*

There seems to be strong empirical and theoretical support for the validity of this hypothesis. A greater acceptance of female-headed households and independence of male support has been shown to have some influence on teen pregnancy rates. As previously noted, Maynard & Rangarajan (1994) found nearly 70% of pregnant teens had mothers who themselves had been teen mothers.

*Social Norms hypothesis: The cause of teen sexual and parenting behavior is directly related to social norms.*

Researchers who have looked at social norms found differences for Black and White adolescents. Black teens who attended segregated schools were far more likely to have had sexual intercourse than Black teens in racially integrated schools. There also

seems to be a greater tolerance for teen childbearing in the Black community. Mixed messages regarding social norms was also cited as a factor in teen pregnancy. Movies, books, radio, and television continually send messages about sex, it is exciting and romantic. Yet at the same time, the message is good girls don't (Jones et al., 1985).

Caldas states,

“It is likely that these conflicting societal messages - that contraceptive preparedness, premarital sexual activity, and adolescent parenthood are bad, yet that sexual activities are also extremely pleasurable and desirable - can account for the fact that otherwise knowledgeable American adolescents engage in unprotected sexual intercourse.” p.13.

The evidence evaluated does appear to support the hypothesis.

*Physiological hypothesis: The act of coitus and resulting pregnancy are directly related to hormonal influences.*

Studies at this time do not support the hypothesis, hormonal influences were not shown to be related to coitus, although a strong relationship was shown to non-coital sexual behavior such as masturbation (Udry & Billy, 1987).

Caldas concluded that the interaction of factors presented by the six hypotheses may account for the high pregnancy rates in the United States.

## Research on Teens with Positive Pregnancy Test Results

The State of Maine tied for the third lowest teen pregnancy rate for females of all races age 15-19 in the nation in 1993. That same year, one in nine teens aged 15-19 became pregnant in the State of Maine. The vast majority (8 out of 10) of those pregnancies were unintended (Family Planning Association of Maine, 1996a).

Unintended pregnancies have been the focus of several researchers. A review of the literature on unintended pregnancies by Klitsch (1993) showed that 39% of women aged 13-19 were at risk of an unintended pregnancy. According to this review, those at greatest risk were young women between the ages of 17 and 19. This group was shown to have a 70% risk of unintended pregnancy. In general, adolescents from families with incomes close to or below poverty level were somewhat more likely be at risk of an unplanned pregnancy. Among 15-17-year-olds, 46% of those from families with a 1989 income under the poverty level were at risk, compared to 32-36% of other teenagers (Klitsch, 1993). Higher income teenagers and

those using the pill have the lowest accidental pregnancy rates (The Alan Guttmacher Institute, 1994).

O'Campo, Faden, Gielden, Kass & Anderson (1993), at Johns Hopkins conducted a research project that ran from December of 1989 to September of 1990. It looked at the contraceptive and sexual practices of single women with unintended pregnancies. The sample was 291 single pregnant women 18 and older. Of those women 28% were 18 and 19-year-olds. Women were asked about contraceptive use. Sixty percent of the entire sample reported using some contraceptive method at least half of the time.

When women reported they were using no means of birth control and STD prevention, they were asked why. Twenty-five percent of the women answered that "they didn't think about it", twenty-four percent "didn't think you needed it" and twenty percent "didn't want to". Twelve percent cited health concerns, only three percent mentioned partner resistance and less than one percent cost or lack of availability.

Women were also asked about drug and alcohol use at the time of sexual encounters. Sixteen percent of the women surveyed stated

that they had used drugs in conjunction with sex. Forty-one percent of the women stated they had used alcohol at the time of sexual intercourse. Alcohol and drug use with sex appeared to be quite common. With adolescents relatively inexperienced with sex and drinking, alcohol use may lessen the likelihood of safer sex practices.

The most common birth control methods used by those surveyed were condoms and birth control pills. Twenty-eight percent of the sample reported using oral contraceptives, compared with thirty-one percent nationally. Twenty-one percent used condoms, compared to fifteen percent nationally.

Overall, thirty-nine percent of respondents indicated that both partners shared in the decision about contraceptives. For condom use, the percentage was a little higher at forty-seven percent (O'Campo et al., 1993).

The Family Planning Association of Maine (1996a) collected data statewide through the use of an unintended pregnancy survey. The surveys were done after a positive test result at a Family Planning clinic visit. The data given is for the first quarter of the

year. The sample size was 217. Of the 217 surveyed, 74 were under 19 years of age, or 34.9% of the sample.

Eighty-nine of those surveyed or 41% stated they were using no form of birth control. The most common form of birth control for those using one was condoms. Fifty-eight women or 27% stated condoms as their method. Forty-eight or 22% reported using birth control pills. The remaining 10% reported using Depo-Provera, sterilization, natural family planning, spermicides, withdrawal, withdrawal and condoms together or a diaphragm.

Of the 41% who stated they were using no birth control methods, they were asked further question regarding their contraceptive history. Fifty-one percent stated the last method was pills. Thirty percent said they last used condoms as a birth control method. Nine percent reported never using contraception. The remaining 10% were various methods.

When those using no method were asked why, they were given the opportunity to chose which factors applied. Most commonly women responded to "decided to chance it" (n=24). "Did not plan to have sex" (n=21) was next most frequently chosen. Sixteen listed side

effects of last method as reason for using no contraception. Ten respondents stated financial or couldn't afford method. Eight women stated that their partner didn't like or wouldn't use method.

Clients were asked questions about how consistently they used their birth control methods. The number of respondents using no method or using their method inconsistently was 145 of the respondents or 67%.

Questions were included in the survey about drug and alcohol use. Of those using no method, 14% sated drug or alcohol use at time of conception. Those using oral contraceptive reported 4% use of drugs or alcohol. Those using condoms reported 5% use of drugs or alcohol at time of conception. Of those using no method, about 25% stated they were the one using, 25% reported their partner using and 50% stated both they and their partner were using drugs or alcohol. For pill and condom users, half stated they were using and half stated they and their partner were both using at time of conception (Family Planning Association, 1996a).

This study is ongoing. Some of the larger clinics were under-represented in this sample. Through continued surveys, it is hoped

that a larger sample will be obtained which will allow researchers to see if there are relationships between factors and incidence of unintended pregnancies. With over 80% of teen pregnancies being unintentional (The Alan Guttmacher Institute, 1994), it is important to take a closer look at factors that are influencing the rates.

The John's Hopkins study and the Family Planning Association of Maine study revealed factors that were common to women with unintended pregnancies. Drug or alcohol use at the time of sexual intercourse appeared to be a factor in both studies. As stated before, alcohol or drug use combined with inexperienced adolescents has been reported to lessen the likelihood of safe sex practices (Leigh, 1990). Both studies indicate this as an area of concern. Inconsistent contraceptive use was also noted in both studies. This is an area that could be looked at further to determine why women are being inconsistent with their chosen methods.

Only one study was found that examined teens with negative pregnancy test results. That study reported that 19% of sexually active girls 17 years old and younger had visited a family planning clinic or physician in the previous 12 months for a pregnancy test.

The sample of the study was 2926 adolescents presenting for pregnancy tests. Of these, 31.9% were first pregnancy test and they were negative. Two thirds of the sample were less than 16 years of age. Of those that tested positive, 35.4% had a negative previous result.

The researchers concluded that the negative test visit presented the opportune time for intervention. Contraceptive education and counseling at that visit could help reduce the risk of pregnancy for those teens. This could be a valuable opportunity to educate teens about the risk of an early pregnancy, contraceptive use and STD prevention (Zabin, Emerson, Ringers & Sedivy, 1996).

## The Purpose of this Study

From July 1, 1995 to June 30, 1996 4,301 women age 20 and under came to family planning clinics in Maine for a pregnancy test. Of those, 3,279 or over 76% were negative (Family Planning Association, 1996b). The present study explored the factors that bring teenage girls to family planning clinics for pregnancy tests. This study focused on those teens requesting pregnancy tests to investigate the circumstances surrounding their concern that they may be pregnant.

## Research Questions

*1. What makes the subject believe that she may be pregnant? (Question 7)*

Zabin, Emerson, Ringers & Sedivy (1996) report that 60% of the nearly 3,000 teens requesting pregnancy tests in their study did so because they had engaged in intercourse since their last period and their period was late.

*2. What are the contraceptive practices reported by this group of teenagers? (Questions 8-14)*

Previous research (The Alan Guttmacher Institute, 1994; Caldas, 1993; Paikoff, 1990; Zelnick, Kantner, and Ford, 1985) indicates that teens are using birth control methods. Nationally 1.7 million teenagers are reported to be using oral contraceptives. One quarter of these teens also report using condoms (The Alan Guttmacher Institute, 1994). Drug and alcohol use has been suggested to decrease the likelihood of contraceptive use among teens (Family Planning Association, 1996a; Leigh, 1990).

*3. What is the pregnancy test history reported by those teens presenting for pregnancy tests? (Questions 15-17)*

Research (Kalmuss & Namerow, 1994) suggests that closely spaced subsequent childbearing is a matter of concern in the teenage population. Other research ( Zabin, Emerson, Ringers & Sedivy, 1996) suggests that negative pregnancy test visits offer the opportune time for counseling and education that could help reduce the risk of pregnancy for teens.

*4. What is the partner's involvement? (Questions 18-20)*

O'Campo et al. (1993) found that partner involvement was significant, yet other research (Gold, Kenney & Singh, 1987; Barr & Parrett, 1995) indicates that teen mothers are relying on welfare to support their children in single-parent homes.

*5. What do they intend to do if the test is positive? (Question 21)*

Data from The Alan Guttmacher Institute (1994) indicates that about half of the teen pregnancies each year end in a live birth; one third end in abortion and the rest in miscarriage.

## Chapter 2

### Methodology

#### Subjects

The sample was obtained from 17 Family Planning clinics in Maine who agreed to distribute the survey to teenage girls who came into their clinic for a pregnancy test. These clinics included Augusta, Bangor, Calais, Dexter, Ellsworth, Farmington, Ft. Kent, Guilford, Houlton, Lewiston, Lincoln, Milbridge, Millinocket, Norway, Presque Isle, Skowhegan, and Waterville. A total of 116 girls ranging in age from 13 to 19 years old completed the survey during the Fall of 1997. No information is available on the total number of girls who actually came into the participating clinics for pregnancy tests during that time.

#### Procedure

The questionnaire was given to each teenage girl requesting a pregnancy test. The questionnaire was included with all the regular paperwork the clinic asks each client to complete before any pregnancy test is conducted. Teenagers were asked to complete the

questionnaire and place it in a sealed envelope provided by the researcher. No identifying information (i.e. name, address) was requested on the survey. Participation was completely voluntary. An informed consent document was included with the questionnaire (see Appendix A).

### Questionnaire

The questionnaire included 21 questions approved by the Human Subjects Committee of the University of Maine (see Appendix B). Questions included demographic information (age, grade in school, family income, age at first intercourse, sex education and family planning history; see Questions 1-6), as well as questions exploring why they thought they were pregnant (Question 7), contraceptive practices (Questions 8-14), previous pregnancy and testing history (Questions 15-17), partner involvement (Questions 18-20), and what they intend to do if they are pregnant (Question 21).

## Data Analysis

The major portion of the data analysis was done through descriptive statistics. Responses were analyzed and examined for commonalties and differences.

## Chapter 3

### Results

Results for this research are organized into six sections.

Demographic information is reported for the study participants and presented in [Table 1](#). The results for each of the five research questions are then presented and are detailed in [Table 2](#).

#### Demographic Information

As presented in [Table 1](#), participants ranged in age from 13-19 years of age. The mean age for the sample was 16.5 years of age. When asked about grade in school, 76% (n=88) indicated they were still in school, while 24% (n=28) indicated they were not in school (21 of the 28 teens had graduated from high school). The majority (59.5%) indicated they were from a middle income family.

When asked about the age in which they first engaged in sexual intercourse, the results ranged from 12 or younger (7% of respondents), to 18 years of age (3.5% of respondents). The average age of first intercourse was 15. The majority (86%) indicated that they had had a class on birth control presented in school, and just

over half (57.5%) indicated they had been to a family planning clinic before.

Table 1

Descriptive analysis for the total sample (N=116)

	Percent	Frequency
<b>Q1. Age of Subjects</b>		
<i>13-14 years old</i>	3.0%	4
<i>15 years old</i>	14.0%	16
<i>16 years old</i>	21.5%	25
<i>17 years old</i>	26.0%	30
<i>18 years old</i>	21.5%	25
<i>19 years old</i>	14.0%	16
<b>Q2. Grade in School</b>		
<i>8th grade</i>	1.5%	2
<i>9th grade</i>	13.0%	15
<i>10th grade</i>	15.5%	18
<i>11th grade</i>	15.5%	18
<i>12th grade</i>	22.5%	26
<i>College</i>	8.0%	9
<i>Not in school</i>	24.0%	28
<b>Q3. Family Income</b>		
<i>Low Income</i>	36.0%	42
<i>Middle Income</i>	59.5%	69
<i>High Income</i>	4.5%	5
<b>Q4. Age of First Sex</b>		
<i>12 or younger</i>	7.0%	8
<i>13 years old</i>	12.0%	14
<i>14 years old</i>	26.0%	30
<i>15 years old</i>	28.5%	33
<i>16 years old</i>	17.0%	20
<i>17 years old</i>	6.0%	7
<i>18 years old</i>	3.5%	4
<b>Q5. Class on Birth Control in School</b>		
<i>Yes</i>	86.0%	100

<i>No</i>	14.0%	16
-----------	-------	----

**Q6. Ever Visited a Family Planning Clinic**

<i>Yes</i>	57.5%	67
<i>No</i>	42.5%	49

## Research Question 1

The first research question asked, “*What makes the subject believe that she may be pregnant?*” (survey question 7). Responses to this question were fairly consistent, with 69% (n=80) of the respondents indicating it was due to a missed or late menstrual period. Others indicated they were experiencing other symptoms such as feeling sick (10%), while others simply listed that they had engaged in unprotected sex and were concerned (13%). The rest (8%) indicated they had already had a positive pregnancy test, either at home or at another doctor’s office. See [Table 2](#).

## Research Question 2

The second research question investigated, “*What are the contraceptive practices reported by this group of teenagers?*” (survey questions 8-14). While 57% (n=66) indicated they were using a method of birth control, just less than half (43%; n=50) admitted they had had unprotected sexual intercourse. Of all the methods of birth control available to teens, the Pill (24% of respondents) and Condom

(73%) were identified as the methods of choice. Only one teen indicated withdrawal, while another indicated Depo Provera.

Of those 66 teens who say they are using a method of birth control, it is interesting to examine the percentage who say they use their method correctly and consistently (every time). Responses indicate that while 77%

Table 2

Responses to questions 7 - 21 for the total sample (N=116)

	Percent	Frequency
<b>Q7. What makes you think you might be pregnant?</b>		
Missed/Late Period	69%	80
Feeling sick	10%	12
Unprotected Sex	13%	15
Positive Pregnancy Test	8%	9
<b>Q8. Are you presently using a birth control method?</b>		
Yes	57%	66
No	43%	50
<b>Q9. If yes, what are you using?</b>		
Condom	73%	48
The Pill	24%	16
Withdrawal	1%	1
Depo Provera	1%	1
<b>Q10a. Do you use it correctly?</b>		
Yes	77%	51
No	23%	15
<b>Q10b. Do you use it every time?</b>		
Yes	41%	27
No	59%	39

**Q11. If you are not using it correctly/every time, why not?**

I didn't plan to have sex	87%	33	
Transportation	8%	3	
I or my partner want to get pregnant		5%	2

**Q12. If not using any birth control, why not?**

I didn't plan to have sex		25	
I want to get pregnant		13	
Side effects		10	
Fear of exam		7	
My partner wants me to get pregnant			7
My partner won't use birth control			3
Expense		2	
Transportation		1	

**Q13. Alcohol/other drugs used with sex?**

Yes	47%	54	
No	53%	62	

**Q14. If yes, does it effect birth control use?**

Yes	28%	15	
No	72%	39	

**Q15. Have you ever had a pregnancy test before?**

Yes	60%	70	
No	40%	46	

**Q16. If yes, where did you have pregnancy test?**

Family Planning clinic	53%	37	
Home test	33%	23	
Doctor's office	14%	10	

**Q17. If it was positive, what was the outcome?**

Live birth	53%	10	
Abortion	21%	4	
Miscarriage	26%	5	

**Q18. Will you involve your partner?**

Yes	79%	91	
No	21%	25	

**Q19a. What is your partner's age?**

16 or younger	11%	13
17 years old	14%	17
18 years old	21%	24
19 years old	21%	24
20 years old	12%	14
21 years old	8%	9
22 or older	13%	15

**Q19b. Difference in age between her & partner**

He's younger	9%	10
He's the same age	17%	20
He's older	74%	86

**Q20. How long have you been in this relationship?**

Less than 6 months	42%	49
6 to 12 months	30%	35
over 1 year	13%	15
2 or more years	15%	17

**Q21. What will you do if you are pregnant?**

I'm not sure	22%	25
I haven't thought about it	4%	5
Have baby and keep it	53%	62
Have an abortion	20%	23
Have baby and give up	1%	1

(n=51) say they use their birth control method correctly when they use it, only 41% (n=27) say they use it every single time. This later group are all condom users. The primary reason given for not using their chosen method correctly or consistently was “I didn’t plan to have sex” (87%; n=33). Three teens indicated that transportation to get birth control was a reason for not using their method; while only 2 responded that either they or their partner wanted to get pregnant.

For those 50 teens who indicated they were not using any method of birth control, the most frequently cited reasons was “I did not plan to have sex” (n=25), followed by “I want to get pregnant” (n=13: Please note that 1 was 14 years old, 3 were 15 years old, 2 were 16 years old, 4 were 17 years old, and 3 were 18 years of age), “Side effects” (n=10), “Fear of the exam” (n=7), and “My partner wants me to get pregnant” (n=7; 5 of the respondents who checked this option also indicated they too wanted to be pregnant). Very few teens cited “My boyfriend won’t use birth control” (n=3); “Expense” (n=2) or “Transportation” (n=1) as reasons for not using a method of birth control.

When asked if alcohol or other drug use effected their use of birth control, 72% (39 of the 54 teens who indicated they use alcohol or other drugs when having sex) did not feel it had any effect on whether or not they used birth control. Less than half (47%) said they mixed drugs and sex. See [Table 2](#).

### Research Question 3

Research question three asked, *“What is the pregnancy test history reported by those teens presenting for pregnancy tests?”* (survey questions 15-17). Sixty percent (n=70) indicated they had had a pregnancy test before, while 40% (n=46) indicated they had never had a pregnancy test before this visit. Of those who had had a pregnancy test previously, 53% (n=37) had been to a family planning, 33% (n=23) had conducted a home test, while 14% (n=10) had been to another doctor’s office.

Of the 70 girls who indicated they have had a pregnancy test before, 19 of these girls (27%) said they had a positive pregnancy test result. Ten of these teens reported having a live birth, four had an abortion, and five girls experienced a miscarriage. See [Table 2](#).

#### Research Question 4

The fourth research question asked, “*What is the partner’s involvement?*” (survey questions 18-20). The overwhelming majority of teen girls (79%; n=91) indicated that they planned to involve their partner in decisions regarding the pregnancy, whereas only 21% (n=25) said they will not involve him. It should be noted that partner’s age ranged from 16 years of age or under (11%; n=13), to 20 years old or older (33%; n=38). The average age of the partner was 18.5 years old. The majority (74%; n=86) of the male partners were older; however, 17% (n=20) were the same age; 9% (10) were younger than her.

In terms of the length of the relationship, most had been together for less than one year (73%; n=84), while 13% (n=15) had dated for over a year and 15% (n=17) had been together for over 2 years. It should be noted that neither her age, her partner’s age, or the relationship influenced her decision on what she would do if she is indeed pregnant (e.g., have baby or abort). See [Table 2](#).

#### Research Question 5

The final research question investigated, “What do they plan to do if the test is positive? (survey question 21). While 22% (n=25) were not sure what they would do and 4% (n=5) indicated they had not even thought about it, the majority (53%; n=62) said that they planned to have the baby and keep it. Twenty percent (n=23) said they would have an abortion. Only one teen (1%) said she planned to have the baby and give it up for adoption. This girl was 15 years old and in 9th grade (her partner is 14) and she wrote, “I will give it to my uncle and aunt because they will let us see the child.” See [Table 2](#).

Chi-square analyses were conducted to determine if there were significant relationships between her age, her partner’s age, or the length of their relationship, and what she intended to do if she was indeed pregnant. No significant differences were found between her age ( $X^2=17.58$ ;  $p=0.61$ ), her partner’s age ( $X^2=30.03$ ;  $p=0.18$ ), or the length of their relationship ( $X^2=12.25$ ;  $p=0.43$ ) and her plans for pregnancy.

## Chapter 5

### Discussion

The findings, limitations, and implications of the present study are discussed in this chapter. The purpose of this study was to explore the factors that bring teenage girls to family planning clinics for pregnancy tests. This study investigated the circumstances surrounding their concern that they may be pregnant.

Results for research question one supported previous research which found that the primary reason teenage girls seek a pregnancy test is due to a missed or late menstrual period (Zabin, Emerson, Ringers & Sedivy, 1996).

While the results of this study did support previous research showing that teens are using birth control (Alan Guttmacher Institute, 1994), results for research question two found that correct and consistent use to be a problem. While most use condoms (73%), over half did not use them every time. It is also interesting to note that these results (based on their perceptions) did not support previous studies that suggest drug and alcohol use decrease the likelihood of contraceptive use (Family Planning Association, 1996a;

Leigh, 1990). In fact, less than half indicated they mixed alcohol with sex, yet most (72%) did not feel it had any effect on whether or not they used birth control. The number one reason given for why a teenage girl was not using a method of birth control or not using it every time was, "I didn't plan to have sex."

Results for research question three found that 60% of these teenagers had had a previous pregnancy test; in fact over half had been to a family planning clinic. While some researchers have suggested that a negative pregnancy test visit is a great time for counseling and education, these results would suggest that this has not been the case for these teens. The other concern in this area is the issue of subsequent pregnancies for those teens who have already given birth. This study found that 9% (n=10) of those teens seeking a pregnancy test had already had one live birth.

When asked about partner involvement, the results for research question four supported previous work which found that teens plan to involve their partner in their pregnancy decision (O'Campo et al., 1993). However, it is not clear what the reality will be since previous research indicates that teen mothers are relying on welfare - not their

partner - to support their children (Gold, Kenney & Singh, 1987; Barr & Parrett, 1995).

Finally, results for research question five supported previous research stating that half of all teen pregnancies end in a live birth (The Alan Guttmacher Institute, 1994). However, this study found fewer girls intending to have an abortion (20% versus 33% nationally).

### Limitations

The primary limitation of this study was the number of respondents. While 116 teenage girls did complete the survey, a previous study of the number of teens attending a family planning clinic in one year's time was approximately 4,500. This study was time-limited in that the collection of data occurred over the course of only three months. In addition, not all clinics agreed to participate, thus limiting the sample size.

The other major limitation is the hypothetical nature of the questions. We do not know what the pregnancy test result was or the reality of the decision to keep or terminate the pregnancy. We also do not know much about the relationship with their partner, let alone

the relationship these teens have with their family. These could play a major role in her decision whether or not to continue the pregnancy.

## Implications

Examining factors that bring teenage girls to family planning clinics for pregnancy tests affords an interesting opportunity to understand the sexual behaviors and contraceptive practices of this population. The results of this study suggest that the rates of risky sexual behavior among these teens is high.

That only 57% of teens in this study report using a method of birth control is surprising, given that most report having had a class in school about birth control, as well as a previous pregnancy scare (indicated by 60% who had had a previous pregnancy test). Few (25%) indicated that they used an effective method of birth control, such as The Pill or Depo Provera. Clearly, we need to do a better job in promoting these methods, especially when we know that condom use among this group is so inconsistent. Both education and access to services is critical.

What is especially disheartening is the high percentage of teens who were using NO method of birth control (43%). Most stated that the reason for their lack of contraceptive use was “I didn’t plan ahead.” This was also the most frequent reason given for not using condoms every time. In an age of AIDS and safer sex discussion, these findings point to the need for continued efforts to educate teens about effective use of condoms.

It is interesting to note that few teens in this study indicated that alcohol or other drugs influenced their birth control use. Despite other studies indicating that this can play a major role in the use of protection, one is left to wonder how honest these teens were in responding to this question.

These findings also raise concerns about the role of her partner in pregnancy prevention. Almost half of the teenage girls stated that they had been in their relationship for less than 6 months. Even more frightening was the age of that partner. Almost three-quarters of the partners were older than her, and a third were men in their 20s. Clearly, we need to focus our pregnancy prevention messages to boys (men) as well as girls.

Family planning clinics need to do a better job in promoting effective birth control to those teens who have been to their clinic previously for pregnancy tests. In this study, over half of the teens who had had a previous pregnancy test had been to a family planning for their test. What happened? One is left to wonder how much attention was given to discussing birth control options, and how thoroughly these methods were presented.

When asked about their pregnancy decision, very few teens selected abortion as an option. Even fewer were willing to select adoption as a means of coping with their pregnancy. Perhaps even more disturbing was how many were undecided or unsure about what they were going to do. Approximately one-quarter were uncertain, which points to the need for high quality pregnancy options counseling to assist teenage girls in resolving their extremely difficult situation.

Finally, if this small study is a reflection of the sexual behaviors and contraceptive practices of a much larger group of teenage girls, we have much to be concerned about. Clearly, we have a lot of work

to do if we are going to make an impact on the rate of teenage pregnancies.

## References

- Alan Guttmacher Institute (1994). Sex and America's teenagers. New York.
- Barnett, J.K., Papini, D.R., & Gbur, E. (1991). Familial correlate of sexually active pregnant and adolescents. Adolescence, 26, 457-472.
- Barr, R.D. & Parrett, W.H. (1995). Hope at last for at-risk youth. Boston, MA: Allyn & Bacon.
- Barth, R.P., Fetro, J.V., Leland, N. & Volkan, K. (1992). Preventing adolescent pregnancy with social and cognitive skills. Journal of Adolescent Research, 7, 208-232.
- Caldas, S. (1993). Current theoretical perspectives on adolescent pregnancy and childbearing in the United States. Journal of Adolescent Research, 8, 4-20.
- Center for Population Options (1987). The facts, teenage sexuality, pregnancy and parenthood. Washington, D.C.
- Davis, L. (1996). The facts, adolescent pregnancy and childbearing. Washington, D.C.
- Family Planning Association of Maine (1996a). Unintended teen pregnancy survey. Augusta, Maine.

Family Planning Association of Maine (1996b). Telephone interview with Evelyn Kieltkyn: Statistics on pregnancy tests conducted on clients during the last year. January 10, 1996.

Frost, J.J. & Forrest, J.D. (1995). Understanding the impact of effective teenage pregnancy prevention programs. Family Planning Perspectives, 27, 188-195.

Gold, R., Kenney, A., & Singh, S. (1987). Paying for maternity care in the United States. Family Planning Perspectives, 19, 188-195.

Henderson, M.T. & Hastedt, C.B. (September, 1996). What does the new welfare reform bill mean for Maine: AFDC, ASPIRE, Emergency assistance and child support. Maine Equal Justice Project. Augusta, ME.

Henshaw, S.K. & Forrest, J.D. (1993). Women at risk of unintended pregnancy - 1990 estimates: The need for family planning services in each state and county. NY: The Alan Guttmacher Institute.

Jones, E., Forrest, J., Goldman, N., Lincoln, R., Rosoff, J., Westoff, C.K., & Wulf, D. (1985). Teenage pregnancy in developed

countries: Determinants and policy implications. Family Planning Perspectives, 17, 53-63.

Kalmuss, D.S. & Namerow, P.B. (1994). Subsequent childbearing among teenage mothers: The determinants of a closely spaced second birth. Family Planning Perspectives, 26, 149-153.

Klitsch, M. (1993). Close to half of women aged 13-44 are at risk of unintended pregnancy. Family Planning Perspectives, 25, 44.

Leigh, B. (1990). Alcohol and unsafe sex: An overview of research and theory. In D. Seminara, R.R. Watson and A. Pawlowski (Eds.), Alcohol, Immunomodulation and AIDS (pp. 35-46). NY: Alan Lisa.

Maine State DHS (1995). Maine adolescent health: Fact sheet Advisory Council on Adolescent Health and the Department of Human Services, Division of Maternal and Child Health, Augusta, ME.

Maynard, R., & Rangarajan, A. (1994). Contraceptive use and repeat pregnancies among welfare-dependent teenage mothers. Family Planning Perspectives, 26, 198-205

O'Campo, P., Faden, R. Gielden, A., Kass, N., & Anderson, J. (1993). Contraceptive and sexual practices among single women with an unplanned pregnancy: Partner influences. Family Planning Perspectives, 25, 215-219.

Paikoff, R. (1990). Attitudes toward consequences of pregnancy in young women attending a family planning clinic. Journal of Adolescent Research, 5, 467-484.

Penquis Health Services (1996). Statistical data for November 1996. Family Planning, Bangor, ME.

Senderowitz, J. & Paxman, J. (1985). Adolescent fertility: Worldwide concerns. Population Bulletin, 40 (Population Reference Bureau).

Trussell, J. (1988). Teenage pregnancy in the United States. Family Planning Perspectives, 20, 262-272.

Udry, J.R., & Billy, J. (1987). Initiation of coitus in adolescent sexual behavior. American Sociological Review, 52, 841-855.

Zabin, L. Emerson, M., Ringers, P., & Sedivy, P. (1996). Adolescents with negative pregnancy test results. JAMA, 275, 113-117.

Zelnick, M., Kantner, J., & Ford, K. (1985). Sex and pregnancy in adolescence. Beverly Hills, CA: Sage.

## Appendix A:

### INFORMED CONSENT DOCUMENT

As a teenager coming to the clinic and asking for a pregnancy test, you are being asked to participate in this survey. This is part of a graduate student's research project at the University of Maine. Through this project we will gather information about birth control behavior and knowledge among teenagers and try to gain some understanding about why teens come to clinics for pregnancy tests.

Do not write your name on this survey. The answers you give will be kept private. Answer the questions based on what you really know, feel, or do. Feel free to skip any questions you do not wish to answer.

Participation in this survey is voluntary and totally anonymous. Your answers cannot be matched to you in any way. When you are done with the survey please place it in the envelope and seal it. Return the sealed envelope with your other paperwork to the receptionist. She will mail it directly to the researcher.

Few risks are envisioned as a result of your participation in this study. It is recognized that some teens may experience increased anxiety due to the subject matter of the survey. It is hoped that some teens may derive personal benefit from participation in this study in that they have the opportunity to contribute to our understanding of why so many teens come to family planning clinics requesting a pregnancy test.

If you have any questions or concerns about this survey, please feel free to speak to the receptionist or the pregnancy counselor. You may also contact the researcher: Norma Reynolds Allen, graduate student in Human Development & Family Studies by calling her home number collect in the evenings (327-2007), or her major advisor, Dr. Sandra Caron: call collect in the evenings: 866-2342.

Appendix B:

TEEN PREGNANCY SURVEY

1. Your Age \_\_\_\_
2. Your Grade in School \_\_\_\_ or Not applicable, I'm not in school  
\_\_\_\_
3. What would best describe your family's income?  
\_\_\_\_ Low income; \_\_\_\_ Middle income; \_\_\_\_ High income
4. How old were you when you first had intercourse? \_\_\_\_
5. Have you ever had a class in school that gave birth control information?  
\_\_\_\_ Yes      \_\_\_\_ No
6. Have you ever been to a Family Planning clinic before?  
\_\_\_\_ Yes      \_\_\_\_ No
7. What makes you think that you might be pregnant? (please explain)
8. Are you presently using a birth control method?  
\_\_\_\_ Yes      \_\_\_\_ No
9. If yes, what are you using for birth control?  
\_\_\_\_ Condoms  
\_\_\_\_ Contraceptive Foam  
\_\_\_\_ Depo Provera  
\_\_\_\_ Diaphragm  
\_\_\_\_ Norplant

- The Pill
- Withdrawal
- Other (please explain):

10. If you are using a birth control method:

Do you use it correctly?  Yes  No

Do you use it every time?  Yes  No

11. If you are using a method of birth control, but you are **NOT** using it correctly or every time (as indicated in Question 10), why not?

- Expense
- I didn't plan to have sex
- I want to get pregnant
- My partner wants me to get pregnant
- My partner won't use birth control
- Side effects
- Transportation
- Other (please explain) \_\_\_\_\_

12. If you are **NOT** using any method of birth control, why not?

- Expense
- Fear of Exam
- I didn't plan to have sex
- I want to get pregnant
- My partner wants me to get pregnant
- My partner won't use birth control
- Side Effects
- Transportation
- Other (please explain) \_\_\_\_\_

13. Do you or your partner ever drink or take drugs and then have intercourse?

Yes  No

14. If yes, do you think that it had any effect on whether or not you used birth control?

Yes     No

15. Have you ever had a pregnancy test before?

Yes     No

16. If you have had a pregnancy test, where have you had it?

Family Planning

Home

Doctor's Office

Other

17. If yes, and the test was positive, what was the outcome of the pregnancy?

Live birth;    Abortion;    Miscarriage

18. If this pregnancy test is positive, will you involve your partner in the decisions regarding the pregnancy?

Yes     No

19. What is your partner's age? \_\_\_\_\_

20. How long have you been in this relationship?

Indicate the number of Weeks: \_\_\_\_\_ or Months: \_\_\_\_\_ or Years: \_\_\_\_\_

21. If this test is positive, have you thought about what you will do?

Yes     No     I am not sure what I will do

If you answered **YES**, I will:

Have an abortion

Have the baby and give it up for adoption

Have the baby and keep it

Is there anything that you would like to add?

Thank you for completing this survey. Please place it in the envelope provided, seal it and return it with your other paperwork.

**THANK YOU VERY MUCH FOR YOUR HELP!**

## Biography of The Author

Norma Reynolds Allen was born in Blue Hill, Maine on March 17, 1950. She attended both Hampden Academy and Brewer High School. She received her G.E.D. in 1985 and enrolled in the Onward Program at the University of Maine. She received her Bachelor of Science degree in Individual and Family Studies in 1991.

In 1992 she was admitted into the graduate program in Human Development. While a part-time student, she worked full-time at Penquis Health Services/Family Planning (both Guilford & Greenville offices) and later at the Rape Response Service (both Bangor & Dover offices). She is the mother of five grown children, and the grandmother of one. Norma is a candidate for the Master of Science degree in Human Development from the University of Maine in August 1998.