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Original article

Ambivalence About Pregnancy and Its Association With Symptoms of Depression in Adolescent Females Initiating Contraception

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A B S T R A C T

Purpose: To examine the association between symptoms of depression and ambivalence about pregnancy in an inner-city adolescent female population.
Methods: This study analyzed data from 220 urban minority adolescent females (ages, 15−19 years) presenting for contraceptive initiation in a comprehensive, free-of-cost, adolescent health center in New York City. Cross-sectional baseline data were examined to define the relationship between participants' ambivalence toward pregnancy (defined by responses to items previously used in the National Longitudinal Study of Adolescent Health) and symptoms of depression (assessed by the Center for Epidemiological Studies–Depression scale). After controlling for covariates, multivariate logistic regression was used to identify the unique contribution of symptoms of depression on the pregnancy ambivalent group.
Results: Over one third of adolescent females self-reported ambivalence about pregnancy (n = 73, 33%). In our sample, 20% (n = 45) reported mild and 14% (n = 30) reported moderate-to-severe symptoms of depression. After controlling for potentially confounding factors, adolescent females who reported mild symptoms of depression had increased odds of reporting pregnancy ambivalence (adjusted odds ratio, 3.53; confidence interval, 1.64–7.62; $p = .001$) compared with those with minimal symptoms of depression.
Conclusions: A substantial number of adolescents, despite planning to initiate contraception, were ambivalent about pregnancy; those reporting ambivalence were more likely to report mild symptoms of depression. When counseling adolescents about contraception initiation, clinicians should be aware that mild symptoms of depression may contribute to ambivalence about pregnancy.
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IMPLICATIONS AND CONTRIBUTION

Adolescents with mild symptoms of depression may display ambivalence about pregnancy, which could negatively affect contraceptive behavior. Findings have implications for deeper insight into a relationship between mental health and pregnancy ambivalence that clinicians might address when initiating contraception with adolescent females.

The majority of adolescents in the United States become sexually active between the ages of 15 and 19 years, and 82% of adolescents in this age range who become pregnant report the pregnancy as "unintended," including unwanted or mistimed pregnancies [1–4]. Within the past two decades, research on "ambivalence about pregnancy" emerged to broaden the conceptualizations of pregnancy intentions as multidimensional

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and moved beyond a conventional measure of pregnancy intentions as a simple dichotomy of unintended and intended [5–7]. Pregnancy ambivalence refers to those with "mixed," contradictory, or not fully established intentions about pregnancy, which involves affective, cognitive, and behavioral aspects that ultimately influences contraceptive adherence. As an explanatory variable, pregnancy ambivalence has been linked to poor contraceptive vigilance, such as gaps in contraceptive use, inconsistent use, or nonuse of contraception, especially for adolescent women [8–14].

Although many studies show that demographics such as age, education level, and family characteristics influence pregnancy ambivalence [8,14–17], very few have examined whether more proximal factors (such as the partner, the mother, or religious affiliation) influence pregnancy intentions. A couple's relationship dynamics (partner age, relationship length, and contraceptive discussions) have been shown to play a role in contraceptive decision making [18–20]. Further, reproductive coercion by a partner or, specifically, his ability to interfere with contraceptive pursuits by exercising "birth control sabotage" has been associated with increased risk of unintended pregnancy and partner violence [21]. Other proximal networks, however, such as religiosity, may play a positive protective role against certain sexual risk behaviors, such as early sexual debut, increased sexual frequency, and failure to use contraception [22–25]. Exploring these characteristics might allow for a more precise determination of one's pregnancy ambivalence risk and promote a socio-relational approach to public health efforts to prevent teenage pregnancies.

Surprisingly, little research evaluates the relationship between depression and pregnancy intentions. The few studies that assess depression show that women with unwanted births are nearly twice as likely to report feeling depressed during the postpartum period [26]. The relationship between depression and shaping pregnancy intentions and reproductive behaviors before conception remains understudied. Of the handful of studies that study psychosexual health, depression has been associated with lowered self-efficacy, impaired motivation, sexual risk behaviors, and less effective contraception [27–32].

No study to our knowledge has evaluated the independent association between symptoms of depression and pregnancy ambivalence. Understanding this relationship may allow practitioners to better influence contraceptive behavior in adolescents. The present study aims to examine the concurrent association between self-reports of symptoms of depression and ambivalence about pregnancy in an inner-city adolescent female population initiating contraception, after considering background characteristics such as partner influences and religiosity. We hypothesize that those with symptoms of depression will endorse pregnancy ambivalence.

Methods

Participants' eligibility

This is a cross-sectional observational study conducted at an urban New York City adolescent health center. The present study focuses only on data obtained from a baseline questionnaire designed for a larger prospective randomized control trial to assess the use of text messaging when initiating contraception. Eligible participants were 15- to 19-year-old sexually active females, with a working cell phone, who sought reproductive health care and obtained a new method of contraception. All participants were contraceptive naïve or free of hormonal contraception during the prior 3 months. Ongoing users renewing a hormonal contraceptive or those who were currently pregnant were ineligible.

Enrollment process

We enrolled 220 eligible adolescent females from April 2012 through April 2013. All participants met with a health care provider who provided standard contraception counseling before initiating contraception. Participants then chose a 3-month supply of the pill, patch, or ring; a DepoProvera injection; or placement/referral for an intrauterine device. Each participant received her birth control method free of charge as is standard of care for all patients at the Mount Sinai Adolescent Health Center, which offers free, comprehensive, scheduled, and walk-in health services to adolescent patients. This environment ultimately removes the cost barrier to effective use of contraception. After selecting her contraception method, each participant completed a comprehensive baseline questionnaire. The Mount Sinai Institutional Review Board approved this research. All participants gave written informed consent.

Key independent measure—symptoms of depression

Participants completed the Center for Epidemiological Studies—Depression Scale (CES-D), a validated and reliable standardized screening instrument used with adolescent samples, which assessed symptoms of depression over the past week [33–35]. The scale included 20 items comprising six subscales reflecting the major criteria of depression. The responses ranged from 0 (rarely) to 3 (most of the time). Total scores ranged from 0 to 60, with a higher score indicating a higher degree of depression symptoms [33,34]. The measure has high internal consistency (alpha = .875). We divided scores into categories of minimal (0–15), mild (16–23), and moderate/severe ($\geq$24) symptoms of depression, as previously categorized by the National Longitudinal Study of Adolescent Health (Add Health) [33].

Dependent measure—pregnancy ambivalence

We assessed pregnancy ambivalence in two ways: (1) using items from the Pregnancy Risk Perceptions section of the Add Health study and (2) those reporting favorable pregnancy attitudes while initiating contraceptives. Following Jaccard, who analyzed pregnancy ambivalence from the Add Health data [14], we used two items rated on a five-point scale: (1) "Getting pregnant at this time in my life is one of the worst things that could happen to me," followed by (2) "It would not be all that bad if I got pregnant at this time in my life." Items were highly correlated ($r = .738$; $p = .001$).

The first item was reverse scored and then averaged with the second item to yield an index that ranged from 1 to 5 with higher scores indicating a more positive attitude toward becoming pregnant. We categorized those with a middle score (2.5–3.5) and with a propregnancy attitude score (3.6–5) as ambivalent. Conceptually, a propregnancy attitude conflicts with the behavior of starting contraception; hence, those with propregnancy attitudes were assigned to the ambivalent group. We also analyzed the propregnancy group in two additional ways, excluding this group from analysis and also examining this group

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