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Debbie Michelle Smith <sup>a</sup>; Ron Roberts <sup>b</sup>

<sup>a</sup> Research Department of Clinical, Educational and Health Psychology, University College London, London, UK <sup>b</sup> Department of Psychology, Kingston University, Surrey, UK

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## Social acceptance; a possible mediator in the association between socio-economic deprivation and under-18 pregnancy rates?

Debbie Michelle Smith<sup>a\*</sup> and Ron Roberts<sup>b</sup>

<sup>a</sup>Research Department of Clinical, Educational and Health Psychology, University College London, 1–19 Torrington Place, London, WC1E 7HB, UK; <sup>b</sup>Department of Psychology, Kingston University, Surrey, KT1 2EE, UK

This study examines the social acceptance of young (under-18) pregnancy by assessing people's acceptance of young pregnancy and abortion in relation to deprivation. A cross-sectional survey design was conducted in two relatively affluent and two relatively deprived local authorities in London ( $n=570$ ). Contrary to previous findings, participants were significantly more accepting of young pregnancy in the more affluent areas and if they were young parents. When controlling for other personal characteristics, only age remained significantly related to acceptance, and there was evidence of an interaction between level of area deprivation and age. The work supported previous findings, with people in more affluent areas being the most accepting of abortion. Age and ethnicity were significantly associated with acceptance of abortion after adjusting for level of area deprivation. An interaction effect between ethnicity and area deprivation was found. The importance of the psychosocial processes behind acceptance of young pregnancy was highlighted. Area deprivation does not have a uniform influence over people who vary in their personal characteristics. Young pregnancy prevention programmes and support groups for young parents must address the influence of social deprivation, age and ethnicity and how this affects the fabric of young people's lives.

**Keywords:** young adulthood; social class; parenthood

### Introduction

The UK has one of the highest young pregnancy<sup>1</sup> rates in the developed world (UNICEF 2001). An association between socio-economic environment and young pregnancy is evident, with deprived areas<sup>2</sup> having higher under-18 conception rates and lower proportions of abortions<sup>3</sup> than affluent areas (e.g. Uren *et al.* 2007). Presently, the processes underlying this association are unclear (e.g. Lee *et al.* 2004) – clarifying them can be considered a necessary step in reducing social inequalities in young pregnancy outcomes (Swann *et al.* 2003). Such information would help the British government meet its teenage pregnancy targets; that is, to lower rates of under-18 conceptions and free young mothers and their children from social exclusion (Social Exclusion Unit (SEU) 1999).

Social acceptance of pregnancy and abortion, that is, more tolerant attitudes, has been reported as influencing young people's pregnancy decisions, both before (Turner 2001) and after (Ellie *et al.* 2004) conception. People in more deprived areas have been

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\*Corresponding author. Email: [debbie.smith-2@manchester.ac.uk](mailto:debbie.smith-2@manchester.ac.uk)

reported as being socially more accepting of young pregnancy than people in more affluent areas (Smith 1993, SEU 1999, Jewell *et al.* 2000, McLeod 2001, Turner 2001). Smith (1993) has argued that the high abortion rates found in affluent areas result from low social acceptance of young pregnancy and cannot be explained solely on the basis of young women's personal choices. Residents in poorer areas are reported as being more likely to disapprove of abortion than those in more affluent areas (SEU 1999, Tabberer *et al.* 2000, Thomson 2000, Lee *et al.* 2004, Turner 2004). Therefore, it has been suggested that the social acceptance of abortion plays a part in young people's abortion decisions (Jewell *et al.* 2000, Tabberer *et al.* 2000, Lee *et al.* 2004). In deprived areas the picture is clear, as 'teenage pregnancy is highly visible and abortion invisible' (Tabberer *et al.* 2000, p. 27). Evidence suggests that community views of young pregnancy influence young parents' decisions through social interactions; for example, friends and family may put pressure on young people to have an abortion (Tabberer *et al.* 2000), whereas young mothers in areas with a high incidence (visibility) of young pregnancy may act as role models (Whitehead 2001).

High rates of postnatal depression (Berrington *et al.* 2005), social exclusion (SEU 1999), and mental health problems are reported for young mothers (O'Hara and Swain 1996, Maughan and Lindelow 1997, Wellings and Kane 1999, Harris *et al.* 2005). Negative treatment (by health professionals and people in society) due to low acceptance of young pregnancy has been reported by young parents (Harris *et al.* 2005). This adverse treatment may contribute to the high rates of postnatal depression and mental health problems and thus requires exploration. The above adversities associated with young pregnancy have led to the framing of young pregnancy as problematic. The authors reject this position and believe these outcomes are consequences of social stigma and economic adversity. Information about the influence of social acceptance on both pregnancy decisions and young mothers' well-being prior to conception will aid health professions working with young people to ensure that young mothers make informed decisions regarding their pregnancy. In addition, results will inform the design of interventions aiming to increase young mothers' well-being and decrease the level of social exclusion they suffer (supporting young parents and their children is one of target of the British Government's Teenage Pregnancy Strategy for England (SEU 1999)).

The present study aims to enhance our understanding of the pathways (structural and interpersonal) linking the socio-economic environment with young pregnancy outcomes (Smith 2007). A key focus in this exploration concerns the Teenage Pregnancy Unit's target to support young parents – an aim that has received the least attention from researchers. The present study will examine people's acceptance of young pregnancy and abortion in relation to deprivation. In addition, the influence of other 'personal' characteristics (age, gender, ethnicity, individual deprivation and parental status) on acceptance of young pregnancy and abortion will also be considered.

## Method

### *Participants*

A cross-sectional survey design was used. Inclusion criteria were that participants were required to live in one of four specified local authorities in London. These four

areas were labelled (based on their rankings on the Office of National Statistics Index of Multiple Deprivation (IMD) (Noble *et al.* 2004) where 1 indicates the most deprived and 354 the most affluent) as relatively 'more deprived' (Newham and Southwark) and 'more affluent' (Kingston upon Thames and Ealing) (see Table 1 for details of the components of the IMD). Details of respondents are described below in the Results section.

A total of 570 participants returned completed questionnaires (a completion rate of 65 per cent). Just over half (52 per cent) came from the 'more deprived' areas and the rest (48 per cent) from the 'more affluent' areas. Thirty-five of the respondents were young parents (18 in the more deprived areas and 17 in the 'more affluent' areas). The mean age of participants was 22.84 years (see Table 2).

### Materials

A short questionnaire was used so that views on social acceptance of young pregnancy and abortion could be sought from a large number of people in each local authority. The questionnaire was written by the authors for the purpose of this study and was piloted in one more deprived and one more affluent local authority (Southwark and Kingston upon Thames). Responses to seven questions were used in the calculations presented here; these questions asked for information on area of residence (postcode), demographic characteristics (age, gender, ethnicity, occupation, pregnancy status) and their acceptance of young pregnancy and abortion (see Appendix A).<sup>4</sup>

### Procedure

Ethical approval was granted from Kingston University and recruitment occurred in 2006.

A total of 870 questionnaires were distributed in a number of different locations and organizations in each of the four local authorities. Each questionnaire contained a cover sheet outlining a brief description of the study, participants' right to withdraw, and assurance of confidentiality and anonymity, together with instructions for its completion and an envelope for returning to the authors once completed. No honoraria were offered. The locations differed on how the

Table 1. Four sampled local authorities; Under-18 conception rates, percentage of conceptions resulting in abortion, and Super Output Area (SOA) level of multiple deprivation ranking.

	Ealing	Kingston upon Thames	Newham	Southwark
Under-18 conception rate per 1,000 in 2004 <sup>7</sup>	36.7	25.6	48.6	85.2
Percentage ending in abortion <sup>8</sup>	57.5	70.1	59.6	61.1
Index of multiple deprivation (IMD) ranking <sup>9</sup>	99	266	11	17

Note: The IMD produces a single measure of deprivation for local authorities by combining information from seven domains (income deprivation; employment deprivation; health deprivation and disability; education, skills and training deprivation; barriers to housing and services; characteristics of the living environment; and crime). The rank of one is the most deprived and 354 the most affluent.

Table 2. Percentage of participants in each age group by area and mean age.<sup>10</sup>

Age group	Total	Ealing	Kingston	Southwark	Newham
Mean age	23	31	27	23	16
11–15	37	0	11	23	75
16–17	6	3	7	2	7
18–20	16	15	27	21	4
21–29	18	40	20	29	5
30–39	12	12	15	20	7
40+	12	29	20	5	2

questionnaires were distributed – in the majority, questionnaires were given to parents (parenting organizations and primary schools) or students (secondary schools). The locations used to distribute the questionnaires were chosen to ensure that a wide variety of people from different ages, levels of education, ethnicity and gender would be recruited (these included parenting organizations, libraries, schools and universities). Informed consent was implied by the participant's agreement to complete the questionnaire. Questionnaires were allotted an individual study number to maintain anonymity and confidentiality.

All analyses used the Statistical Package for the Social Sciences (SPSS) (Version 14).

1. General linear models were used to explore the relationship between area and personal characteristics (gender, age, ethnicity and young parent status) and acceptance of young conception and abortion.
2. Further analyses (using general linear models) were conducted to explore the possibility of mediation occurring between these variables. The strengths of significant relationships were described by standardized effect sizes ( $\eta^2$ ). Where main effects for particular predictors were found, further models were constructed to assess whether interaction effects were present with level of area deprivation.

## Results

The more deprived areas, however, had a substantially lower mean age than the more affluent areas (18.19 compared to 27.19;  $P < 0.001$ ). It was not planned to recruit low numbers of young people; this happened as a result of high response rates in secondary schools and colleges. Based upon frequencies, participants were split into six age groups: 11–15 years, 16–17, 18–20, 21–29, 30–39, and 40 plus. The ethnicity of sampled participants was broadly representative of the areas when compared to national census data<sup>5</sup> – a higher proportion of black participants were recruited in the more deprived areas and a higher proportion of white participants in the more affluent areas (see Table 3).

### *Acceptance of young pregnancy*

Initial analyses found that participants were significantly more accepting of young pregnancy in the more affluent areas (mean = 3.14) than the more deprived areas (mean = 3.44;  $\eta^2 = 0.20$ ,  $P < 0.01$ ). Likewise, young parents were significantly

Table 3. Percentage of gender and ethnicity of participants by area type.<sup>11</sup>

		Total	'More affluent'	'More deprived'
Mean age		23	28	18
Gender (%)	Female	74	79	68
	Male	26	21	32
Ethnicity (%)	Black	19	11	27
	White	52	65	41
	Asian	14	11	17
	SE Asian	3	4	3
	Mixed	3	2	4
	Other	8	8	9

( $\eta^2=0.01$ ,  $P<0.05$ ) more accepting (mean = 5.00) of young pregnancy than participants who were not young parents (mean = 3.32).

A significant age difference was found in acceptance of pregnancy ( $\eta^2=0.07$ ,  $P<0.0001$ ). Participants aged 18–20 and 21–29 had the highest levels of acceptance, whereas participants aged 11–15 had the lowest. Neither gender ( $P=0.105$ ) nor ethnicity ( $P=0.171$ ), however, was found to have a significant influence on acceptance of young pregnancy.

When other characteristics were controlled for, age remained significantly related to acceptance of young pregnancy ( $\eta^2=0.07$ ,  $P<0.0005$ ). However, the effect of area deprivation was no longer significant ( $\eta^2=0.00$ ,  $P=0.891$ ). Further analyses were therefore conducted in order to determine which personal characteristic(s) were influencing the association between area deprivation and acceptance of young pregnancy. These revealed a significant interaction between the age of participants and area deprivation, when controlling for all other personal characteristics. Marked differences in acceptance of young pregnancy were found for younger (11–15 years) and older participants (40 plus) (see Figure 1). For younger participants (11–15

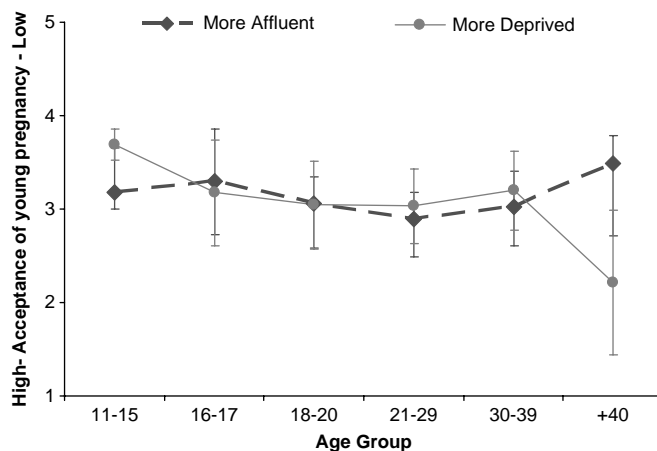


Figure 1. Mean acceptance rating (95% CI) for young pregnancy as a function of the age and level of area deprivation (lower scores denote higher acceptance).

years), more affluent respondents were more accepting of young pregnancy (mean = 3.28) than the more deprived respondents (mean = 3.64), whereas among older participants (40 plus) the reverse was true – lower acceptance of young pregnancy was now found among the more affluent (mean = 3.45) than the more deprived respondents (mean = 2.24) (see Figure 1).

### *Acceptance of abortion*

Respondents in more affluent areas were significantly ( $\eta^2 = 0.09$ ,  $P < 0.005$ ) more accepting of abortion (mean = 2.82) than those in more deprived areas (mean = 3.55). A significant difference was also found in acceptance of abortion with age ( $\eta^2 = 0.14$ ,  $P < 0.001$ ). The two youngest age groups (11–15 and 16–17) were found to be least accepting of abortion compared to the other, older age groups (see Table 4).

Acceptance of abortion also varied with ethnic group ( $\eta^2 = 0.09$ ,  $P < 0.0005$ ). Black participants were least (mean = 3.69) and white participants the most accepting (mean = 2.87). No significant differences in acceptance of abortion were found for gender ( $P = 0.09$ ) or whether participants were teenage parents or not ( $P = 1.00$ ).

When personal characteristics were controlled for, area deprivation was no longer significantly associated with acceptance of abortion. Both age ( $\eta^2 = 0.10$ ,  $P < 0.0001$ ) and ethnicity ( $\eta^2 = 0.068$ ,  $P < 0.001$ ) remained highly significant. However, ethnicity was significantly associated with area deprivation ( $\chi^2 (1, n = 570) = 7.435$ ,  $P < 0.05$ ). The more affluent areas had more white participants than the deprived areas (62 per cent cf. 43.5 per cent), and the more deprived areas had more black participants than the affluent areas (25.5 per cent cf. 12.5 per cent). As the acceptance of abortion by these two ethnic groups is significantly different, it is important to control for ethnicity in analyses involving area. When this was done, both level of area deprivation ( $\eta^2 = 0.02$ ,  $P < 0.005$ ) and age ( $\eta^2 = 0.05$ ,  $P < 0.0005$ ) were significantly related to acceptance of abortion.

An interaction effect was found between ethnicity and area deprivation (see Figure 2). White participants were more accepting in the more affluent areas (mean = 2.61) than in the more deprived areas (mean = 3.24), and Asian participants were more accepting of abortion in the more affluent areas (mean = 3.10) than in the more deprived areas (mean = 3.86).

Table 4. Mean scores (standard deviation) of acceptance of abortion by age group (lower scores indicate higher acceptance).

Age group	Mean score (standard deviation) of acceptance of abortion.
11–15	3.73 (1.12)
16–17	3.44 (1.31)
18–20	2.71 (1.10)
21–29	2.99 (1.26)
30–39	2.85 (1.28)
40 plus	2.77 (1.24)

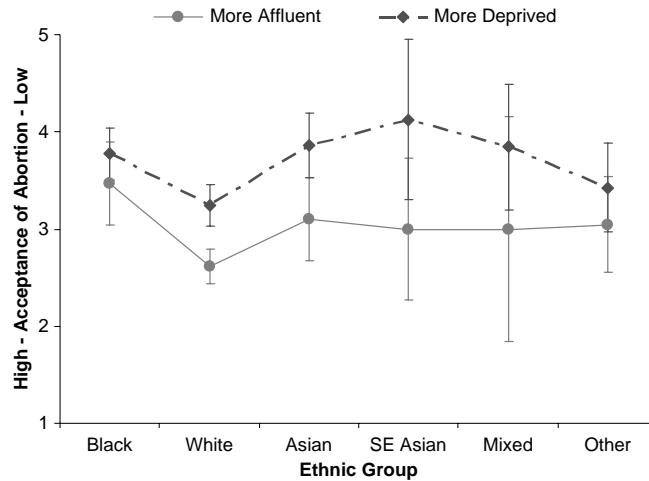


Figure 2. Mean acceptance rating for abortion as a function of ethnicity and level of area deprivation (lower scores denote higher acceptance).

## Discussion

### *Acceptance of young pregnancy*

In contrast to previous research (Smith 1993, SEU 1999, Jewell *et al.* 2000, McLeod 2001, Turner 2001), we found more affluent participants were more accepting of young pregnancy than more deprived participants. The current findings therefore add to work showing the influence of structural factors, such as educational and occupational opportunities, on people's acceptance of sexual behaviours, and such factors contributing to social inequalities in young pregnancy (Brewster *et al.* 1993, McCulloch 2001, McLeod 2001). Affluent areas have a high concentration of professional careers, which require lengthy periods of education – hard to fulfil with the financial and time responsibility of a child. However, in the more deprived areas, manual and unskilled jobs are highly concentrated and do not require long periods of education – thus, they can be fitted around a young pregnancy. Having a baby in an area where people work and are affluent could also be seen as an incentive for young parents to return to education or work, so they do not stand out in comparison to other people, whereas, in a deprived area, where unemployment is high, the same motivation does not exist. Unless young parents' needs and the influences on their attitudes to education, training and employment are understood, the Teenage Pregnancy Strategy will fail to meet its second target of supporting 50 per cent of young parents in education, training and employment, and the level of social exclusion suffered by young parents will not alter.

The most accepting of young pregnancy were 18–20-year-olds and 21–29-year-olds, and 11–15-year-olds were the least accepting. The sample frame may be partly responsible for this, as the younger participants were recruited through schools, and school attendance lowers the risk of young pregnancy (Bonnell *et al.* 2003). Alternatively, 11–15-year-olds' low acceptance of young pregnancy may be related to their internalization of parental values.



Younger participants (11–15-year-olds) were significantly more accepting of young pregnancy in more affluent areas than in more deprived areas. On the face of it, this is surprising, as higher acceptance of young pregnancy might suggest a greater risk of young pregnancy, as which would be expected in the more deprived areas. It could also signal that people in more affluent areas have a greater tolerance of others – the association between acceptance of young pregnancy and risk of young pregnancy is evidently complex and requires more attention. For participants aged 40 and over, the effect of area deprivation was in the expected direction – less acceptance in the more affluent areas. This difference in acceptance between younger and older age groups may be due to women in the older group having teenage children and holding high aspirations for them that they believe (perhaps on the basis of their own experience) would be disrupted by young pregnancy. These data show a powerful interaction between age and area of residence in attitudes to young pregnancy, suggesting that social representations of pregnancy do not exert uniform effects across age groups and exist within specific material environments. Thus, the relationship between area and personal deprivation is specific to a given location – the effects of deprivation and the relationship between deprivation and age are not uniform across or even within regions. This could occur in two ways. Firstly, the social representations held by people may differ by age and socio-economic environment due to life experiences and pressures; for example, in a more affluent area, education precedes parenthood as it is people's means to a career, money and a house. A young pregnancy does not fit this representation and thus is not accepted. Secondly, social representations of pregnancy may influence people in different ways. As we saw earlier, lower social classes are more likely to conform to external agents while higher social classes follow self-direction (Kohn 1977), suggesting that dominant social representations will have a greater influence on more deprived individuals, whereas upper classes will be able to interpret such representations in a more personal light. Exploration from a lifespan perspective should be undertaken to understand the influence of area of residence at each stage of one's life and the influence it has upon social representations of pregnancy, and vice versa. In the case of young pregnancy, this may help to understand the 'cycle of deprivation'.

The lack of future planning and low aspirations held by deprived people (Wardle and Steptoe 2005) may mean that they see young pregnancy as an alternative route to attaining an adult status and role, thus increasing their acceptance of young pregnancy. Numerous structural inconsistencies between areas, such as schooling and career opportunities (Brewster *et al.* 1993, McCulloch 2001, McLeod 2001), may also contribute to differences in acceptance, more affluent people, for example, placing greater emphasis on education. Thus, in these areas, having a baby at a young age could be seen as having a negative impact on one's future (DfES 2003).

The prevalence of young pregnancy was considered to influence the acceptance of young pregnancy by a greater number of more affluent than more deprived participants. This mirrors previous findings (Cater and Coleman 2006). Given that young pregnancy is more prevalent in deprived areas, the process by which prevalence influences awareness requires elucidation.

Young parents themselves were more accepting of young pregnancy – findings discordant with Jewell *et al.*'s (2000) and Phoenix's (1991) work, which suggested that young mothers separate themselves from other young parents and view them in a negative light. Our results actually suggest a level of solidarity between young

parents, and imply that young-parent-only groups may have a positive effect on young parents. Once again, the discrepancy between the results from these and previous studies warrants careful reflection. It is conceivable that the method of data collection used may have influenced the results – the current study used a survey whereas the other two mentioned studies used interviews to explore people's personal attitudes – something possibly missing in the present survey study.

### *Acceptance of abortion*

The current study found that participants in more affluent areas were more accepting of abortion than those in more deprived areas. This concurs with previous work (Burghes 1999, SEU 1999, Tabberer *et al.* 2000, Thomson 2000, Lee *et al.* 2004, Turner 2004). Similarly, both Smith (1993) and Tabberer *et al.* (2000) have claimed that external social pressure is the main influence of abortion acceptance, as social pressure appears more prominent in the lives of the more deprived young people. In this context, Musick's (1993) argument that rational sexual choices cannot be made by young people in deprived areas is pertinent, as is the observation that people on low incomes have a diminished sense of control (Lachman and Weaver 1998) and give less emphasis to self-direction (Kohn 1977). This lack of self-reliance can be explained by feelings of control; people from lower social classes have a greater external locus of control<sup>6</sup> than those in higher social classes, who place more emphasis on internal locus of control (Jensen 1990). Similarly, Lewis *et al.* (1999) found a low sense of personal control to be associated with a higher risk of non-marital pregnancy in American women.

In the case of abortion acceptance, conformity in more deprived areas is brought about through the influence of others' negative views of abortion and the lack of personal control to make decisions that deviate from those around one – in lower social classes, rates of young pregnancy have traditionally been high and the proportion of conceptions aborted low. The difference in perceived future attainment between areas may account for the difference in abortion being seen as a personal choice. Pregnancy is an alternative to a future of low future aspirations and low educational achievement for many young mothers in areas of deprivation (SEU 1999). Parenthood might therefore be the only 'choice' available to young women after an unplanned conception. Young people from more affluent areas, in contrast, have choices tied to future aspirations inspired by the heightened availability of educational and other opportunities. Clements *et al.* (1999), for example, found that students were more likely to have an abortion than non-students, due to educational empowerment. Finally, the lack of personal choice in deprived areas may arise from a lack of education about abortion (Tabberer *et al.* 2000).

Policy implications from these findings include improving knowledge about abortion in areas of social deprivation, in order to promote self-reliance by allowing young people to make an informed choice regarding abortion. On a wider level, improving education opportunities in more deprived areas will help to protect young people against several adverse outcomes such as an unplanned pregnancy, by offering them an alternative future path through education. In order to provide educational opportunities that are both available and appeal to the young people, policymakers must understand the meanings that young people in deprived areas

place on life and success – as these may differ from the meanings given by young people in more affluent areas and may also be region-specific.

Analyses demonstrated that the area difference in abortion acceptance was eliminated when other personal characteristics were controlled for. However, age and ethnicity were still significantly associated with abortion acceptance after adjusting for level of area deprivation. A correlation between area deprivation and ethnicity was found to partially explain the decrease in significance of area deprivation when personal characteristics were controlled for. Black participants were the least accepting of abortion and white participants the most accepting. This is particularly interesting, as there is some evidence that certain black communities (Afro-Caribbean) are most likely to have abortions (Lee *et al.* 2004). One possibility is that the religious and cultural beliefs of the participants underpin these apparently diverse findings. Another is the association between ethnicity and income (Lillie-Blanton and Laveist 1996, Nazroo 2001, Nazroo and Williams 2006), whereby the characteristics of deprivation (e.g. lack of alternative options due to no positive role models, external locus of control, poor education, and low employment opportunities) could account for black participants' beliefs (Geronimus 2003).

An interaction between ethnicity and socio-economic environment was evident in abortion acceptance; white and Asian participants were more accepting in more affluent areas. Similar results were found in the USA; white women's risk of young pregnancy increased with neighbourhood deprivation, whereas for young black women this was not the case (South and Crowder 1999). Furthermore, young white people benefited more from having affluent neighbours than young black people did (Brooks-Gunn *et al.* 1993). These findings demonstrate that the effects associated with ethnicity (for some ethnic groups) depend on the broader social and economic context (or that the effects of area-wide factors depend on ethnicity). It could be that living in more affluent areas protects against effects normally linked (through social deprivation) with ethnicity by providing social norms such as those suggested by Wilson (1987) – aspirations for the future and better education.

It has been suggested that people from black minority ethnic (BME) groups perceive available community resources in a more favourable light than white groups in the same community (Karlsen *et al.* 2002). Such findings suggest that BME groups actively make use of interventions and resources in deprived areas, thereby attenuating the effects of socio-economic environment. In addition to ethnicity, age may also influence people's attitudes to and treatment of young parents. In a society labelled as 'sexualized' (UNICEF 2001, p. 8), it is possible that young people may have become more accepting of pregnancy because of having more open-minded attitudes to sex.

Testa and Coleman (2006) highlighted conflicting beliefs and norms about sexual health in BME youth in London. These authors suggest that BME youth face conflicting messages about sexual health; they are exposed to highly sexualized media messages and a sexual silence from their communities and families – this influence is stronger than for many white young people due to religious beliefs being stronger in BME people than white people. The promulgation of such media imagery could also be viewed as a legacy of the slave trade, in which black slaves (male and female) were overtly sexualized by white slave masters (Littlewood and Lipsedge 2001). Health professionals and practitioners need to be aware of the cultural beliefs of young people from BME groups; only then will adequate and efficient support be

offered to these young people to enable them to make informed decisions regarding sexual behaviour.

In order to understand how decisions on abortions are in fact made, the substantial influences on young people's acceptance of abortion need to be clarified in more deprived areas, among different ethnic groups and young people. Only then can we start to understand the decision-making process and ensure that abortion is an informed decision.

### ***Strengths and limitations***

The fact that a large number of participants were 'unclassified' on the socio-economic classification of the Office of National Statistics prevented exploration of the influence of personal deprivation in the analysis of this study. This is principally because many participants were either full-time mothers or in full-time education. In future, participants in full-time education could be asked to state their main carer's occupation – this would enable classification to be based on family social status and, following McCulloch (2001), a more appropriate assessment of the influence of personal deprivation. In addition, an interaction between area and personal deprivation has been found in several factors that increase vulnerability (e.g. future aspirations and early sexual activity) to unplanned pregnancy (Smith and Elander 2006).

One issue relates to the choice of words used in the questionnaire – in particular, the use of the word 'young'. This was carefully chosen, as the term 'teenage pregnancy' could invoke negative stereotypes, something that the researcher was at pains to avoid. One advantage of the chosen term was that the research was interested in young parents (e.g. aged 20 and 21), who of course would not be covered by the term 'teenager'. However, in a few cases, the term 'young' seemed to induce confusion. One possible remedy for this would be to ask participants at the outset what they thought the term 'young parent' meant and if necessary to produce an agreed definition.

Finally, the current study evidenced a younger cohort of respondents in the more deprived areas. This arose from the much less successful recruitment of participants in the 11–15-year age bracket in the more affluent areas. We suggest that, although this recruitment barrier introduces difficulties from a purely methodological perspective, we believe that it does not undermine the significance of the findings in regard to acceptance of young pregnancy outcomes by area of social deprivation. Far from it – it perhaps underscores the findings from other studies (Smith and Roberts, in press) that the attitudes of professional people to young parents (in this instance those who perform the role of gatekeepers to the young people) could be less than helpful, and this could be seen here as being responsible for preventing their voices from being aired. Future studies could perhaps seek a way around this through quota sampling.

### **Conclusions**

The findings reported here have highlighted quantitative differences in people's acceptance of young pregnancy and abortion. Examining the relationship between deprivation and acceptance of young parenthood increases our knowledge of the

processes by which deprivation makes some young people more vulnerable to unplanned pregnancy and exposes them to the possible adversities associated with young pregnancy. This is extremely important if social inequalities in young pregnancy, as highlighted by Uren *et al.* (2007), are to be reduced. According to Bradshaw *et al.* (2006), deprivation accounts for three-quarters of the area variation in under-18 conception and abortion rates. The personal characteristics explored in this study may well account for much of the remaining variance. It is important that future work does not stop with analyses of main effects and assumes that area deprivation has a uniform influence over people who vary in their personal characteristics. This is particularly important given the interactions with area for age (on acceptance of young pregnancy) and ethnicity (on abortion acceptance) that have been observed here. Understanding such interactions should assist the design and planning of effective area-based young pregnancy prevention programmes as part of the overall teenage pregnancy strategy. In line with the current findings from this study, interventions may well need to be targeted at specific groups. Further research in this area should adopt a lifespan perspective to understand the influence of area of residence at each stage of one's life and as part of the life story. In the case of young pregnancy, this may help to understand the 'cycle of deprivation'.

Finally, if we wish to change the level of acceptance of young pregnancy and reduce or eliminate the adverse treatment of young parents, it is important that we understand how social representations of young pregnancy circulate in society and how these come to inform acceptance of young pregnancy and abortion. The current results imply that position in the social and material hierarchy is a crucial factor in how (and what) meanings are generated and of course in what actions are possible from them.

## Notes

1. 'Young pregnancy' is used here to represent all pregnancies that are conceived under the age of 18. This definition is used as the UK Government's Teenage Pregnancy Strategy for England highlights under-18 conceptions as being the target (Social Exclusion Unit, 1999). The term 'teenage pregnancy' suggests that 19-year-olds will be included.
2. Social deprivation was assessed with the Carstairs index, which produces a composite variable from an unweighted combination of four census variables – unemployment, car ownership, overcrowding and social class.
3. In the UK, abortion is legal up to 24 weeks. See [http://www.opsi.gov.uk/acts/acts1990/Ukpga\\_19900037\\_en\\_1.htm](http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900037_en_1.htm).
4. The rest of the questionnaire asked participants qualitative questions to explore what they thought were 'young' to have a baby and why they had the views they did regarding acceptance of pregnancy and abortion.
5. <http://www.statistics.gov.uk/census>.
6. Health locus of control is concerned with whether people feel that they have control over their health (internal locus of control) or whether it is controlled by factors outside their control (external locus of control) (Wallston *et al.* 1978).
7. Office of National Statistics (2006).
8. Government Statistical Service (2006).
9. Noble *et al.* (2004).
10. Figures are rounded to the nearest whole number.
11. Figures are rounded to the nearest whole number.

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### Appendix A

*Please answer the following questions about yourself:*

What is your postcode? \_\_\_\_\_.

How old are you? \_\_\_\_\_.

What is your gender? \_\_\_\_\_.

What is your ethnic status? \_\_\_\_\_.

What is your occupation? \_\_\_\_\_.

*Please state your answers to the following questions:*

Is to have a baby at a young age acceptable in today's society? (Please choose your answer):

1                      2                      3                      4                      5  
Highly Agree   Agree agree or disagree   Neither   Disagree   Highly disagree

Abortion of pregnancy is acceptable (please choose the appropriate answer):

1                      2                      3                      4                      5  
Highly Agree   Agree agree or disagree   Neither   Disagree   Highly disagree