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Family Functions during Adolescent Pregnancy: Cases Study

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ABSTRACT

Adolescent pregnancy is an overlapping situation during the normal development period for individuals and families, potentially causing impact and crisis as adolescents are not prepared both physically and psychosocially. The impacts could be more severe if the family does not accept the situation, rendering their functions incomplete or flawed, particularly in terms of caring, coping, socialization, and behavioral control in the hope to promote normal health and parenthood for pregnant adolescents. However, previous studies and most healthcare services emphasized evaluation primarily on the physical and mental health of pregnant adolescents, with limited focus on family functions. This three-case study thus endeavored to grasp family functions among families with adolescent pregnancy; by evaluating the health conditions of families with adolescent pregnancy both intentional and unintentional pregnancy. The content analysis revealed family emphasized the provision of financial support, conducted limited expression of love and care, and found no direct socialization on good parenting, inappropriate coping methods, and health issues among pregnant adolescents and families. Therefore, nurses and health personnel should create effective interventions to support and promote family health as a whole system; during adolescent pregnancy, postpartum care, raising their children, including strengthening new family.

Keywords:
Family Function, Adolescent Pregnancy, Cases Study,

Introduction

Adolescent pregnancy is a critical health risk, particularly for females less than 17 years of age. Statistics had illustrated 57% of children worldwide were given birth by 21 million mothers aged 15-19 years. Every year, 700,000 mothers aged less than 15 years were found to be giving birth. Moreover, adolescent pregnancy rates have become higher than 10%--the rate defined by the World Health Organization (WHO) [1,2]. For Thailand, the live births rate among females aged 10-14 years is 1.1 per thousand, while the same rate among females aged 15-19 years is 31.3 per thousand [3]. Despite all the attempts to simultaneously prevent and solve the issues, its emergence is high in areas with low-income households, educational opportunity deficits, low employment rate, and low income; adolescents thus tend to marry rapidly [4]. Additionally, data indicates pregnant adolescents tend to experience stress-inducing situations which could contribute to emotional crisis situations, regardless of the intentionality (or unintentionality) of pregnancy [5]. The situations might lead to complications during pregnancy, labor, and postpartum, making adolescent pregnancy to be regarded as a high-risk pregnancy. Physical impacts during pregnancy include malnutrition, anemia, hypertension in pregnancy, infection from premature rupture of membranes, dystocia which requires cesarean section, and risk of postpartum hemorrhage [6]. Regarding social impacts, pregnant adolescents need to stop studying or quit school, decreasing self-development opportunities and social approval. For economic impacts, a low level of educational qualifications affects career opportunities and amount of income [2,7]. Emotional impacts of pregnant adolescents include stress or anxiety towards physical, emotional, and mental changes, and role change from adolescent child to mother and wife, which could pose more risks of depression and suicidal tendencies. Regarding impacts on family, as families have been found with adolescent pregnancies—both intentional and unintentional, families experience changes in terms of function and relationship among the members [7]. Several families have been found to unwillingly accept the pregnancy and attempted to adapt functions for caring for adolescent health during pregnancy: by providing appropriate food, counseling, following up on symptoms, as well as reminding and supervising antenatal

care appointments [8,9]. Families also needed to teach and assist in postpartum childcare and counsel in each period of life, as well as attempt to conduct family functions in new situations that emerged from untimely, adolescent pregnancy [7,10,11].

Analyzing the situations and previous research, most studies on family functions in case of adolescent pregnancy both intended and unintended had been found to emphasize mainly understanding the health conditions of pregnant adolescents. Adolescents tend to experience physical, mental, and societal issues, which often change negatively, impacting adolescents. These include a lack of acceptance from family and other individuals, inappropriate adaptation or coping, financial limitation, and in-family relationship issues [11]. Pregnant adolescents are found to fear, anxiety, embarrassment, and attempt to conceal their pregnancies. Inappropriate and inadequate self-care behaviors have also been found, regardless of whether the pregnancy is intended or pre-planned [12]. Early adolescents less than 15 years of age tend to be concerned about physical changes and appearance, as well as the inability to predict and plan for their own future [5], and therefore considerably depend on and need assistance from family. In this regard, the family is influential in the health behavior of pregnant adolescents, providing material support, information, knowledge, and emotional support. Societal support from family is particularly found to enable pregnant adolescents to perform maternal functions during pregnancy, contributing to role changes from normal adolescents to being a wife and preparing for becoming a good mother [13]. Family members in charge of caring for pregnant adolescents are mostly mothers of the adolescent, as they are significant and close, able to reinforce confidence and provide care for pregnant adolescents during both pregnancy and the postpartum period [14]. However, if pregnant adolescents reside with a husband, husband family, or lover, obstacles, and limitations in receiving appropriate and adequate support from family could arise. Additionally, families with pregnant adolescents have been found to experience expectations, stress, changed relationships among individuals and members, and conflict; particularly in the case of unintended pregnancy [7,10].

This study of 3 cases of families with pregnant adolescents was conducted by applying the family function concepts of Friedman, Bowden, and Jones [15], which outline family functions in 6 aspects—i.e., response to basic needs, affective function, socialization, behavioral control, and monitoring, coping and solving problem function, and economic function. Family with pregnant adolescents need to conduct all 6 aspects of functions with adjusted approaches to emphasize good health in all aspects for the family and its members [15].

Objective

This case study was aimed at exploring family functions among families with adolescent pregnancy in the community setting of Thailand.

Cases Study Method and findings

The case study was conducted by selecting case studies with less than 20 years of age who came to receive antenatal care at health-promoting hospitals in rural areas of Khon Kaen province, from October 2021 to March 2022. Initiating from fostering relationships and trust with pregnant adolescents and family members, the study then proceeded with interviews and therapeutic communication, conducted health assessments and home visits for 4-6 times until data had been collected in all aspects, as well as provided health services in accordance with the responsibilities of registered nurses both at home and health facilities. The details of the 3 case studies are as follows:

Case Study 1

Pregnant adolescent aged 17, studied at grade 11; and received antenatal care for the first time at 25 weeks of pregnancy. She needed to conceal the pregnancy from her family, as her husband (lover), aged 19, was charged with a drug-related crime. Her family consisted of 4 members, including her: her father (43 yrs.), and mother (42 yrs.) whom both graduated in Grade 4 and had no congenital diseases; and her younger brother (8 yrs.) who was studying in grade 2. The father and mother were farmers and sellers of knives and agricultural equipment, traveling to other provinces to sell the merchandise during their free time from farming. The monthly average income of the family was 30,000 bahts, which was sufficient for all expenses, although with installment debts for the truck and motorcycle. Whenever the father and mother went to other provinces to sell the merchandise, the pregnant adolescent tend to be left with 2 younger brothers with no adult supervision. The parents would come home 2-3 days a month, and provide 3,000-5,000 bahts monthly via bank transfer for expenses of their children-which the eldest daughter was responsible for withdrawing and spending the money.

Prior to being associated with the boyfriend, having sex, and getting pregnant, the female adolescent was well-behaved, obedient, did not loiter, came home on time, and the parents did not observe any risky behaviors. The parents had subsequently learned about the association with the boyfriend, the mother thus urged her daughter to be careful, value herself, avoid sex, and subsequent pregnancy. During the next period, the parents had observed behavioral change—being quiet and talking less-and therefore attempted to inquire. As the female adolescent then had informed that, she had sex with her boyfriend without contraception, the parents thus organized marriage with a traditional handfasting ceremony. The female adolescent had somewhat searched for knowledge on contraception from close friends and searching from online media, while was not courageous enough to inquire mother in fear of berating. Initially, the female had acquired emergency contraceptive pills from a common dispensary, then received the 21-pill contraceptive pills and forgot to take the pills for some days, leading to the eventual detection of pregnancy. The adolescent then consulted her boyfriend and a close friend whose advice was to conduct an abortion. Fearing the procedures, the female adolescent denied the idea of abortion. Moreover, that period was concurrent with the COVID-19 pandemic in which the

school was conducting classes online, the adolescent thus decided to conceal the pregnancy from her family. Nevertheless, when the pregnancy had reached the second quarter, the physical changes and abnormal symptoms were apparent to the mother, as the adolescent ate more—both in terms of volume and frequency, slept more, wore loose clothes, and spent the most time in her room.

"*The mother hence inquired about her daughter and learned of the pregnancy. The mother had then spoken of this matter to the father, who was enraged with the daughter, concerned about her education as he expected her to study at higher levels and consequently earn a good career. The father was also concerned that the boyfriend would not take responsibility, and therefore negotiated for the boyfriend to be engaged to his daughter. Later he learned that the boyfriend had prior convictions related to a drug abuse case."*

Regarding the health condition of the pregnant adolescent, assessments revealed her body mass index of 18.35 kg/m^2 (below standard criteria) and anemic condition. The father was concerned about possible health issues and therefore had the mother take care of the pregnant adolescent at home, while he traveled to sell the merchandise alone. During the third quarter, with 31 weeks of pregnancy, the pregnant adolescent slipped and fell in the toilet, and frequently had a uterine contraction. She was then transferred for further treatment and tocolysis at the hospital for 1 week. During this period, the parents had made adjustments to the toilet floor and stairs within the house, purchasing non-slip mattresses and laying them on the house floor to prevent falls and other accidents. When nearing the labor period at 38 weeks of pregnancy, with an estimated infant weight of 3,050 grams, the pregnant adolescent upon receiving antenatal care was observed to be tight-lipped, mostly came alone, and tend to isolate herself from other service recipients. Upon being inquired about these caveats, the adolescent revealed that on some occasions of her presence to receive the services from this place, she needed to also attend online class by listening to it via smartphone. In case she could not keep up with classes, she would ask her close friend to review the classes for her. Additionally, she came to all appointments, spoke to, and increasingly as well as gradually familiarized herself with the nurses responsible for providing antenatal services. She also occasionally sought counseling from a Line group in case of abnormal symptoms. Regarding pregnancy, the adolescent seldom spoke to her husband via phone.

"*The parents refused to let the husband stay in the same household. Moreover, the adolescent: was concerned about future family life; "seldom spoke to and consulted with mother about general matters, while avoiding pregnancy matters in fear of her mother being uncomfortable"; "felt she was a bother to her parents, uncertain of the future, sad that she disappointed her parents but could not do anything to fix it and therefore needed to move forward, afraid of the future and how to raise the baby, what career to pursue, would attempt to complete Grade 11 before planning further, seldom called her boyfriend as he was in prison and therefore unable to help her".*

Case Study 2

Pregnant adolescent, aged 14, was studying in Grade 8 and was taken in by her maternal grandmother for a urine pregnancy test. It was the first and without-foreknowledge pregnancy. The assessment revealed that the pregnancy was approximately 8 weeks. The boyfriend/husband, aged 20, was a general employee. Her family consisted of 5 members: maternal grandmother, aged 67, who had hypertension; mother, 34, who divorced her first husband, remarried, and had 3 daughters, aged 17, 15, and 8. The grandmother graduated from Grade 4 and earned income from an elderly allowance scheme. The mother graduated from Grade 9 and worked in general employment. Most of her income came from her new husband who worked at a factory in another province. The overall monthly income of this family was approximately 6,000-8,000 bahts. The financial status of the family was not optimal and coupled with debts.

The grandmother was the first person who had known of the adolescent pregnancy; thus, was highly enraged at her daughter and grandchild. Prior to the pregnancy, the grandmother had observed her grandchild's association with her boyfriend and thus had the grandchild implanted with contraception. Later, however, the adolescent had secretly requested the doctor to remove the contraception as she was feeling distrust and discomfort in the implanted area.

This pregnancy was recognized, though with dissent, by both families, as the adolescent was still studying and a minor. The mother and grandmother thus would like for the unborn baby to be aborted, with concerns about family life insecurity and arising burdens in the coming future. Despite these, the adolescent insisted on keeping the baby, the mother and grandmother thus requested the adolescent to quit studying and allowed the pregnancy to continue, with engagement to the boyfriend as a condition. The mother and grandmother believed this incident was fate and therefore would like for the adolescent to learn about associated hardships by herself. They thus had the adolescent work for income, plan on child raising, and let her and the husband take care of each other; in the home, the couple could learn the hardships of life.

The husband of the pregnant adolescent hence took her to live in his house in another district with other 6 members—father, mother, older brother, sister-in-law, husband, and 1-year-old nephew. The husband worked in general employment. The grandmother and mother of the pregnant adolescent had never visited, only seldom making phone calls to talk and make inquiries. Regarding health conditions of the pregnant adolescent, her body mass index was at 18.08 kg/m^2 (below criteria), with anemia, and syphilis. The adolescent had also been found to have sweets and ice creams every day, while occasionally taking pregnancy-improving medication received from the hospital. To conceal her growing belly, the adolescent increasingly wore loose clothes, and frequently rode a motorcycle. At 33 weeks of pregnancy, she was detected with antepartum hemorrhage and therefore admitted to the hospital in which then premature labor could be suppressed. Premature labor, nevertheless, occurred at 35 weeks of pregnancy, giving birth to

a baby that weighed 2,460 grams. Throughout the pregnancy, the husband was responsible for taking the adolescent to antenatal care, although not always as scheduled, as he could not request to leave work. The adolescent thus needed to frequently attend the appointment alone. While attending antenatal care appointments, the adolescent rarely spoke, spending time chatting or gaming on her phone, never asking for any suggestions or pieces of advice apart from what the personnel had already suggested or inquired from her. The rare occasions when she spoke or asked, were about possible labor day -e.g.,

"*wish the labor will be soon, feeling uncomfortable, want to see her friends soon"*. She also mentioned *"misses her mother and (maternal) grandmother, but not that much. Until now, her mother had often beaten her, loved her younger sister more than her, felt closer to her maternal grandmother than to her mother, and felt she needed to depend on herself and her boyfriend to live in the coming future". She felt: "indifferent towards this pregnancy, as others at her age also have children"; "when the baby is born, it will be breastfed at first as the nurses had suggested. Then will think again, might look for a job"; "still have not thought about studying after this"; and "the older sister-in-law of the husband shared her child's clothing with the adolescent sometimes". "The husband took the adolescent to the appointment as required, although never went in to speak with the nurse as he thought it was female matters. Was notified of the infection and inoculated until fully recovered. The future goal was to be determined, without any planning at the present*".

Case Study 3

Pregnant adolescent, aged 18, graduated from Grade 12, and traditionally married at age 17. She met her husband in Grade 11 when he was aged 20. They graduated together and continued living with their parents after marriage. Using no contraception, the wife got pregnant 6 months after marriage and went to receive antenatal care after 3 months of pregnancy. Her family has 5 members, comprising a father aged 52 and a mother aged 48, whom both had health conditions with no congenital diseases. Her family also had an older brother, aged 21, who was diagnosed with a psychiatric disorder, rendering him have difficulties communicating. The pregnant female and husband jointly conducted business with their families—e.g., digging a pond and transporting soil, farming, as well as planting and selling seasonal vegetables. Their family had a monthly income of 30-40 thousand bahts, with debts from bank loans for business investment. Their income was nevertheless adequate for daily living expenses. The husband was hardworking, patient, laconic, and not involved with drugs, thus was loved by the family of the female. The pregnant female was well-mannered, helped her family by tending to housework, took care of her older brother who has been ill, and did not loiter. Therefore, she gained approval from both families to be in a relationship with her husband during her school days. When she got pregnant, both families were delighted as they had not have grandchildren before. The husband and other family members were alternatively and consistently bringing the adolescent into antenatal care.

The Father and mother of the husband had also been consistently purchasing and bringing milk to nurture the pregnancy. During pregnancy, the pregnant adolescent often had irregular meal timings, with no symptoms of morning sickness though with a small amount of food ingestion, sometimes with little to no appetite. Her body mass index was evaluated at 17.18 kg/m^2 (below criteria), with anemia (Hematocrit at 31-33 %).

The adolescent felt indifferent towards pregnancy, although with the need to see the baby's face. Upon further investigation, it was noted that she "felt both her and husband's families were satisfied with her pregnancy. The pregnant female never consulted on pregnancy with anyone. She often seeks knowledge on the issue via her smartphone and asked her mother sometimes about unhealthy foods and abnormal symptoms during pregnancy. However, she mostly read about pregnancy from the brochure provided by the hospital. She is afraid of labor, feeling uncertain about raising a child, though she also thought it would not be too difficult, as her mother—who was living together—could advise her. The mother mostly advises against eating any unhealthy foods, and caution towards road accidents and falling. Until then, the adolescent had never consulted her mother on labor and parenting, as she thought her mother and maternal grandmother would help her when the time comes. She also felt her husband was kind and caring, although he does not speak more.

Analyzing family functions from the 3 cases study, family functions during adolescent pregnancy could be summarized, as illustrated in the table below:

Family Function	Intended Adolescent Pregnancy (Case III)	Unintended Adolescent Pregnancy (Case I and Case II)
1) Affective function	- Husband was caring though could benefit from speaking more and having more time. - Felt both her and her husband's parents were satisfied with her, thought could talk with each other more daily. - The mother was always asking what she needed and responded accordingly.	- Father and mother talked inadequately, with indifference, particularly the father. - Felt father and mother were enraged by her disobedience and of her narcotics case-charged husband. - Mother was concerned for the adolescent but expressed nothing; indifferent. - Sister-in-law shared baby clothing with the adolescent. - Percepting that the maternal grandmother cared for her, but felt neglected by her mother.

Family Function	Intended Adolescent Pregnancy (Case III)	Unintended Adolescent Pregnancy (Case I and Case II)
2) Socialization and behavioral control function	- No family members advise on this issue. Mother mostly told the pregnant adolescent to avoid unhealthy foods, ride a motorcycle, and be cautious of falling. - Mother had been urging pregnant adolescents to have good food.	- Mother told her not to have a boyfriend, though without monitoring, hence the pregnancy occurs. - Mother warned and commanded to consider the unborn baby when doing anything; pointed out that the adolescent was already a mother and should not be self-indulgent anymore (felt mother was still angry of her disobedience and inappropriate behaviors which led to pregnancy) - Mother did not say anything, though she asked the maternal grandmother to give advice in her stead. - Father and mother advised the adolescent on finding jobs—e.g., sugar cane cutting, but still complained that since she should have been studying, but got a husband instead, she thus had to manage her own life.
3) Health Care function for a pregnant adolescent	- Mother told the adolescent to avoid unhealthy foods and be cautious of accidents, restricted her from riding a motorcycle, and inquired about her sometimes on abnormal symptoms. - The pregnant adolescent searched for information and used a mobile application to facilitate health care for herself. - Mother took the adolescent to antenatal care and often urged the adolescent to take pregnancy vitamins. - Mother provided food and helped with housework since the beginning of pregnancy.	- Mother often prohibited the adolescent from behaving based on traditional/ preexistent beliefs—e.g., no overabundantly savory foods and no late-night showers as the birthed baby would be sick often. - The adolescent went to antenatal care alone as the mother was still angry and had no time. - The husband occasionally escorted the adolescent to the care, as he was occupied with work. - The maternal grandmother advised and told the adolescent to get antenatal care. - Family members did not recommend antenatal care as the required information was already provided by the nurses. . Moreover, in their perspective, the adolescent would not listen in any way. - The sister-in-law had had an experience in pregnancy and childrearing and then helped instruct and advise the adolescent on conduct and parenting.
4) Stress response and family coping function	- In case of issues and unease, the adolescent could consult with all family members. - Rarely had issues, all situations were normal.	- Father and mother felt they were to blame for the adolescent's pregnancy (previously they focused on work and thus left the adolescent with the maternal grandfather. When the grandfather died, the adolescent had to live alone). -Mother frequently scolded the adolescent, and sometimes reprimanded repeatedly for past wrongdoings, which the adolescent had to accept the consequences… - Father and mother were still filled with anger and sorrow and did not regularly talk to the adolescent. They nevertheless observed and provided advice. - Father told the adolescent to quit school and plan for further studies after labor, in the hope of a better future. - Mother and maternal grandmother were enraged, telling the adolescent they would not help raise the baby. The adolescent had rather learn about it by herself. - The adolescent did not dare consult family members on self-care, as she feared of being scolded and blamed for her past conduct. - Maternal grandmother blamed the mother for not adequately taking care of the pregnant adolescent, contributing to various issues.
5) Economic function	- Fathers and mothers of both the pregnant adolescent and the husband provided financial support for expenses. - The husband attempted to earn more income to cover monthly expenses	- Mother provided financial support to cover daily expenses as the adolescent had been receiving since she entered school. - Paternal grandmother helped more with formula expenses as she pitied the adolescent. - The family reduced personal financial support for the adolescent as necessary.
6) Provision of Basic physical necessities	- Mother let the adolescent buy clothes according to her own preferences. - Father and mother provided food that aligned with the preferences of the adolescent and strengthen the pregnancy. - Family members managed and arranged space for caring for the coming infant.	- Father and mother of the husband were indifferent and did not care for the adolescent. Sister-in-law, on the other hand, shared her things with the adolescent. - Mother of husband and sister-in-law provided food and shared appliances for the coming infant. - Adjusted the environment both interiors and exteriors of the house after the falling of the adolescent - Repartitioning of house spaces for caring for the coming baby during the latter periods

Lessons Learned from Cases Study: Discussions

From the 3 cases study on adolescent pregnancy, the first 2 cases were found to be unintended or unprepared pregnancies in low-aged, adolescent mothers, who had not graduated from high school and had no occupation. The 3rd case, on the other hand, was an adolescent pregnancy in the late adolescent period, in a mother who graduated from Grade 12, and was accepted by both families. Upon investigation of previous studies, most adolescent pregnancies had been found to be unintended, and tend to be in families with poverty and debts [16,17]. Even though some of the pregnancies had been found to be intended, unpreparedness in terms of maturity and growth was also apparent. This was evident, particularly in the cases of early adolescents who had limited capacity in forecasting future consequences. These adolescents

thought pregnancy would help fulfill their family lives, wifehood, and capability in raising the infant [5].

Adolescents, however, lack physical and mental preparedness, as illustrated in a case study in which the pregnancy was coupled with low body weight and anemia. The causes could partly be of physical development of adolescents which was still incomplete, and the fact that they needed to conceal the pregnancy, contributing to stress and related behavioral adjustment as well as lowered attention to the care of self and the unborn infant [9,11,18]. Additionally, inappropriate self-care conduct and consequent health issues could also be found among intended adolescent pregnancies [12].

The cultural contexts of Northeastern (Isan) families were apparent in this cases study. Most adolescents resided with the elderly-e.g., maternal grandfather and grandmother-in the form of skipped-generation families. As people of working age needed to work for income, the elderly thus replaced the parents in parenting. Living without parents contributed to the conditions of no control, directions, and promotion of appropriate paths on premarital sexual behaviors, as well as the lack of knowledge on pregnancy prevention. These were in line with the study of Sansanee Nisu [16], which explored parenting styles and relationships within families of pregnant adolescents. Among 39 pregnant adolescents, most of the adolescents were found not residing with parents, and raised with affectionless control, accounting for 42.1%. Moreover, relationships within the family in which communicative issues were apparent affected adolescent pregnancy with statistical significance ($p < 0.001$) [16]. The issues eventually led to adolescent pregnancy. When families from the two case studies noticed pregnancy in adolescents, the consequent reactions were prone to anger, embarrassment, sorrow, and disappointment. As a family member who tends to be the first one to notice pregnancy, the mother of the pregnant adolescent would be the one making decisions on abortion, antenatal care, and informing the other family members of the pregnancy. If pregnancy was agreed to continue, the mother of the pregnant adolescent would be involved in antepartum and postpartum care—appropriate and adequate support for pregnant adolescents [8,14].

In a case study, the father and mother blamed themselves for inadequate conduct in parenting their child, leading to the issue of pregnancy. This caveat coincided with the study by James S. et al. [11], which found when an adolescent had become pregnant, family members, particularly the grandmother, felt the pregnant adolescent and mother should be reprimanded. They should also admit the emerging wrongdoings and accept them as life lessons. However, the findings indicated that extended family with maternal and paternal grandfathers and grandmothers tend to emphasize the situation, and accordingly acted as mediators-persuading other family members to understand and care for the pregnant adolescent, as she was a pitiful person [19].

Additionally, adolescent pregnancy stimulated family functions to be more flexible, and able to accept the pregnancy of the adolescent-a family member. As illustrated in Case Study 1, despite its unintended nature, the family eventually accepted the pregnancy and adjusted its functions to care for the pregnant adolescent simultaneously. In terms of affective and care function, the family was found to understand and sympathize with the issues experienced by the adolescent, with the mother as the main supporter-monitoring and supervising health behaviors, as well as training the adolescent in preparation to become a mother, although this role was not entirely clear. The mother mostly acted on discouragement, not adequately focused on teaching and suggestions. The mother also focused on the provision of support for daily expenses, as well as resources for pregnancy care as required. Planning for postpartum care of infants and continuation of studies for the adolescent was also conducted by the mother. These caveats coincide with the study of Espinosa et al, which emphasized family functions of the family of pregnant adolescents in Mexico. Evaluated with FACES II, 53.5% of 90 families were found with a medium level of adaptability, and a tendency to become balanced eventually [8].

Moreover, some families did not accept adolescent pregnancy, similarly to Case Study 2, rendering the adolescent deprived of care and support from family, as well as responses to care needs required by pregnant adolescents [17]. Expression of inappropriate affective behaviors, coupled with inefficient communication, motivated pregnant adolescents to seek affection and care from outside their family. Moreover, the pregnant adolescent needs support for self-care during pregnancy development of motherhood, and wifehood, but with poverty within the family, such needs were more difficult to achieve [20]. The husband of the pregnant adolescent hence played a key role to support her. Studies on factors influencing participation in caring for pregnant adolescents among husbands indicated factors in the aspect of awareness of capability in caring for pregnant adolescents impacted participation in caring for pregnant adolescent females [21]. Additionally, promotion and development for a more profound relationship between wife and husband facilitated the wife-the pregnant adolescent—to work towards family development. This, coupled with support from an appropriate family network of the pregnant adolescent, affected the increase of body weight in both the pregnant adolescent and newborn infant. Residing with a husband's or husband's mother's family, additionally, posed a limitation in receiving inappropriate support from family [20,22,23]. From these findings, evaluation of pregnant adolescents and families as responsible by nurses [6] and appropriate, jointly planned nursing guidelines with families, would enable families to adapt to situations and function to care for pregnant adolescents [10]. Regarding this, there have been several proposed guidelines on nursing and family health care-e.g., family-centered nursing, which promoted better adaptability among families and pregnant adolescents, both in the aspects of motherhood and health care [24,25].

Conclusion and Suggestions

From all 3 cases studied, the first 2 cases were families with unintended adolescent pregnancies. They were of school age with middle adolescents, disapproved and reprimanded by, had a conflict with, and were in a poor relationship with their families. They thus

did not receive direct care and support from their families. However, all families—particularly father and mother—in the group of an unintended pregnancy still provided monetary and material support, though with a low level of guidance and behavioral supervision. On the other hand, negative conducts were evident, with blaming, as well as low level and unclear expression of affection and care, which then could affect emotional and psychosocial health conditions of pregnant adolescents, husbands, and family. The intervention of health care was conducted indirectly-i.e., emphasizing the use of command and dissuasion, as well as unclear and vague expressions of affection and care. Implementation of family function as discovered in the case study was thus considered negative-or inappropriate—conduct, which might not be able to support both pregnant adolescents and husbands towards becoming good parents, potentially affecting their parenting behaviors and the health of infant/child in the coming future. The study also found poor relationships within the family between parents and pregnant adolescents. Nurses and related health personnel should thus improve their operations to be more efficient, emphasizing assessment of the family as a whole system, which would then gain data integral to comprehensive family health care and promotion [25].

Such conduct could contribute to the promotion of well and complete family function, conforming with new development period-i.e., adolescent children prematurely creating a family and becoming parents. Healthy relationships within the family would also be built. Accordingly, nurses could also provide counseling in advance for families on planning and preparation for coping with potential health issues, counseling for families on appropriate coping, as well as on positive patterns of communication among family members. To realize these, nurses might conduct home visits, build relationships and trust, and provide information via online media, particularly during the COVID-19 pandemic in the current day-in which limitations and impacts on daily conduct on family have been detected. This is evidently supported by the fact that in all 3 families in the case study, family members rarely brought the pregnant adolescent member to antenatal care, as they had no time and needed to work for more income to meet the higher expenses. Health services thus need innovation and good intervention guidelines of health services in accordance with life conduct and limitations shared within the family, with the aim to ensure good health of the family as a whole system and with continuity of care consistent with family developmental stage.

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